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10 August 2011

Dr. Ian Holland,
Committee Secretary,
Community Affairs References Committee,
The Senate,
Parliament House,
CANBERRA. ACT. 2600

Email: community.affairs.sen@aph.gov.au

Dear Dr. Holland,

REVIEW OF THE PROFESSIONAL SERVICES REVIEW (PSR) SCHEME

The Medical Indemnity Protection Society Ltd. (MIPS) is a "not for profit" discretionary mutual and parent company of the MIPS Group that includes a wholly-owned subsidiary **MIPS Insurance Pty. Ltd.,** an APRA regulated general insurer providing medical indemnity insurance to MIPS members.

MIPS is a membership organisation with approximately 30,000 health care practitioner and student members.

MIPS' principal activity is to provide medical indemnity cover for its members.

The MIPS Constitution requires it to promote honourable and discourage irregular practice and to consider, originate, promote and support, or oppose legislative or other measures affecting members.

MIPS welcomes the opportunity to provide comment in relation to this review. We believe it is important to ensure that those providing services that attract a Medicare benefit do so appropriately. That assurance is essential if the community is to have confidence that the benefits of health expenditure are maximised and that potential waste of health funding and possible risk to patients through inappropriate provision of health services is minimised.

In summary, MIPS believes that additional measures need to be introduced to improve the current PSR scheme. These relate to:

- Transparency
- Fairness/natural justice
- Timeliness/efficiency
- Accountability of stakeholders.

MIPS also proposes that the Professional Services Review Scheme legislation is amended so that it is clear that the Australian Health Practitioners Regulation Agency (AHPRA) is the only agency that can determine whether a health practitioner has engaged in inappropriate clinical practice. That is because AHPRA's role is to ensure that the public is protected and it is best placed to consider issues of appropriateness of practice.

That change would permit the PSR Scheme to focus its resources on issues relating to the Medicare benefits paid in relation to services provided and ongoing access of health care providers to Medicare benefits.

Context

Under legislation the object of the Professional Services Review Scheme is stated as "*... to protect the integrity of the Commonwealth medicare benefits and pharmaceutical benefits programs and, in doing so:*

(a) Protect patients and the community in general from the risks associated with inappropriate practice; and

(b) Protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice"

There is a widespread perception that the PSR Scheme appears focussed on (b). We believe that there would be significant benefit in ensuring that stakeholders appreciated that protecting patients is a primary consideration. That view would be reinforced if consideration of all issues of appropriateness of clinical practice were referred to AHPRA and by regularly providing appropriate educative material to stakeholders about the risks that specific inappropriate practice poses for patients.

We anticipate that increased transparency of the drivers of PSR Review will be helpful and constructive for all stakeholders.

An area of concern is the developing tension between what might be described as conservative or gold standard clinical practice and a perception of health care providers of endeavours by Medicare and use of the PSR scheme to reduce the cost of Medicare benefits paid.

There appears to be an ongoing disconnect between the primary driver of the PSR Scheme to *"Protect patients and the community in general from the risks associated with inappropriate practice"* and the secondary driver of *"Protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice".*

The following is an example of the untoward consequences that can be anticipated if the focus of the PSR Scheme is primarily on (b) rather than (a).

In general terms best practice for a skin lesion thought to be malignant is excision with the specimen sent for pathology for confirmation of diagnosis and clearance margins. By ensuring that a malignancy is not missed many lesions that are excised from patients by their doctors might be found to be benign on histological diagnosis. That observation, in retrospect, should however not provide a reason to pressure practitioners to take a chance with patients' health by requiring a higher risk approach ranging from "wait and see" or presumption of non-malignancy and/or ablation of lesion without histological diagnosis, or taking a biopsy sample that may not be representative of the lesion and will not be curative.

In this example the "savings" in Medicare costs from doctors not undertaking their preferred course of conduct may be significantly outweighed by patient morbidity and mortality as well as the added indemnity costs from the resulting increase in significant adverse outcomes. It should be remembered that such outcomes will in turn put further pressure on health service costs. In our experience the costs of an average missed melanoma claim, (such costs being required to be met from health care dollars via the provision of health services), are greater than the Medicare costs that would be incurred by undertaking several thousand excisions including consultation and histopathology costs.

Increasing clinical risk to patients is not the intent of the legislation and therefore we strongly believe it is inappropriate to use the PSR process as a means of reducing costs if that increases the risk to patient health and subsequently increases the risk of litigation to practitioners. Litigation is a wasteful and inefficient use of health care funding. We believe the wider community needs to be informed of the tensions that can develop between health care affordability and potential risks and benefits of introducing measures to reduce costs. Only in that way can the community debate such issues to form a view that ultimately is implemented through their elected representatives.

We also understand that there is currently a strong and widely held belief that if rather than the approach outlined above the practitioner refers the patient to a specialist for excision of the lesion, that there is little likelihood of PSR censure despite higher overall Medicare costs and additional costs to the patient.

Fairness

We are concerned that there continues to be a view held by many General Medical Practitioners (GPs) that the Medicare audit and PSR processes are directed primarily at them.

That perception has a historical basis but also appears fuelled in part by a lack of visibility of monitoring and audit processes undertaken of other health care professionals. The relative lack of transparency of those processes does not help moderate an entrenched view held by many that the PSR is there to get GPs.

Regular communication by Medicare outlining Medicare's proposed initiatives applying to the whole spectrum of health provider groups should be encouraged.

Historically GPs were the first group targeted and the view that many GPs hold - that they remain the primary focus of Medicare/PSR attention - is unfortunately reinforced in a number of ways.

For example, in the wording of the Regulations *"Health Insurance (Professional Services Review) Regulations 1999, Regulation 10, Part 3,* ***9 Practitioners affected by these Regulations ...*** it lists *(a) general practitioners; (b) other medical practitioners rendering professional services".*

We are unaware of why general practitioners should remain separately mentioned rather than included under all medical practitioners, i.e. as *"medical practitioners rendering professional services".*

In our experience it is rare during the PSR process for supportive reports obtained from independent parties to be referred to, or considered alongside, any adverse reports. Such behaviour is not consistent with promoting perceptions of fair, open and impartial conduct and undermines confidence in the PSR process which is currently regarded by many as highly partisan.

A consequence arising from not being perceived to provide balance and fairness is that the very small number of practitioners who are found through the PSR process to be at the more flagrant end of inappropriate practice may be given undeserved benefit of the doubt by colleagues because of the wider perception of apprehended bias of execution of the PSR process.

Timeliness/Efficiency

The current PSR process requires significant investment of resources from all stakeholders. We believe that the current process provides opportunities to improve efficiency and more timely intervention to achieve better outcomes for all.

The timeframes for PSR review matters (that may consider Medicare services over the previous two years), may take years to resolve. We do not believe that is fair nor appropriate and is especially punitive if no or only innocent transgressions are found.

In our view uncertainty must be avoided through strict adherence by all parties to set review timeliness. All matters should therefore be finalised within 12 months from the date of Medicare notification to the Director of the Professional Services Review.

Health care professionals should be able to regularly compare their practice profile with that of their craft group rather than being made aware that their practice varies significantly from their peers "after the horse has bolted". Similarly, practitioners should be able to regularly check whether they have breached or are likely to breach any statistical trigger such as the "80/20" rule. In that way practitioners will be in a position to consider the variances and reflect on the reasons for such variation at the earliest opportunity as unusual trends start to develop.

We suggest that the best means of providing such insights is to provide appropriate on-line access for practitioners so that they can regularly check how their Medicare billing statistics compare against the various potential triggers.

Such an approach would significantly improve transparency and perception of fairness; will help prevent inadvertent breaches and is expected to result in a significantly more efficient PSR process.

We also recommend that:

- Medicare introduces a practice of issuing appropriate generic system generated letters to advise individual practitioners when any material variance (from their peers) is detected or when they are nearing some other statistical threshold (such as the 80/20 rule). Such communications will inform the practitioner that their practice is different and allow that practitioner to consider the reasons for such variance and act where appropriate.
- The PSR process should provide for more exit/resolution points especially at the Committee stage. Issues should be brought to a practitioner's attention at the earliest opportunity and more resolution/process exit points should assist earlier finalisation of matters.

Such early intervention will allow Medicare and PSR resources to be used more efficiently (rather than entrenched in lengthy and detailed examination of individual matters where there is a risk of escalation of commitment/reluctance to discontinue because of the time and resources invested) and reduce the likelihood of practice variances due to innocent causes (such as use of reasonable but less appropriate item numbers).

Such an approach should also help reduce the financial burden on practitioners where repayment of Medicare benefits is required as matters will be nipped in the bud.

Contemporary Craft Specific Practice

MIPS believes that health professionals engaged in the PSR process as Committee members should hold appropriate contemporary craft specific practice for the practitioner under review.

That is especially important in light of the subjectivity that the definition of inappropriate practice involves:

(1) A practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that:

- *(a) If the practitioner rendered or initiated the services as a general practitioner – the conduct would be unacceptable to the general body of general practitioners; or*
- *(b) If the practitioner rendered or initiated the services as a specialist (other than a consultant physician) in a particular specialty – the conduct would be unacceptable to the general body of specialists in that specialty; or*
- *(c) If the practitioner rendered or initiated the services as a consultant physician in a particular specialty – the conduct would be unacceptable to the general body of consultant physicians in that specialty; or*
- *(d) If the practitioner rendered or initiated the services as neither a general practitioner nor a specialist but as a member of a particular profession – the conduct would be unacceptable to the general body of the members of that profession.*

Use of retired and/or non-craft specific practitioners as members of a PSR Committee and/or in providing advice to the Director may reasonably be perceived by practitioners as unfair and inappropriate. It also creates doubt as to whether legislative intent is being met.

We recognise that obtaining best "craft specific" fit may be difficult at times, and in some situations nigh impossible, however with increasing super/sub specialisation amongst General Practitioners and other health care practitioners, failure to do so will lead to poor decisions and further erosion of confidence of practitioners in the system.

The Australian Health Practitioners Regulation Agency has increased the range of recognised "specialist" practitioners to reflect that ongoing trend of super/sub specialisation. It is obvious that the practice profile/pattern of clinical services of a GP providing a skin cancer practice will be different to a GP conducting a sports medicine practice and different again to a GP providing counselling services. That increase in numbers and proportion of practitioners super or sub specialising will have significant implications for the statistical filters that we understand are applied by Medicare to service provision. It is important that those developments are recognised and addressed. Failure to do so will also further undermine confidence in the PSR Scheme.

The definition of inappropriate practice currently relies on a statistically unsound subset of the general body of the profession (to which the person under review belongs), being members of the PSR Committee considering the issues. To objectively test whether the conduct which is the subject of the PSR process is *"unacceptable to the general body"* of similar practitioners would require polling of that general body on the issue. A similar approach would also be required to objectively confirm whether the Committee did reasonably conclude that the conduct is inappropriate. Such an approach is unworkable. We do speculate however that where there may well be many other practitioners in the general body involved in similar practice, that is of concern to Medicare and undergoing PSR, the application of the current definition may be less certain.

We believe that the current framework can be improved in a flexible manner to provide a higher and more objective level of confidence amongst stakeholders that a PSR Committee does comply with the *Health Insurance Act, Part VAA The Professional Services Review Scheme* legislative requirements.

Similar to being called up for jury duty we recommend that there is a role for the various colleges/societies and interest groups to be called upon when a Committee is formed. Under our proposal it would be up to such groups to put forward a number of practitioners appropriate for the role at that time. That process would allow fresh consideration of appropriateness of members of a PSR Committee rather than relying on potentially stale or static lists of panel members that may include non-current, non-craft specific practitioners.

We believe that engaging those no longer involved in contemporary practice is unlikely to safely meet the requirements of the legislation in respect of determining inappropriate practice and therefore recommend that only those currently in practice should be involved.

Without the benefit of similar contemporary craft specific experience we do not believe that it is reasonable for a PSR Committee to *"... reasonably conclude that"* a practitioner has engaged in inappropriate conduct.

Support regarding PSR process rules should be provided to such contemporary craft specific practitioners who are members of the PSR Committee by a PSR scheme secretariat rather than relying on practitioner members to hold extensive and intimate knowledge of administrative review proceedings.

Accountability

Healthcare practitioners who are investigated may also be referred to AHPRA and face other sanctions. Adverse PSR findings have the potential to cause great distress for subject practitioners and can result in disastrous relationship, reputational, health and financial consequences.

For that reason the PSR Scheme needs to maintain appropriate transparent checks and balances to ensure that process and outcomes are fair and timely and seen by stakeholders to be so.

Such checks and balances should include appropriate annual independent quality assurance and audit of PSR processes including review of compliance of stakeholders with relevant legislation and regulation as well as considering the appropriateness of Committee members and their appointment processes.

The results of such annual reviews should be made available publicly to help promote the aims of transparency and fairness of process and facilitate ongoing improvement of the PSR processes.

In that way potential issues and unintended outcomes may be addressed early and health care service providers who come before the PSR will have greater confidence in the process.

A different model

As outlined earlier in this submission our view is that part (a) of the object of the Professional Services Review Scheme *(a) Protect patients and the community in general from the risks associated with inappropriate practice;* is not promoted nor seen by health care providers as the primary reason for the PSR Scheme, rather *(b) Protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice* is seen as the primary goal.

We also observe that the objective of (a) is met through the operation of the Australian Health Practitioners Regulation Agency. It would seem that the current review of the PSR Scheme provides an opportunity for recasting the PSR Act and processes to more appropriately reflect the current focus on cost recovery. That could be achieved by leaving it to AHPRA to determine whether to investigate and form a view if the practice undertaken by a health care practitioner is clinically inappropriate.

Where there is no concern of inappropriate clinical practice (requiring AHPRA consideration) the PSR framework should permit more streamlined processes for recovery of benefits for example in relation to billing irregularities. We suggest that where there is a resolution agreed between health care provider and Medicare, subsequent referral to AHPRA in relation to the issues under consideration should not be allowed.

Removal of the risk of double jeopardy (of PSR process and referral to AHPRA) is likely to lead to more efficient, timely and commercial resolution of those matters not relating to irregular clinical practice.

I am happy to discuss further any of the points raised in this correspondence.

With kind regards,

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is a Doctors for Doctors, "not for profit" organisation that provides membership benefits to over 30,000 members.