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Committee Secretary
Senate Standing Committee on Community Affairs
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Dear Sir/Madam

REVIEW OF THE PROFESSIONAL SERVICES REVIEW SCHEME

Please find enclosed my submission for the abovenamed Senate Inquiry.

I have prepared this submission as not only a concerned member of the community by also as an individual with a unique perspective of the healthcare industry.

For 20 years I have been the Chief Executive Office and owner of Health and Life, an accounting, taxation and consultancy firm specialising specifically in the provision of services to the healthcare industry. Whilst our focus is primarily on general practice, we have advised a broad range of clients operating within the public and private healthcare spheres including hospital, allied healthcare providers and specialists Nation wide.

Although we are advisers to doctors and practice managers, Health and Life was established and continues to operate with a view towards improving patient care, access and individual patient and provider empowerment through education.

I thank you for the opportunity to provide this submission to the Committee: it is a culmination of my 20 years of experience in the healthcare industry.

Yours faithfully

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Review of the Professional Services Review (PSR) Scheme

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Who Are We?

We have operated nationally for 20 years and see ourselves as patient advocates in the healthcare system.

We provide taxation, accounting and healthcare consulting services to the healthcare industry across all disciplines, but primarily to General Practices. I have worked with and advised over 1,200 practices nationally including major public hospitals and after hour clinics with significant private practice arrangements. Our clients have come from all over Australia: from Hobart to Humpty Doo.

My personal experiences and circumstances developed my interests in the healthcare industry and led to me establish the practice as it is today.

While working at KPMG as an auditor I had a motor vehicle accident in 1984 which lead to nine operations. I did receive a high quality of care at the time but also felt that some services were not necessary. As a result of my experiences, I do share similar concerns the Professional Service Review Committees have in relation to over-servicing and have a low tolerance to this sort of behaviour.

Following my recovery from my accident, I established my own national accounting and practice management consultancy firm specifically catering to the needs of General Practices, specialists, allied health providers and hospitals. Since our establishment we have serviced over 1,200 clients. Apart from being a registered tax agent, I have a broad range of experience in the following areas:

- Served for over 10 years on the Australian Association of Practice Managers (AAPM) (www.aapm.org.au)
    - National and State Boards and special purpose committees whose members work in the healthcare industry across all healthcare disciplines in the primary and tertiary sector as practice managers and consultants.
    - I am the national chair of AAPM's Certified Practice Manager education program.
- I have worked as an Australian General Practice Surveyor for 10 years.
- I have also worked as the national financial analyst for the National Primary Care Collaborative in relation to their longitudinal study into general practice. My report was fully accepted in relation to building General Practice multi-disciplinary capacity, setting national access benchmarks that reduce patient waiting times without compromised patient access to quality care.

I am also active in the media and public speaking circuits including:

- National public speaking circuit to healthcare practices supported by many healthcare associations including AAPM and the Australian General Practice Network.
- Medical Observer promotes me as a go to person for doctors to enquire about any practice management issues practices may have. This national magazine is circulated weekly to over 20,000 doctors a week.

This year we were recognised by the South Australian 2011 Telstra Awards, taking out the Small Business and Socially Responsibility categories. We are currently National Award Finalists in these two categories, to be determined at the end of August.

Our interest in this Senate Enquiry is due the following:

- We have experienced a growing number of enquiries over recent years from our clients and practices generally, regarding MBS item numbers and the audit and prosecution process
- We have been involved with one practice who recently been the subject of a Medicare inquiry. Our first hand experience in relation to the conduct of the Medicare staff at a local and national level was very concerning. I was alarmed at the process and how easily the audit procedures are open to abuse.

After our encounter with Medicare investigators, I discussed their procedure with the Australian Tax Office and confirmed they do not operate in a similar way. This matter has fuelled my interest to ensure due process is being adhered to. In particular the question of why Medicare has chosen not to adopt processed and procedures already developed by other Government agencies such as the Australian Tax Office is of great interest to me.

Most importantly, we have prepared this submission in the public interest of all Australians who want better and more equitable access to a healthcare system that is sustainable and socially responsible. We do not own any interests in any healthcare practices and do not have any intention to do so. We are advisers to many healthcare practices across Australia and feel compelled to provide an account of our experiences as such to the Committee.

Our key focus is on better consumer health and financial literacy programs where patients are empowered to take greater ownership of their care and providers are empowered to deliver this care without unnecessary fear of retribution. I believe that have the capacity patients should be encouraged to shift away from self entitlement to personal ownership. This should be the Governments ultimate healthcare objective. More effective mutually beneficial provider and consumer self regulation programs that are equitable transparent and open is critical in guiding the profession, patients and the community towards better health outcomes.

Reasons for making this submission

The Medicare system requires improvement in the following areas:

1. Legal Scope – ensure the legislation and or activities are not operating outside the Australian Constitution and their terms of implied and express authority. In particular healthy competition, equity, transparent and open rules, freedom of choice and innovation must be preserved in order to run a sustainable and socially responsible healthcare system.

2. Detection systems are poor – no red flag early warning systems appear to exist with appropriate support mechanism. The present system is punitive, intimidating and esoteric by nature. No effective reception desk audit trail or integrity measures are in place to ensure unauthorised billing does not occur.

3. Overzealous audit culture and poorly trained staff provide inconsistent verbal advice – we consistently hear complaints from practices across the country regarding audit staff. This includes but is not limited tooverzealous investigations to the point where healthcare professionals are placed in a position where they are not accorded simple rights such as reasonable notice of investigations and the right to seek advice (legal or otherwise) before handing over information requested by auditors. Our overall experience in such matters has been that there appears to be a presumption of guilt where a doctor or General Practice is required to prove their innocence.

   Nationally Medicare staff appear to be inadequately trained; we have regularly been provided with conflicting verbal advice by call centre staff who are reluctant to commit to providing a clear explanation in writing. On many occasions' it is up to the provider to assess the appropriateness of item numbers and documentations required and not Medicare which pushes the same issue back on to the provider without any clear guidelines.

   At times, our clients have sought advice from Medicare on the interpretation of MBS item numbers. This advice commonly includes much buck passing, often to many people, within the Department and sometimes over several weeks. Meanwhile, reception staff and practice managers are expected to make decisions with respect to which MBS item number is appropriate within minutes, if not seconds while a patient stands frustrated at the front counter. This places practices in an impossible situation: either charge a large gap to the patient or do not bill certain MBS item numbers at all and lose money for time spent and services rendered in an attempt to reduce the risk of an audit inquiry.
4. Ineffective Education program – no effective or ongoing provider and practice staff training programs. They either do not exist or are not readily accessible, the Medicare newsletter published monthly does not delve deeply enough into the issues and concerns experienced by practices.

5. Prosecutions appear to lack due process and are intimidating – the conduct of what appear to be fishing expeditions, demands for information leading to entrapment and the apparent disregard for principles of natural justice. Investigations, audits and prosecutions are expensive to fight, often leading to early confidential settlements. The lack of transparency leads to poor or no public healthcare policy debate. Currently a consultation process of limited

effectiveness exists. Issue are addressed at the discretion of Medicare based on its own policy directives.

6. No Accountability - no organisation accepts responsibility for the Medicare Benefits Schedule interpretations. Prosecutions do not appear to be open, equitable and transparent. The Professional Services Review (PSR) does not publish the rules governing their process and procedure in a timely, clear and transparent manner. The PSR do not appear to be accountable for their actions and decisions. There appears to be no clear incentive for Medicare to resolve issues quickly, leading to matter being referred higher and higher within the Department for weeks and months, on some occasions with no resolution. Often the only way to resolve such matters is to give up. We have also experienced situations of Department heads intentionally cherry-picking which queries they want to answer and ignoring inconvenient questions.

7. The PSR's role is unclear – The role of Government in healthcare is becoming blurred. The Government is attempting to make clinical judgement calls that is beyond the role and scope of Government.

8. No natural and efficient patient empowerment or engagement. While healthcare is provided for free, patients do not have the incentive to determine whether they are receiving value for money.

9. Without a stable, uniform and understandable healthcare system succession planning in the healthcare industry is at a real risk as healthcare professionals either chose to not engage in high risk activities such as practice ownership or leave the profession altogether, leading workforce shortages. The current Medicare and bureaucratic system is a primary cause of this problem, as research discussed in the article attached at Appendix 2 shows. The direct result of this, being the lack of access to healthcare in the community. Without logical and sustainable healthcare reforms in this area, we believe the Nation's productivity economic development are at significant risk.

Due to our specialisation in the industry in the provision of services solely to the healthcare industry, we have seen evidence of several alarming trends outlined below. We believe these occurrences are a direct result of the lack of transparency of the process and decisions of the PSR and Medicare and have recently been considered at length in the decision of *Tisdall v Webber* [2011] FCAFC 76 and *Kutlu v Director of Professional Services Review* [2011] FCAFC 94.

1. To ensure economic certainty and avoid attracting the attention of Medicare and the PSR practices will reduce bulk billing
2. Practices are cautious to adopt Government sponsored healthcare initiatives and programs e.g. specialisation in areas of chronic disease may attract an audit if outside the normal distribution curve
3. Reduction in high quality and cost effective speciality clinics as specialisation often leads to the perceived over-use of certain MBS item numbers often leading to practitioners being unfairly targeted for audit activities
4. Healthcare innovation is stifled due to healthcare professionals' perceived inability to become specialised in various fields
5. Recruitment and retention of doctors and succession planning are at risk due to economic uncertainty. This is an issue as Medicare payments can now be clawed back up to 2 years if

an inappropriate claim is made in relation to systemic error that fails early detection. Currently Medicare has no effective education or competent early warning system in place to prevent such occurrences for example invalid specialist referrals.

6. Medicare is not seen to be addressing its own short comings as the same issues have persisted over two decades.

We do not condone over servicing or the inappropriate practices in which a minority of doctors take part. We do however express concern for the lack of transparency and openness of process as well as the apparent inequity in policies leading to overzealous behaviour by auditors, as has been recently reported in the press. We argue these practices fail to provide natural justice to those who must submit themselves to the tyranny of Medicare and the PSR in order to maintain their livelihoods., Please see Appendix 1: Health and Life News Alert, published on 1 July 2010 by me, in an attempt to explain the, then new, healthcare board registration rules to our concerned clients, which have significant PSR implications.

No implied or explicit accountability measures appear to apply to Medicare in terms of responding to concerns raised by practices on a timely or accurate basis. We believe this is leading to unfair prosecutions in areas of compliance as the Medicare rules are not clear to Medicare staff, Medicare systems do not have appropriate early warning and/or educational systems to prevent fraud.

Most importantly Medicare do not accept responsibility for the interpretation of the Medicare Benefit Schedule. However, in our experience, Medicare has no hesitations to enforce the MBS.

Addressing Your Terms of Reference

(a) The structure and composition of the PSR

(i) criteria for selection of the executive and constituent members encompassing their experience in administrative review proceedings

The criteria are broad and do not demand medical skill or expertise of panel members

Under the *Health Practitioner Regulation National Law Acts*, enacted by the States on 1st July 2010, cases of inappropriate practice prosecuted under *Health Insurance Act 1973* can be referred to the PSR. This is extremely important because the powers of the PSR are even broader and the potential consequences far greater than breaching the *Health Insurance Act 1973*.

A provider can face the ultimate and most intimidating penalty of deregistration. Without appropriate due process, openness and fairness of proceedings natural justice and a fair hearing would not be possible under the *Health Insurance Act 1973* or the *Health Practitioner Regulation National Law Acts.*

I refer to *Health Practitioner Regulation National Law Acts* as it sets the tone of public policy making which I believe is not in the public interests. The legislation gives unfettered and unrestricted powers to the Board. In particular, I refer to the numerous Federal Court decision recently made against the PSR, most notably for reasons of being improperly constituted. This only highlights a new set of unprecedented problems being created in a new area of law that is directly integrated with the *Health Insurance Act*.

The concern is that PSR matters can be referred to this agency for prosecution poses a problem because this agency has the power to prosecute and deregister providers without evidence. I consider that this creates an opportunity for intimidation and bulling tactics to be used in order to secure a settlement or an admission of guilt. This agency is even less accountable and more powerful than the PSR and can have the same if not more damaging consequences for the community than the PSR. Patients' health and welfare are at risk in this environment.

Under the *Health Practitioner Regulation National Law Acts*, the criteria for appointing an inspector, set out in sections 81 of the Acts, is very broad and does not require any would-be inspectors to possess specialist knowledge, experience and integrity we would expect an inspector who refers matters to a panel for review. As a result of this, I would argue it is likely matters can be referred for review unnecessarily.

Please refer to Appendix 1 to illustrate this point.

The new *Health Practitioner Regulation National Law Acts* serve as an umbrella law to the *Health Insurance Act. The attached* article at Appendix 1 clearly demonstrates the poor standard and expectations of the prosecutors that appears to be echoed in all related legislation.

The legislation does not prescribe a minimum level of skill or expertise this is of grave concern as this new powerful overarching law give the PSR authority to make decisions that have serious economic, social and professional implications on healthcare providers including doctors, nurses and allied health providers, the pinnacle of which is the ability to take away their licence to practice. In our view this not only destroys the

lively-hoods of individual doctors without the accord of natural justice, but also denies access to healthcare by reducing the number of healthcare professionals available to the community.

We do not propose that providers that engage in unlawful or prohibited practices should be left to continue to practice as they do, however, any investigation processes should be based on the following:

- Procedure and process should be open, transparent, understandable and accessible to those who have the rules applied against them.
- The application of rules should be in accordance with principles of natural justice.
- The rules should be open, transparent, understandable and accessible so as not to discourage new provider from entering the profession or currently practicing doctors from exiting.
- If rules are enforced against a practitioner suspected of unlawful or prohibited conduct, this should be done in accordance will well established legal principles and in a manner that is cost effective (both to the taxpayer's purse and the practitioners).

Natural justice rules based on evidence is not required and they can make up the rules

For example section 185 of the Queensland Health Practitioner Regulation National Law Act, (similar provisions have been passed in all other states) Procedure of panel states:

> (1) Subject to this Division, a panel may decide its own procedures.
>
> (2) A panel is required to observe the principles of natural justice but is not bound by the rules of evidence.

This leaves the whole process as well as prosecution open to interpretation. Without the right checks and balances this leaves the integrity of the legislation open to abuse and intimidation as has been alleged against the PSR.

(ii) the role of specialist health professionals in assisting in cases where members lack relevant specialist expertise

Once again we refer to *Health Practitioner Regulation National Law Acts* and to Appendix 1 which illustrates this point.

The national board can appoint inspectors with no minimum requirements of experience of education.

Section 239 of the Queensland Health Practitioner Regulation National Law Act *Appointment of inspectors*

> *(1) A National Board may appoint the following persons as inspectors—*
>
> *(a) members of the National Agency's staff;*
>
> *(b) contractors engaged by the National Agency.*

The Health Practitioner Regulation National Law Act does provide for a medically qualified person to inspect records; however this does not mean they have the necessary skills to bring a case together like the Inspectors referred to above. Potentially unnecessarily expensive cases are being called into

question due to the lack of specialist expertise that may be required or not available on the day. This has the potential to turn any prosecution into a long and drawn out process to due ignorance. For example, we are currently assisting a practice in dealing with a matter where the auditor does not understand basic commercial principles related to price-setting and is seeking to cherry pick their arguments by selecting and reviewing information in isolation from commercial circumstances.

(iii) accountability of all parties under the Act;

Prosecutions are implicitly not open or transparent

A lack of openness and transparency opens prosecutions to administrative abuse.
Once again we refer to *Health Practitioner Regulation National Law Acts 2009* and to Appendix 1 1st July 2010 National Healthcare Provider Rules this article illustrates this point. Specifically quoting the Act:

***Section 189* of the Queensland Health Practitioner Regulation National Law Act**

A hearing before a panel is not open to the public.

When serious offences are being committed have can any system be open, equitable and transparent when a public hearing is being denied? The option to have a publicly open hearing should at least be given to a provider under review. Without this option we believe abuse of authority is inevitable.

PSR and the Government's role is outside their legislative authority and is duplicative

Parliament cannot interfere in the doctor patient relationship

The Government are given no express or implied power to interfere in the doctor-patient relationship. This was expressed by the High Court in the case of *General Practitioners Society v Commonwealth* [1980] HCA 30.

> *"Gibbs J delivered the leading judgment. His Honour reiterated the principle that there is no explicit head of power under which the Federal Parliament can regulate private medical practice, in the sense of the physician–patient relationship."*

Source: Danuta Mendelson 'Devaluation of a Constitutional Guarantee: The History of Section 51(XXIIIA) of the Commonwealth Constitution' (1999) 14 *Melbourne University Law Review* available at http://www3.austlii.edu.au/au/journals/MULR/1999/14.html#Heading46

Section 51 (xxiiiA) of the Commonwealth Constitution was inserted following the successful referendum of 1946. The Constitution only allows for the Commonwealth to make laws in relation to paying doctors for their medical services. This power supports the Commonwealth operating the Medicare program, but not the entire Australian Health System. It certainly does not support the Government, be it via Medicare or another body, dictating the terms of doctor-patient relationships.

We note that the rules of natural justice do not have to be complied with in the act. To the contrary the High Court recognises that bikie gangs and Illegal immigrants have more rights than healthcare professionals. See Appendix 1 1st July 2010 National Healthcare Provider Rules

We note existing consumer and common law rules exist to protect patients such at the powerful *Competition and Consumer Act 2010.* Once again, these laws are duplicative and wasteful as they

seek to replicate already existing consumer protection in the healthcare arena. What the Government fails to recognise is that patients are already consumers and have recourse under the existing consumer protection legislation.

Existing consumer and common law exists to protect patients from clinically inappropriate practice and the conduct of the PSR duplicates these activities that are already well served by these other jurisdictions. Is this the role of the PSR it is not clear as the lines are being blurred. For example the PSR have recently attempted to prosecute a partitioner for ordering too many CT scans.

Medicare is an insurance company and not a healthcare provider. Their behaviour should not directly interfere with the access to care patients have without the patients implicit or explicit knowledge.

(b) current operating procedures and processes used to guide committees in reviewing cases;

It is concerning to note that recent Federal Court decisions are based on the evidence brought to it by the PSR. The PSR appear to subjectively determine a breach based on statistical analysis rather than actual evidence.

(c) procedures for investigating alleged breaches under the Act;

Fishing Expeditions

Given our unique connection with the industry, we have been advised by practices that they have received telephone calls from Medicare without advising clearly that any information may be used in future prosecutions against practitioners. In a number of instances we have been advised a friendly telephone chat with short notice given has been requested by Medicare. Practitioners are time poor and do not want to be seen not be co-operating with Medicare. Unknowingly they volunteer benign information, for example that they employ a practice nurse, not appreciating that this may lead to a full audit enquiry of chronic care item numbers. Not being aware of the full nature and scope of the enquiry leaves providers with a sense of entrapment.

Specialty Clinics

In the 1990's assisted with establishing a female doctors clinic only to find Medicare knocking on the door querying a high number of pathology tests were being ordered when compared to what a traditional general practitioner would order. As discussed above, this type of audit profiling and behaviour has led the profession to shy away from developing specialisations and efficiencies in areas that could be beneficial to the community.

Timing of Consults

Another example are practitioners who have geriatric patients that deliberately charge a standard MBS item B consult when the longer timed item C should have been charged. In these circumstances, practitioners

fear being outside the statistical norm and triggering an audit or investigation. This sort of audit activity only encourages shorter consults and/or the practice become less viable and does not make a sufficient profit to reinvest in practice infrastructure and training. In the long run, we do not consider this to be a sustainable practice and practitioners either have to bill or perish.

Audit Investigations

Our experience with auditors to date has been that they are reluctant to put their allegations in writing prior to a visit and are not clear about a providers rights and obligations. When asked directly, they are not able to provide specific references to legislating from which they derive their powers of investigation.

In a recent experience, we noted an auditor gave less than 9 days notice for a rural procedural practice to respond and flew from SA to WA for the face to face meeting at the practice. We became involved and requested the nature and the scope of the enquiry to be put in writing which at that point had not been clearly detailed to the practice. At the time we became involved in this matter, we posed specific questions to the auditor in charge of the investigation relating to the procedure and conduct of the investigation. We have for the last five months requested responses on four occasions in relation to this matter with no response from the new national General Manager of Medicare.

Rulings and Interpretations

The Australian Tax Office issue public rulings on a variety of tax matters, especially matters considered ambiguous and at a high risk of misinterpretation or perceived fraud. We find it unusual that given the apparent high incidence of fraud in the medical profession that similar rulings and interpretations are not reported by Medicare and are not included on the Governments website or in various education programs.

Furthermore many practice managers report an inconsistency in verbal advice provided to them by employees of Medicare with very little reference to any written rulings. Yet they stand accused for misunderstanding the said rules or interpretations that have not been published or circulated widely to practices and even their own Medicare advisers.

The publication of Medicare Benefit interpretations on line has been introduced in recent years. However, the information content is poor and does not address the numerous concerns raised in the PSR Annual report.

In our view ‘sledge hammer’ legislation could be avoided with a more effective and timely education program. We believe the most effective way to achieve this is though a collaborative effort between the PSR and Medicare to close this gap in education and deliver interpretations via the internet, phone line assistance and industry presentations.

For decades it appears the same issues continue to be raised with no clear answer from Medicare.

Medicare Public Relations

I do believe it is highly inappropriate to ask practice staff at public industry meetings to hand over confidential patient information to auditors without the practitioners consent. This should not be allowed

unless the practitioner has been given the opportunity to consider the consequences of and consent to this request. Patient records are private and confidential and both the practitioner and practice have a legal obligation to abide by these laws. At a minimum, we believe patients should be notified if their information is being viewed by anyone outside of the practice. How this is to be achieved without drawing unnecessary attention needs to be resolved.

(d) pathways available to practitioners or health professionals under review to respond to any alleged breach

There are no alternative pathways that do not encourage adversarial behaviour. Medicine and healthcare needs the opposite culture in order to progress like the airline industry where the same mistakes are not made twice. Issues and breaches should be fully investigated and resolved expeditiously without the blame game culture. The laws presume we as humans know everything there is to know about the practice of medicine and human health and that absolute rights and wrongs exist. This is clearly not so.

(e) the appropriateness of the appeals process

It takes too long and is too difficult and expensive to defend oneself.

(f) any other related matter

Support Community based Cultural Change that is not based on self entitlement

Support cultural change by providing health and well being education programs with good role models and clear explanations of the consequences of poor health decisions targeting providers and the public media. The financial consequences of ill health are poorly understood, however with greater awareness this is the easiest thing for people to understand and respond to. When you have this you have an engaged patient and not a self entitled one.

The unemployment rate is currently hovering at 5% which suggests that most Australian citizens can afford basic healthcare. It is just not a priority. More people are aspirational about their financial security than health. This attitude needs to change so it is given equal importance. Patients are more willing to spend $5 on a chocolate muffin that can kill them over time through obesity than on their local GP who could save their life. Patients should consider a small $20 patient gap as a speeding ticket. I have previously made public statements of this nature to a number of community groups and after the initial anger, this notion was well received.
For many people health is not a priority until they are sick. It is not valued because it is perceived to be a human right. These well intentioned policies at times are intellectually flawed as there is no discernable pricing mechanism where patients are forced to consider the value proposition of the services they are provided. Patients need to take mutual ownership of the issue. To have skin in the game, starting at the hip pocket is a simple way to get their attention and improve the system.

This should lead to better health outcomes and reduce many claims of over servicing. There is a safety net for the needy so this is not about fleecing patients for more money. The problem is people will not think twice spending $200 on alcohol and cigarettes on a Friday night but will seriously lament spending $20 on their local GP – this is the social attitude we seek to address.

Ultimately it should not be seen as the taxpayers' responsibility to fund lifestyle diseases that are the result of consumer choices. People should be free to make whatever lifestyle choices they deem appropriate for them, even if their choices are harmful, however the taxpayer should not be expected to pay for this.. There is no incentive or disincentive for doing the right thing. A new social healthcare policy message needs to go out like the pension message.

Over time this expensive acute "lifestyle" care money should be re-directed to healthcare programs where ill health is not due to poor choices. Patient and gate keeper provider education programs would represent a better allocation of resources.

Succession planning, workforce shortages, healthcare reforms and economic development are under significant risk.

Public policy uncertainty - sending the wrong public message doctors are rorting the system

A primary concern is the contempt with which the profession is dealt with in the public media in relation to a very complex issue.

Breeding Sub optimal and inefficient services

The Government spends a lot of well intentioned resources trying to encourage General Practitioners to engage in chronic disease management activities. The rules are often unclear and change approximately every two years which makes these initiatives unviable. From our experience in the industry, it generally takes a practice one to two years to set up a new service delivery system and infrastructure to make these service available to the community. This consequently leads to significant resource wastage. Then when a practice is seen to be outside a traditional GP's Medicare servicing patterns, they curb their activity so as to avoid an audit. This results in a sub optimal service because full time resources are used only half the time. When 85% of practice overheads are fixed, this results in many unviable healthcare programs that practices invest in. This in turn drives more services to cover the loss or completely shut down the service such as firing experienced nursing staff.

Practice sustainability – The corporatisation and commoditisation of healthcare

To add insult to injury for practice owners who want to sell their practices, because the practice struggles to remain profitable, nobody will pay a fair price for it. For the self–employed, their business represents their "9% employer superannuation" nest egg.. Hence the business model for healthcare is lost and new infrastructure and services funded by the private sector are at risk. This burden is then left for taxpayers to shoulder which leads to more healthcare welfare such as the troubled GP Super Clinics program. It would be financially unviable for the Government to replace all practices with this sort of program. It is critical that private practice can survive attracting more private provider investment to meet the Nation's healthcare goals.

Currently practices are forced to become larger or perish. This can be a good thing if managed properly, however this requires significant private investment and solid governance and business training. Any Medicare uncertainty can wipe out such initiatives. By default this opens the door for corporate practices that have deeper pockets to play a major role. This is not an issue except their legal responsibility is to their shareholders and they are openly expected to put profits before patients. This can only force the commoditisation of the entire healthcare system, devoid of ethical principles where profit is paramount rather than patient wellbeing. This can only add to the over servicing

problem the Government now fears. This will fuel a greater disconnection between the provider, patient and these well intentioned Government initiatives.

Provider Exodus from Baby Boomers and Gen Y and Overseas Doctors

This can only fuel a provider exodus if there is a continued loss of confidence in the system. When each GP sees an average of 6,000 to 9,000 patients per annum this is a significant loss of community knowledge and care. This directly and indirectly impacts employers especially in mining towns which we have done a lot of work in.

Mines stop operating when the only GP's in town leave or are unavailable. Families will only move to towns where there is sufficient access to essential health infrastructure such as a family doctor. If they perceive there is a problem, young families will not establish themselves in these towns, workforce uncertainty for employers cause projects to be shelved.

We have been involved in negotiating a whole range of benefits from housing, travel, locum relief, ultra sound equipment, council and corporate support for local doctors. This issue is an extremely sensitive one and affects the very viability of towns and high growth outer metropolitan developments.

At risk Key Sustainable Communities – the mining industry

Roxby Downs in South Australia is a case in point. We have done much work in this area and in similar regions. It is a big issue if young miners and their families have to take a lot of time of work and suffer the unnecessarily inconvenience and high costs for travel and accommodation to fly to Adelaide to have their babies or to attend appointments.

In areas such as Roxby Downs many GPs are obstetricians and anaesthetists by day, orthopaedic surgeons and emergency workers by night dealing with crushed hands in conveyor belts where mines operate 24/7. Their hours are long and arduous with very little back up. Yet on paper due to their Medicare statistics being outside the normal distribution for a traditional general practice they can easily be accused of over servicing. I do worry we take so much for granted. Statistics do not tell the whole picture and the whole audit process is extremely stressful, time consuming and expensive to defend when the bureaucracy is slow to respond to requests and are not even clear on their own rules.

Workforce Shortages and Healthcare Reform Engagement at High Risk

It does not encourage the next generation to not only want to practice medicine but also to own a practice. This is important if a corporatised environment is something the Government seeks to avoid. If not, this is likely to fuel the growth of corporate practices who unwittingly promise naive doctors that they can escape the red tape. This is another myth as all breaches of health and consumer laws predominately target the provider and not the practice owner. This responsibility can never be shifted or sold off.

Why people do not want to the control the environment that gives them more control of their destiny is a perplexing issue. Instant gratification, apathy and ignorance tend to be the primary drivers that better final year registrar programs can deliver on. The Adelaide to Outback program which we have been involved with is a successful case in point. Registrars are told what to look out for before they join a practice.

Practice Ownership by Clinicians is the key to healthcare reform

It is critical for a significant number of doctors to aspire to own their practices, in order to protect and preserve the moral and ethical framework that patients and the community have come to expect of healthcare providers.

It is the difference in buying versus renting your home. It does make a big difference. People start to care about the garden, the painting and the cracks in the walls. It is no longer the landlord's problem. The same applies in healthcare; it shouldn't be the Government's problem.

When practitioners aspire to ownership they take a longer term view and are likely to invest in the social and health demographic issues that impact their local community. Engaging in the long term healthcare needs in the community and planning the health workforce and infrastructure with certainty is critical. This is because they feel empowered and therefore it is personal. People do not invest emotionally and financially when there is uncertainty. So any major Federal or State healthcare initiatives will be lost where economic uncertainty prevails. At the end of the day everybody needs to put food on the table until their bellies are full they cannot give on to others. I refer to meeting one's need and not greed.

A significant number of Generation Y are planning on quitting General Practice

Good role models are critical and for decades senior doctors frustration with General Practice bureaucracy is spilling over to the younger generation that is putting them off medicine.

A recent Sydney study revealed (that will be published in Australian Doctor before the hearings) that more than 85% of Gen Y doctors are likely not to continue in general practice. This is very concerning from a patient, community and taxpayer point of view. Any overzealous audit behaviour or red tape response will precipitate early, retirements alarmingly starting with Gen Ys. Alarmingly, increasing bureaucracy and GP Super Clinics account for 50% of the reason for young doctors quote as being obstacles to general practice.

Please refer to Appendix 2 for the full article.

Overseas Doctors are not the total solution

Overseas doctors are not the total solution. We have seen significant community anxiety over this issue.. The Patel and other high profile incidences involving overseas trained doctors has not helped to ease these anxieties relating to communication and culture barriers that exist. This will take years to resolve. I am acutely aware of this issue an my father and in laws were all overseas Indian trained doctors who came to Australia via the UK training program in the 70s.Premature retirement is a significant and permanent loss to the community that is difficult and expensive to replace. The fact is, the healthcare industry is a feminised workforce. Medicare data has shows that after the age of 30 many female GP's will drop out of the workforce for 10 years, many will not return or will work part time. So despite a high number of training places 65% are female graduates, many more need to be trained to replace the Baby Boomer workforce.

It takes a minimum of 15 years to train a doctor in Australia so they can feel confident to practice on their own. This void is currently being met by overseas doctors who take a little longer in understanding our rules, clinical and social cultures.

It is interesting to note the high number of non-Anglo doctors that have been prosecuted.

Thought Leadership and Education Makes a Real Difference

Public vilification and more rules is not the solution. Better provider governance, education and mentoring needs to be undertaken by the Government and practices such as practice managers. This can happen only when the Government rules are clear and their education programs can be used as template for understanding. They need to be open, transparent and equitable from day one.

Our ageing workforce is only compounding this problem, together with a reluctant Gen Y at the other end. This means as a community we are burning the candle at both ends. The candle is now also being burnt in the middle with these questionable audit rules and audit activity. It is sending the wrong tone and creating a new hidden crisis amongst the professions. A happy and self empowered healthcare provider is an enabler. It generates engagement which translates to a higher quality of care and therefore a happy patient. Yes they need to be accountable and patients should drive this agenda not Government.

To ignore this means we are breeding indifference and a lower quality of care as the goodwill and passion for medicine starts to run out. I do not think anyone wants to be treated by these doctors. Education of all stakeholders is the key. None one really has a complete understanding of our system. Until this is broadly understood can we then begin to solve the problem with a clear community and not just a financial or political end in mind. There is a positive and sustainable way forward.

Summary of Recommendations

Legislative

1. Review natural justice and equitable principles and are applied to their full extent.

2. Observe the Australian Constitution and ensure there is no interference in the doctor patient relationship.

3. Ensure the PSR observe Federal Court rulings; they are administrators, not law makers.

4. Establish and publish investigation and prosecution roles based on those adopted by the Australian Tax Office. All audit questions must clearly be put in writing in advance.

5. No verbal fishing expeditions should be allowed.

6. All rights and obligations must be detailed in writing. For example the right to consult an I adviser, legal or otherwise, must be provided. A clear statement from Medicare that any information provided is done so on the basis that self incrimination is not a permissible defence.

7. Self incrimination should be a permissible defence given Medicare fraud is a criminal matter.

8. Third party tip offs should not give rise to an audit investigation. Where clearly the credibility of the witness is in question cases should be dropped to prevent vexatious claims from competitors.

9. Sufficient time should be allowed to respond to inquiries. Depending on the severity of matters and charges being investigated up to 90 days in the first instance.

10. A lack of response should not constitute an admission of guilt.

11. Establish a Healthcare Ombudsman.

12. Establish a patient and provider rights and obligation charter.

Government and Healthcare Reform Policy

1. Investigate further by surveying practice staff and relevant bodies such as the Australian Association of Practice Managers in relation to Medicare systems and processes including appropriate training programs.

2. Delay all prosecutions until all necessary integrity measures have been reviewed.

3. Timely communication of quality and reliable information.

4. Ensure timely due process does occur this will reduce budgetary pressures.

5. Support self regulation and education and not more regulation.

6. Introduce a more effective provider and practice education and communication programs where the PSR works with Medicare staff to address concerns raised in the Annual PSR report.

7. Allow more free market solutions to prevail with an appropriate safety net scheme this is will ensure both providers and patients more judiciously take responsibility for each other rather than always leaving it up to the Government to provide a solution. Avoid unnecessary and duplicative "nanny state" legislation.

8. Practice staff should get provider consent prior to releasing patient information to auditors

9. Support freedom of choice that empowers patients and providers.

10. Support providers to innovate as well as provide the most cost effective and highest quality of care to patients. A healthy competitive environment not burdened with red tape will achieve this goal.

11. Support cultural change by providing health and well being education programs with good role models and clear explanations of the consequences of ill health targeting providers and the public media.

The Profession

1. Provide funding to allow relevant specialities to develop, interpret and educate their members on the Medicare Benefits Schedule.

2. PSR panels should be appointed by the relevant accredited Clinical Colleges responsible for training this includes the AMA if they represent the profession. For example a General Practitioner should be reviewed by the Royal Australian College of General Practice. An AAPM representative should also be appointed to any panel.

3. Clinical Colleges need to be accredited and undertake annual governance program. Independent accreditation of these bodies must occur to ensure appropriate appointments are being made including an annual governance education and compliance program for the organisation and its members.

4. Recognising continuing professional development points for attending Medicare education programs as part of the annual healthcare provider registration criteria.

5. Review whether the AMA may be conflicted in its role. There may be a perception it does not have clinical expertise in specialist areas and cannot represent the interests of the entire profession. We suggested that each specialty College should provide the AMA with written authority to represent their interests.

6. Promote and celebrate successful succession planning programs and role model practices that adopt a macro and micro view of the healthcare environment. It should encourage healthcare providers to remain aspirational about taking community ownership of local health care issues. Delivering a strong internal governance and mentoring education framework that recognises private practice participation in the public sector even by providing higher Medicare rebates should be considered to prevent private practice isolation.

Patients

1. Introduce a $20 patient co-payment system so patients will scrutinise their healthcare bill. Even if this means lowering Medicare rebates which is already happening by default as Medicare increases do not keep up with inflation. Over servicing occurs when this is a slow process, it will stop if it is a significant drop.

2. All patients must sign their Medicare forms. Integrity checks must be in place at a practice and Government level.

3. Patient should be notified their records are being accessed by anyone outside the practice.

4. Promote programs that engage patients with providers which reduces the need for third party interference in the consulting room.

5. GP patient gaps should be marketed as a speeding ticket and a warning that hospital bills are more expensive if they don't look after themselves now! The community needs to become aspirational about their health like their careers and wealth creation/financial security objectives. We need smaller hospitals and more community based preventative healthcare solutions.

Conclusion

I would like to thank the Committee for taking the time to consider by submission.

I am happy at the request of Senate Hearing Committee to present this paper in person to the Enquiry. Please advise if this is appropriate. We are aware of some of the submissions before Parliament. We do not seek to duplicate these arguments in detail but add our in principle support where applicable.

We know ill health breeds poverty and poverty breeds ill health. This is why health and financial literacy should be the primary objectives of any Government given that every aspirational society seeks to be sustainable. This can be achieved by using education to build a culture and not by more patronising rules and policing. This is the cheapest and most effective solution that promotes a freer society. Thought leadership and education is the answer.

APPENDIX 1

1st July 2010 National Healthcare Provider Rules

EXTRACT ONLY

CURRENT CIRCULATION: 7802

DATE: 22nd November, 2010

ISSUE NO: 174

Welcome to Health & Life's free email newsletter service. Tell a friend that we would be happy to add their email address to the distribution list. This service is to provide Health and Life's clients and those who attended our presentations with up to date information on key financial and Practice management issues that may affect your Practice. Please do not use this as a substitute to seeking professional advice.

Writer in charge: **Mr David Dahm BA.Acc, FCPA, FTIA, Ffin, FAAPM, GLFG.**

1st July 2010 National Healthcare Provider Rules!

Introduction

The new *Health Practitioner Regulation National Law Act 2009*, enacted on 1st July 2010.

This Act establishes a national registration body for the majority of healthcare workers in Australia. These include doctors, dentists, nurses and all allied health including pharmacists.

After reading the Act carefully, it is my interpretation that the new legislation has the potential to introduce by stealth a defacto Australia card plus many more onerous conditions on all healthcare providers and practices which can have significant consequences.

The Act effectively gags practitioners in closed hearings which may not be in the public's interest.

The legislation gives greater clandestine powers to the Government. It can significantly reduce privacy, access and affordability of healthcare services to patients. If a healthcare provider (such as a doctor) does not comply with these new rules, then he/she risks losing their medical registration and access to Medicare rebates. This is not an issue so long as the process is open, fair and transparent.

The new national laws:

1. Introduce by stealth a defacto Australia Card by effectively forcing patients and practices to submit information to the Government via conditional practice accreditation grants;

2. Create the potential for breaches to national privacy principles by allowing other organisations to access patient records without due process;

3. Threaten harsh mandatory reporting penalties, which are expensive and impossible to defend, if practitioners fail to comply;

4. Breach the Australian Constitution on four grounds:
    - Price fixing services;
    - Denying natural justice;
    - Legally a practitioner can be prosecuted without the need for any evidence; and
    - Allows for the interference with the doctor/patient relationship;

6. Introduce legislative teeth to gag providers from speaking out against decisions;

7. Fail to clearly identify the qualifications and skills of prosecuting inspectors;

8. Create an environment whereby a practitioner can be denied re-registration because their practice is not accredited. This potentially leaves a practice open to being sued for loss of earnings; and

9. Can discriminate against part time doctors, especially female practitioners on maternity leave.

This legislation if too onerous will lead to poorer health outcomes which unnecessarily increases the need for more expensive acute care hospital services.

Recent High Court Decisions - 11th November 2010

The new Board rules make it law that you can be prosecuted and gagged without evidence unless you are a Bikie Gang member or refugee. The recent 11th November 2010 High Court ***Bikie Gang and Refugee*** decisions undermine the integrity of the High Court. These healthcare laws have the same effect and can only undermine our confidence in the system.

Below is our interpretation of relevant areas of case, statutory law and healthcare standards to illustrate the points made above. I also draw on personal experience where providers have complained of bullying and entrapment in relation to recent Medicare Audits.

The writer does not condone over-servicing, but is concerned when a “sledge hammer” is used to crack the walnut of 1% of providers who abuse the system. The unintended and adverse impact of tarring all providers with the same brush is significant. Despite the Governments best intentions, the rules are un-Australian as they infer provider guilt and do not give the people who help us a fair go. They also presume patients and doctors are incapable of knowing what is in the patient’s best interest and a bureaucrat knows better which can only create a bigger divide that nobody wants.

Conflict of interest statement

We have no clients who are the subject of inappropriate practice. We are not financed by a law firm or any other agency. These comments are made out of our concern as members of the public which is in the interest of protecting patients. They are based on the writer’s 10-year experience as an Australian accreditation surveyor and 20 years working at the coal face of the healthcare system. We are happy to stand corrected on any matters raised in this document. We also encourage readers to challenge the Government and ourselves on issues raised. To our knowledge many of these have not been raised in the media and/or there is little awareness.

We note the unusual lack of protest by professional bodies regarding these legislative changes and cannot explain the reason for this silence. Our financial and political non-alliance with any other body allows us to present independent and non-biased views. If not for the support of clients we could not bring these matters before the industry and the community.

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1st July 2010 National Healthcare Provider Rules!

1.0 The Problem

Patient privacy and doctor patient interference by the Government is legal. Practice Accreditation will be linked to Provider Registration.

The new legislation effective from 1st July 2010

The new *Health Practitioner Regulation National Law Act 2009*, enacted on 1st July 2010.

This Act establishes a national registration body for the majority of healthcare workers in Australia. These include doctors, dentists, nurses and all allied health including pharmacists.

AHPRA was formed by an Act of Parliament and is bound by the Health Practitioner Regulation National Law as in force in participating jurisdictions, and its Regulations.
http://www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx

- Health Practitioner Regulation National Law Act 2009 (1.26 MB,PDF)
- Health Practitioner Regulation National Law Bill 2009 - Explanatory Notes (510 KB,PDF)
- Links to State and Territory Drugs and Poisons Legislation (47.6 KB,PDF)
- Health Practitioner Regulation National Law Regulation

Queensland	Health Practitioner Regulation National Law Act 2009
New South Wales	Health Practitioner Regulation Act 2009
Victoria	Health Practitioner Regulation National Law (Victoria) Act 2009
Australian Capital Territory	Health Practitioner Regulation National Law (ACT) Act 2010
Northern Territory	Health Practitioner Regulation (National Uniform Legislation) Act 2010
Tasmania	Health Practitioner Regulation National Law (Tasmania) Act 2010
South Australia	Health Practitioner Regulation National Law (South Australia) Act 2010
Western Australia	Health Practitioner Regulation National Law (WA) Act 2010

All States and Territories have enacted the National Law.

We note the national legislation refers to Queensland, however understand these are national laws and they are not State specific.

2.0 The Impact

The problem arising from the new rules can be best explained by addressing the people whom they most affect. In order of importance we address the patient impact first then the practitioner and what is a more reasonable and practical solution.

2.1 Patient Impact

The Australia Card is back which means:

- Loss of privacy and the back door introduction to the AUSTRALIA CARD.
- higher out of pocket expenses
- reduced freedom to choose a provider
- reduced access to services

For those who are not aware of the original Australia Card debate see:
http://en.wikipedia.org/wiki/Australia_Card

Why this is the case is addressed below.

2.1.1 Australia Card by stealth by accessing your health records?

Practice accreditation is used to establish whether the environment a provider works in meets patient needs. A practice will receive a grant by complying with their professional standards. In General Practice this is called the *RACGP Standards for general practices: 4th edition* www.racgp.org.au/standards. By implication, these standards have been legislated otherwise a practitioner may lose their annual registration if there is non-compliance.

New Accreditation Standards - The RACGP Standards for general practices: 4th edition

The following is an extract from the ***RACGP standards book, pg. 87***…..

Section 3. *E-health initiatives*

The RACGP Standards have been updated to allow for evolving national e-health initiatives including standardised electronic health records and unique patient identifiers.

The criteria which reflect e-health initiatives include:

• *Criterion 1.7.1 Patient health records*

• *Criterion 1.7.2 Health summaries*

• *Criterion 3.1.4 Patient identification.*

Unique patient identifiers

The National E-Health Transition Authority is developing a system of unique patient identifiers for patients, as well as individual healthcare providers and organisations.

Unique patient identifiers will support the electronic transfer of information and where available should be used to complement the three required patient identifiers. These identifiers will facilitate the accurate and secure transfer of patient health information between the different areas that provide care to an individual patient. With the introduction of unique patient health identifiers, the practice's capacity to collect patient data and utilise this in quality improvement activities will be enhanced.

Is this information accessible to police and other government departments? When will you be informed if at all? The current national Privacy Laws carry a secondary implied consent rule that does not require explicit permission by the patient if information is used in the name of "quality assurance". The role of the Primary Healthcare Organisations (i.e. Medicare or your local Division of General Practice) under this Act gives these local employees access to your medical records under this global mandate. These are locally operated, independently run government funded non-for profit organisations. See www.agpn.com.au. We do support the activities of these organisations so long as there is a clear mandate which is open, fair and transparent.

Practice accreditation linked to provider registration? Practices must be accredited.

If a practice is not accredited, does this mean the provider will lose their annual registration? Will providers counter-sue a practice for accreditation non-compliance? Do smaller practices have the resources and capability to remain accredited? What are the implication for recruitment and retention? The rules link accreditation to annual provider registration.

Health Practitioner Regulation National Law Act 2009 provides …(all quotes in *green italics*)

Section 25 Functions of National Agency

The functions of the National Agency are as follows—

(a) to provide administrative assistance and support to the National Boards, and the Boards' committees, in exercising their functions; …….

(c) to establish procedures for the development of accreditation standards, registration standards and codes and guidelines approved by National Boards, for the purpose of ensuring the national registration and accreditation scheme operates in accordance with good regulatory practice;

'..approved accreditation standard means an accreditation standard—

(a) approved by a National Board under section 47(3); and

(b) published on the Board's website under section 47(6).

To ensure that they are able to practise competently and safely, medical practitioners must have recent 'practice' in the fields in which they intend to work during the period of registration for which they are applying.

'Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.'

Annual Provider Renewal Conditions

Section 109 Annual statement

(1) An application for renewal of registration must include or be accompanied by a statement that includes the following—

(a) a declaration by the applicant that—

(i) the applicant does not have an impairment; and

*(ii) the applicant has met **any recency of practice** requirements stated in an approved registration standard for the health profession; and*

*(iii) the applicant has completed the continuing professional development the applicant was required by an **approved registration standard** to undertake during the applicant's preceding period of registration;*

*(d) if the **applicant's billing privileges were withdrawn or restricted under the Medicare Australia Act 1973** of the Commonwealth during the applicant's preceding period of registration because of the applicant's conduct, professional performance or health, details of the withdrawal or restriction of the privileges;*

Section 55 Unsuitability to hold general registration

(1) A National Board may decide an individual is not a suitable person to hold general registration in a health profession if—

*(f) **the nature, extent, period and recency of any previous practice of the profession** is not sufficient to meet the requirements specified in an approved registration standard relevant to general registration in the profession; or*

Section 140 Mandatory notifications

Definition of notifiable conduct In this Division— notifiable conduct, in relation to a registered health practitioner, means the practitioner has—

(a) practised the practitioner's profession while intoxicated by alcohol or drugs; or

(b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or

(c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or

(d) placed the public at risk of harm because the practitioner has practised the profession in a way ***that constitutes a significant departure from accepted professional standards****.*

2.1.2 Diabetes Program – Increased out of pocket expenses, decreased choice and it's unconstitutional!

Providers will be prosecuted for billing outside the Medicare rules. The proposed diabetes program is a case in point.

Under the original diabetes scheme proposed in April 2009, practices would receive block-funding of $950 for each patient they enrol, plus annual payments worth an average of $10,800, based in part on GPs' performance in keeping patients healthy.

Medical Observer Nov 2010 - http://www.medicalobserver.com.au/news/victory-for-gps-as-government-puts-diabetes-scheme-on-hold

and

http://www.heraldsun.com.au/news/breaking-news/roxon-shelves-450m-diabetes-care-plan/story-e6frf7kf-1225952785657.

In principle the scheme may sound quite generous but is subject to audit where there are no published or clear clinical protocols and not all patients respond to treatment based on Government funding criteria. This is fundamentally flawed. This sets a new precedent that if funding runs out the doctor is prohibited from charging a fee, so the patient's healthcare needs remain unmet.

Irrespective of the absolute dollars of remuneration, this severely limits a patient's choice by restricting the nature and type of care they can receive. Many other similar programs have been proposed. Any fund capping proposal is intellectually flawed as it assumes a person's chronic health condition is finite and is readily treatable in the short term, as the diabetes program appears to suggest.

Thankfully this has been put on the "back burner" because the government has finally recognised these issues are complex and a 'one size fits all' solution does not work. Funding models are not the key to better health outcomes, patient engagement is a point that is not recognised.

The real issue is, if a doctor continues to treat a patient and charges for it they are breaking Medicare rules. They can then be de-registered and lose their entire living. In a court of law, a doctor has a duty of care to their patient irrespective of whether or not they receive a fee. This can create a dilemma for remote rural practitioners where patients have no access to medicine. The practitioner can either go broke or get sued for negligence whichever comes first.

Are medical practitioners expected to develop a relationship with a patient based on a guaranteed health outcome reliant on fixed funding and then dump the patient or go broke when the funding runs out? Is this what patients want? Is this reasonable? These types of funding arrangements only reduce access and increase out of pocket expenses, as well as eliminate any healthcare innovation. Most importantly this creates a lot of uncertainty.

We believe this approach is illegal and against the Australian Constitution as the government is fixing prices for services by deeming any additional charges as prohibited and inappropriate practice.

(See 1973 Referendum). http://en.wikipedia.org/wiki/Australian_referendum,_1973_(Prices).

2.1.3 Female practitioners are affected by the legislation.

Female practitioners planning on being out of work for greater than a year face more onerous re-registration requirements. Nationally 65% of medical graduates are female, the majority of whom may be planning a family around the age of 30 including extended leave. This will cause an acute workforce shortage if the appropriate support mechanisms only achievable in larger practices are able to accommodate them. This will result in a workforce shift to large group practices as smaller practices will have reduced or no capacity to recruit and retain a female workforce.

Health Practitioner Regulation National Law Act Regulations 2009

Requirements

1. For practitioners returning to practice within their previous field, provided they have at least two years' experience prior to the absence:

a) Absence less than one year — no specific requirements to be met before recommencing practice.

b) Absence between one and three years — complete a minimum of one year's pro rata of CPD activities relevant to the intended scope of practice prior to recommencement designed to maintain and update knowledge and clinical judgement.

This also includes 'practice' experience which means non-clinically related work in a practice. See recency rules.

2.2 Provider Impact

Providers can be prosecuted *without evidence and gagged*. Bikie Gang's and refugees have greater rights. The system is open to abuse.

The major impact to providers is the uncertainty and fear that arises from unfair prosecutions.

The key issues are:

- The lack of transparency, skill, expertise and competency in the Medicare Audit system;
- The presumption of innocence is lost – no access to natural justice which is a civil right. The Government does not need evidence to prosecute a provider;
- Providers are not able to defend themselves in an open, fair and transparent legal system;
- Loss of confidence to invest in skills, expertise and practice infrastructure due to legal uncertainty.

2.2.1 Do you really have to roll over if you get investigated!

The Health Practitioner Regulation National Law Act 2009, Part 8 Health, refers to performance and conduct of providers. Some interesting things can happen if you do something that may find you in breach of the rules and ***they don't need any evidence to prosecute***:

2.2.1.1. The national board can appoint inspectors

Section 239 Appointment of inspectors

(1) A National Board may appoint the following persons as inspectors—

(a) members of the National Agency's staff;

(b) contractors engaged by the National Agency.

The legislation does not provide for any minimum qualifications or experience for a person to become an 'Inspector' other than an approved person or contractor. This is similar to the refugee processing rules.

2.2.1.2. Your hearing is not open to the public

Section 189 Hearing not open to the public

A hearing before a panel is not open to the public.

2.2.1.3. You are denied the ability to defend yourself!

Section 185 Procedure of panel

(1) Subject to this Division, a panel may decide its own procedures.

(2) ***A panel is required to observe the principles of natural justice but is not bound by the rules of evidence.***

This is stunning piece of law. This Act denies S.80 Trial by Jury under the Australian Constitution in front of a Court.

See: http://www.austlii.edu.au/au/legis/cth/consol_act/coaca430/s80.html

It flies in the face of High Court principles relating to 'natural justice' which is about due process. Specifically it there is a tripartite rule consisting of the hearing rule, the bias rule and finally the evidence rule. All three must be upheld for natural justice to prevail. The evidence rule has illegally been denied to healthcare workers across Australia.

The "natural justice" laws provide every citizen a right to procedural fairness, a requirement under the Australian Constitution to prevent government from abusing its power over its citizens.

The new Act empowers the Board to bypass the Courts and use an internal tribunal system. This may impose significant personal and financial costs, with no procedural certainty.

The following three common law rules relate to natural justice or procedural fairness. These are used by the High Court to prevent government from interfering with an individual's rights. The Government has argued with similar laws the necessity for such rules that the patient is disempowered due to the importance nature and complexity of healthcare. The need to refer to the courts is better served in a closed hearing. This is concerning. The same could be said about the legal and accounting professions as they are not subject to the same rules.

The Hearing Rule

This rule requires that where certain interests and rights may be adversely affected by a decision-maker, a person must be allowed adequate opportunity to present their case.

When conducting an investigation in relation to a complaint it is important that the person being complained against is advised of the allegations in as much detail as possible and given the opportunity to reply to the allegations.

The Bias Rule

This second rule states that no one ought to be judge in his or her own case. This means the deciding authority must be unbiased when conducting the hearing or making a decision.

In addition, investigators and decision-makers must act without bias in all procedures connected with the making of a decision. A decision-maker must be impartial and must make a decision based on a balanced and considered assessment of the information and evidence before him or her without favouring one party over another. Even where no actual bias exists, investigators and decision-makers should be careful to avoid the appearance of bias.

Investigators should ensure that there is no conflict of interest which would make it inappropriate for them to conduct the investigation.

The Evidence Rule

The third rule is that an administrative decision must be based upon logical proof or material evidence. Investigators and decision makers should not base their decisions on mere speculation or suspicion. Rather, an investigator or decision maker should be able to clearly point to the evidence on which the inference or determination is based.

Clearly abolishing the need for the evidence rule under the new legislation is like practising medicine without scientific proof. Some may argue this approach is bordering on negligence.

Confidence in the integrity of the new legislation or its administrators is under a cloud as it leaves the system potentially open to abuse.

2.2.1.4. It's the Government - you can trust them right?

The following Federal Court case where Medicare lost its prosecution case against a doctor due to a lack of evidence, illustrates no matter how well intentioned the Government is, the system is not perfect. The system does get it wrong and it needs its own checks and balances. Ironically the new Board rules totally ignore this long held ruling.

Medicare - guilty of not offering procedural fairness - Pradhan v Holmes [2001] FCA 1560 (8 November 2001)

(j) the Act provides a complete and comprehensive code which has natural justice features built in at every stage'…. 'there is a "rolling" requirement of procedural fairness'

Source:
http://www.austlii.edu.au/cgibin/sinodisp/au/cases/cth/FCA/2001/1560.html?stem=0&synonyms=0&query=title(Pradhan%20and%20Holmes%20)

2.2.1.5. Do you really have to roll over if you get investigated?

The Australian Constitution is the highest authority in the country. The High courts are empowered to set and interpret laws. These laws, referred to as Executive Powers, are referred to Parliament. It is a bit like a Board of owner doctors (High Court) referring their powers to a Practice Manager or Chief Executive Officer (Parliament). If there is a problem then the matter is referred back to the Board (High Court) for a final ruling. Any ruling is read and determined in relation to the Australian Constitution. This is like the company constitution or trust deed for your practice. This is supposed to uphold the community's contemporary value system and establish fundamental principles.

The Australian Constitution

The Constitution clearly states every person has a right to the judicial system.

Commonwealth of Australia Constitution Act (The Constitution). This compilation was prepared on the 25th July 2003 taking into account alterations up to Act No. 84 of 1977.

Section 80 Trial by jury

'The trial on indictment of any offence against any law of the Commonwealth shall be by jury, and every such trial shall be held in the State where the offence was committed, and if the offence was not committed within any State the trial shall be held at such place or places as the Parliament prescribes'.

Part V—Powers of the Parliament

The Constitution clearly states the High Court refers the power of making laws to Parliament.

Section 51 Legislative powers of the Parliament

The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth *with respect to:*

(xxiiiA) the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances;

Parliament cannot interfere in the doctor patient relationship

They are given no explicit or implicit power to interfere in the doctor-patient relationship. This was also High Court tested.

General Practitioners Society v Commonwealth 1980 High Court of Australia

"Gibbs J delivered the leading judgment. His Honour reiterated the principle that there is no explicit head of power under which the Federal Parliament can regulate private medical practice, in the sense of the physician–patient relationship."

Source: http://www3.austlii.edu.au/au/journals/MULR/1999/14.html#Heading46

Section 51 (xxiiiA) of the Commonwealth Constitution was inserted following the successful referendum of 1946. The Constitution only allows for the Commonwealth to make laws in relation to paying doctors for their medical services. This power supports the Commonwealth operating the Medicare program, but not the entire Australian Health System.

The Government has passed a law beyond its own powers

The latest High Court Ruling upholds an individual's right to procedural fairness. Parliamentary laws cannot deny a person natural justice. Therefore, the new Health Practitioner Regulation National Law Act 2009 is open to a High Court challenge to this unfair law.

The Bikie Gang High Court Decision **– 11th November 2010**

This decision prevented the SA Government from introducing laws that precluded bikies from associating with each other. They could only be prosecuted if they were guilty of misconduct, not just by mere association, otherwise such rules would serve the political arm of Government and thereby compromise the integrity of the judicial system.

"The High Court has said that there is a separation of powers, the Parliament cannot tell to the courts what to do."

Source: http://www.abc.net.au/news/stories/2010/11/11/3063266.htm

Furthermore -

"The High Court has ruled the Act undermines the independence of the court " and " It also found that requiring the courts to impose the will of Government, based on assumptions and without evidence, was contrary to the rule of law"

Source: The Advertiser 20.11.2010

The Refugee High Court Decision **– 11th November 2010**

This case further reinforces the Australian civil right of 'natural justice' for people who are not even Australian citizens. Section 185 of the new Act denies the same rights to our healthcare workers.

This decision allows anyone who enters Australia's jurisdiction the right to procedural fairness, even if they are not an Australian citizen.

'However, in a unanimous decision, the High Court has ruled that was an error of law and that the two men were denied procedural fairness when Government contractors reviewed their case'

Source:
http://www.abc.net.au/news/stories/2010/11/11/3063298.htm

Under the refugee laws, the legitimacy and integrity of the High Court was being brought into question. The decision was of no surprise. The High Court had ruled that this is not the case. Any prosecution a provider may face would or should have a good chance of defeating certain parts of the National Board rules if based on the rules of evidence. Your advisers need to be made aware of this issue (many are not) should you find yourself being scrutinised by the Act.

Clearly these landmark High Court cases put the Government on notice that these new laws will be subject to a High Court challenge. There is a high probability that any challenge on these grounds would be successful. ***They are by nature bullying the very people who we all ultimately have to trust to care for us which is unconscionable***. There are enough existing laws protecting the community. Effective policing is the real problem, not the lack of legislative reform. ***So let commonsense prevail and we should all email our local members of Parliament this news alert.*** This is to avoid any further unnecessary fear and uncertainty that we all have to ultimately pay for from practitioners who may decide that these new laws may be the last straw on the camels back and therefore unnecessarily accelerate their retirement plans.

Fairness, openness and transparency is critical to an efficient healthcare system, otherwise we face the following risks:

- Workforce shortages across all provider classes;
- Reduction in healthcare infrastructure investment;
- Immediate clinical needs not being met on a timely basis with the demise of the primary carers who predominately work in private practice;
- Sicker communities requiring more expensive acute care;
- Gross misallocation of resources;
- Nationalisation of healthcare without a political mandate will eliminate innovation and reduce patient choice;
- Solo and marginally profitable practices may be pushed past their tipping point resulting in early retirements. Smaller practices will have little or no chance of growing or attracting new providers unless they can resource the new compliance requirements. It is impossible to replace a practice once it has disappeared; and
- More 'hotel' practitioners will not take a long term view of the healthcare needs of the community as they operate in a disempowered environment.

3.0 Where to From Here – The Solution

All professions should be independently responsible for peer review, including internally reviewing and censuring members, where necessary. I am member of Certified Practising Accountants Australia. This is a very effective model that has been in place since the 80's for the largest professional membership in the Southern hemisphere. Professionals should encourage self-regulation and ensure they are effective in managing their own members. Doing nothing only encourages more external regulation, including interference in the doctor-patient relationship, which is not permitted by the Australian Constitution. A focus on openness, fairness and transparency for all stakeholders is critical.

Encourage a free market, a small patient gap price-sensitizes patients to become more discerning about the care they receive. The Nobel Prize winning economist Milton Friedman argues this point and it is relevant in healthcare for those preventable chronic diseases and illnesses. See: http://www.youtube.com/watch?v=-MQp-5lZToE.

Shared responsibility between the patient and provider empowers both parties in the relationship. In relation to preventable illnesses, capped or responsibly uncapped patient gaps are healthcare 'speeding tickets' that remind us to look after ourselves or pay more in hospital where the bills are bigger and sometimes it's too late. The real solution may be a hybrid funding system for healthcare which consists of a small patient gap and healthcare vouchers for preventable diseases. Milton Friedman elaborates on this point in relation to education voucher concept that can easily be applied to healthcare in certain scenarios.

See: http://www.youtube.com/watch?v=EUSOtID5RsQ. Friedman's comments in relation to the role of Government and the poor are also interesting view points given last week Australia was rated by the United Nations the second highest after Norway in terms of Quality of Life measured by health, poverty, wealth and education. See: http://www.youtube.com/watch?v=Rls8H6MktrA&feature=related. The bottom line is we are not as bad off as the Government may feel and any legislation must have balanced approach. These solutions may not be perfect, no system is, but it is better than excessive government intervention.

Conclusion

Ultimately any legislation must be patient focussed. The new national consumer laws commencing 1st July support this ideology and make any contract with a consumer null and void if they are deceitful. Patient education and provider-patient empowerment programs are more sensible, as providers are more likely to respond to this than to legislation. More openness and transparency with patients should be strongly encouraged via website, email, patient brochures and messages on hold so patients and not governments can determine for themselves the kind of care they want to receive and at what price. Government resources should be focussed on this issue alone. Combined with effective competition, this will prevent fraud, abuse and poor quality services. It is inexpensive and simple to achieve without more red tape.

All providers need to petition their patients in their waiting rooms and send this news alert to their local member to get the laws changed otherwise, they will face higher out of pocket costs, doctor shortages and no freedom to choose their healthcare provider. Finally, the industry needs a national Ombudsman for Health to ensure there is a fair and level playing field.

4.0 2010/11 Seminar Presentations – New Topic "*The World's Best Practice"*

We are pleased to announce *The World Best Practice* topic for the 2010/11 year. This is a new presentation and we have already received excellent reviews. It is new material based on 80 years of international research in the US, Europe, Japan and China on what makes a great organisation. It focuses on the simple and effective elements of what makes a **great** business as opposed to a **good** one and reveals simple solutions to common day problems that can dramatically lift practice morale, efficiency and work related stress. It will allow principals and practice managers to work more on and not in the practice, doing the fun stuff. We use this for our ***Director Pathway program*** that assists in selecting, grooming and mentoring future like-minded owners for your practice. The surprising thing is these ideas cost nothing to implement. For more information visit www.healthandlife.com.au.

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LETTER

Work intentions and opinions of general practice registrars

Thomas D Brett, Diane E Arnold-Reed, Cam T Phan, Robert G Moorhead and Dana A Hince

To the Editor: The work intentions and opinions of general practice registrars are important in estimating the future supply of Australian general practitioners. Declining popularity of general practice has led to entrenched, long-term shortages (especially in rural areas),[1,2] with 700 new entrants annually — well short of the 1100–1200 required to meet community needs.[3] Between October and December 2008, we mailed questionnaires to 147 GP trainees (69% women) registered with Western Australian General Practice Education and Training, asking about their career intentions and opinions. Ethics approval was obtained from the University of Notre Dame Australia Human Research Ethics Committee.

The response rate was 61% (89/147). Seventy respondents were women (79%). Median age of respondents was 30 years (interquartile range [IQR], 28–35 years). Most had graduated in Australia (82%, 73/89) and most between 2000 and 2006 (83%, 74/89). Twenty-nine per cent (26/89) made their career choice in the first 2 years after graduation, while others decided in their third year after graduation (26%, 23/89), or later (24%, 21/89); medical school was the next most common stage at which respondents made their choice (20%, 18/89). Forty of the 89 registrars (45%) were working eight or less sessions per week; 34 (38%) were working more than eight; and 15 (17%) had not yet started work.

Registrars favoured rural, outer metropolitan and metropolitan areas equally as practice locations (Box 1). Becoming a practice principal was not a priority, probably reflecting respondents' current training status and uncertainty about the future. Low numbers were planning to undertake home, nursing home or hostel visits.

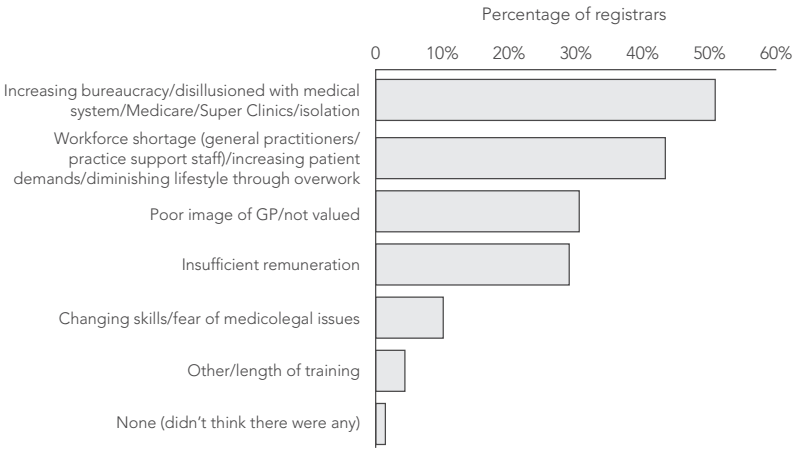
Using a five-point Likert scale, respondents rated flexibility and better lifestyle of general practice as major influences on their career choice (median score, 5; IQR, 4–5). Appraisal of own skills and aptitudes (median score, 4; IQR, 3–4) and intellectual influences (median score, 3.5; IQR, 3–4) were other important factors. Twenty per cent had converted from another specialty. Reasons for changing specialty included work demands and stress (50%) and career flexibility, lifestyle and family reasons (33%); in previous research, these were found to be key determinants favouring general practice as a career option.[2]

Obstacles to general practice selected by respondents were, in descending

1 Work intentions of study respondents ($n = 89$)

	No. of registrars
Intended practice location	
Metropolitan	23 (26%)
Outer metropolitan	24 (27%)
Rural	28 (31%)
Combination	13 (15%)
Unanswered	1 (1%)
Position	
Practice principal	16 (18%)
Other	72 (81%)
Unanswered	1 (1%)
Practice size	
Solo	1 (1%)
2–4	19 (21%)
5 +	43 (48%)
Unsure	26 (29%)
Sessions worked per week	
< 5	13 (15%)
5–8	55 (62%)
> 8	17 (19%)
Unsure	3 (3%)
Unanswered	1 (1%)
Out-of-surgery visits	
Indigenous health	21 (24%)
Home visits	16 (18%)
Nursing home/hostel	24 (27%)

2 Factors considered by general practice registrars to be obstacles to general practice* (*n* = 69)



* Percentage frequencies of the 69 participants who gave answers to the open question "What do you see as the major obstacles to general practice in Australia?" When more than one response was given by an individual participant, each response was coded and counted separately. ◆

order of frequency: increasing bureaucracy, workforce shortages, the poor image of GPs and poor remuneration (Box 2).

Increased exposure to general practice via rural clinical schools and clinical attachments as a medical student and prevocational doctor has been shown to be a positive influence on future GP career choices.[2,4] We found the first 3 years after graduation were the most important in making career decisions, supporting earlier research[5] and highlighting the potential benefits that exposure via the Prevocational General Practice Placements Program (PGPPP) brings to general practice. Suggestions that the PGPPP be open to Australian medical graduates in their first and second postgraduate years[2] deserve support.

Despite survey limitations of sample size and an over-representation of women registrars, our findings reflect the views of 60% of current WA GP registrars. Fifty-one per cent planned to retire at 65 years or above, and 44% planned to retire before then, with the rest unsure. Involvement of experienced GPs in health care delivery is also waning (as we outline on *page 75*).[6] Recruiting and training new doctors in sufficient numbers to replace retiring experienced colleagues is critical in redressing the balance and meeting future workforce demands. Strategies to make general practice a more attractive career option for new doctors deserve increased priority if general practice is to remain a competitive discipline.

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Competing interests: Thomas Brett is a director of WAGPET. Robert Moorhead is a former director and training advisor with WAGPET.

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