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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
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(Submitted electronically, and to:
community.affairs.sen@aph.gov.au)

Dear Secretary

Submission to the Senate Review into the PSR

The Australasian College of Nutritional and Environmental Medicine (ACNEM) Inc is the peak body representing medical practitioners practising Nutritional and Environmental Medicine (NEM).

ACNEM is a not-for-profit medical college established in 1982, providing post graduate training in NEM (recognised by RACGP for CPD) and representation and collegiate for practitioners in this area of medicine.

Nutritional and Environmental Medicine

Nutritional and Environmental Medicine (NEM) is concerned with the interaction of nutritional and environmental factors with human biochemistry and the resulting physiological and psychological symptoms and pathology.

Treatment is aimed at correcting underlying causes as well as providing symptomatic relief. This may involve a 'lifestyle prescription', removal of certain foods from the diet or toxins from the patient's environment, and prescription of supplements such as vitamins, minerals, trace elements and essential fatty acids where diet and lifestyle alone cannot rectify physiological imbalances.

NEM is evidence-based, drawing on the latest biomedical science, research and clinical application to develop treatment approaches to illness and disease, for primary prevention and to promote optimal health and well-being.

NEM and Integrative Medicine

NEM is not, by definition, a form of complementary medicine. It is the clinical application of nutritional biochemistry, most commonly in General Practice, but also by specialists and non-VR (vocationally registered) doctors. Therefore NEM can be viewed both as a sub-specialty of GP and a medical specialty in its own right.

The practice of NEM is not well understood by doctors who have not undertaken post-graduate training in NEM. Unfortunately, nutritional biochemistry is generally not taught in the undergraduate medical curricula.

However, NEM doctors are commonly considered to be "integrative" by reference to their interest in nutritional, environmental and lifestyle factors in disease and illness. Therefore ACNEM maintains close ties with the Australasian Integrative Medicine Association (AIMA), and through AIMA, with the AIMA/RACGP Integrative Medicine (IM) Joint Working Party, the Integrative Medicine Network of the RACGP National Faculty of Special Interests and the AMA.

The ACNEM Primary Course (ACNEM's foundation post-graduate training in NEM for doctors) has been reviewed and accepted by the AIMA/RACGP Joint Working Party as approved training under the proposed (future) RACGP IM Fellowship.

ACNEM also strongly supports the AIMA submission to the Senate Enquiry into the PSR.

Sub-specialties of GP

The Royal Australian College of General Practitioners (RACGP) recognises sub-specialties of GP to a certain extent through their National Faculty of Special Interests (NFSI), which includes;

- Addiction Medicine
- Breast Medicine
- Child and Young Person's Health
- Custodial Health
- Integrative Medicine
- Medical Education
- Military Medicine
- Pain Management
- Psychological Medicine
- Refugee Health
- Sports Medicine
- Musculoskeletal Medicine
- Clinical Forensic Medicine

NEM is currently seen as part of the Integrative Medicine (IM) 'Network' of the NFSI, yet being recognised by the RACGP NFSI as a special interest network currently does not confer any recognition of speciality peer group in matters before Medicare, the PSR or Medical Boards. The NFSI is a recent initiative of the RACGP and NFSI recognition is acknowledged to be a step towards more formal recognition as a field of speciality within GP.

However, recently, as a result of a formal approach by AIMA, the Attorney General of Victoria agreed that in Medical Board matters being heard by the Victorian Civil and Administrative Tribunal (VCAT) involving Integrative Medicine (IM) doctors, there should be an IM doctor on the peer review panel.

Discussions of a similar nature have been held between AIMA and PSR Director Tony Webber in the last few years. Clearly, there is a growing acknowledgement that members of the wider GP population are not an appropriate peer review group for doctors practising in a sub-specialty area of GP.

Medicare and the PSR

Although not specifically mentioned in the terms of reference of this Senate Review of the PSR, referral to the PSR may take place as a result of Medicare statistical analysis and subsequent audit, therefore the following matters are very relevant for consideration:

Inherent unfairness in the current system

Statistical analysis of Medicare claims gives rise to audit of a doctor by Medicare, which in turn may give rise to referral to the PSR. Our understanding of this process is that it is intended to identify doctors who are billing Medicare inappropriately or unusually and therefore potentially fraudulently. Naturally ACNEM supports this objective but with the following reservations:

Analysis to identify statistical outliers, will by definition, identify doctors who practice significantly differently from their peers. Therefore, the choice of comparison peer group becomes an important consideration in order for the analysis to maintain statistical credibility.

General Practice is well understood to be the broadest of the vocational medical specialties, encompassing many areas of sub-specialty. Therefore to statistically compare an individual GP who is specialist in a particular area of GP with the wider GP population is inappropriate as a statistical method and also inherently unfair to the GP.

Predictably, a GP with an area of specialty such as NEM, will have a non-standard statistical profile in respect of consultation duration, pathology requests and specialist referrals, and this will likely be compounded by the GP also having a non-standard patient group, as these GPs are often sought out by patients with chronic and complex problems not addressed by other doctors.

These considerations together are likely to ensure that the GP appears more than two standard deviations from the mean in some respects of the Medicare statistical analysis.

Therefore any doctor, or group of doctors practising significantly differently from the majority of their (GP) peers by reason of their specialty or sub-specialty is currently more likely to audited and therefore potentially referred more often. This is unfair, and is particularly unfair given that Medicare audit and PSR review are known to be significant life-stress events for doctors.

ACNEM's records suggest that this has indeed been the case for our members, who appear to have been disproportionately audited by Medicare compared to the GP population, leading to a disproportionate rate of referral to the PSR, by virtue of their practice of NEM, which surely is at odds with Medicare's objectives of identifying incorrect and fraudulent billing.

ACNEM also believes that if a statistical comparison could be conducted of the average total cost to Medicare per patient/year managed by our member GPs, despite that they may undertake longer consultations, order pathology for diagnosis and management differently to other GPs, and manage patients with more complex and chronic conditions, this would be a lower cost on average to Medicare than for the general GP population.

Therefore, ACNEM proposes that if a doctor is identified as having a practice focusing on an area of special interest, which may also be evidenced by way of post graduate training, or by way of practice as a specialist or in an area of sub-specialty of GP (such as in an area of interest recognised by the RACGP NFSI or represented by a college such as ACNEM), any initial statistical analysis must be revisited to ensure comparison with the appropriate sub-specialty peer group.

Likewise, the Medicare representative charged with the responsibility of conducting the audit should have an appropriate understanding of the area of speciality to avoid unnecessary referral to the PSR.

In this respect, ACNEM represents a large peer group of many hundreds of NEM doctors with many senior Fellows of the College, and is willing to assist both Medicare and the PSR to ensure that an appropriate peer group is used for statistical comparison and peer-review of practitioners practising NEM.

Finally, in the interests of transparency and fairness, doctors should have access to, or be provided with on a periodical basis, their Medicare statistical profile, so that they can become aware of the characteristics of their practice from a Medicare point of view, and be able to compare this with the aggregate statistics of the wider population.

ACNEM's response in relation to the terms of reference of the review:

(a) the structure and composition of the PSR, including:
(b) (i) criteria for selection of the executive and constituent members encompassing their experience in administrative review proceedings;

There is inherent unfairness and lack of transparency in the PSR structure and operation.

- The structure and composition of the PSR needs to broadly represent the whole population of medical practitioners; including medical specialists and sub-specialist GPs, such that those who practice in areas of specialty or sub-specialty are not marginalised.

- This can be established by reference to and consultation with the areas of medical speciality given by AHPRA and their professional Colleges, and in the case of GPs, by the areas of special interest recognised by the NFSI of the RACGP and the colleges and associations representing doctors practising in those special interest areas. For example, in the case of rural GPs, by reference to the Australian College of Rural and Remote Medicine (ACRRM) and in the case of doctors trained in NEM, by reference to ACNEM.

- These colleges and associations should be consulted in respect of establishing an appropriate peer review process for any of their members undergoing review, or which involves their area of specialty.

- A standardised training program in PSR procedures and administrative review could be provided to members inexperienced in such matters. This is important to ensure that peer-reviewers are thoroughly briefed in the terms of their engagement and the basis on which they are required to adjudicate, to ensure that personal medical training or practice preferences do not inadvertently inform 'inappropriate practice' deliberations.

(ii) the role of specialist health professionals in assisting in cases where members lack relevant specialist expertise, and
(iii) accountability of all parties under the Act;

- As above, the PSR must establish channels of communication with the colleges and associations representing the areas of specialty of practitioners being reviewed, in the interests of ensuring an appropriate peer review process, transparency to the profession and fairness to the practitioner.

- PSR members must, above all, be accountable for the fairness of the reviews conducted under the scheme to the practitioner.

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

- The PSR's interpretation of the Medicare descriptor items should be based on the agreed positions of the organisations concerned. Medicare item descriptors may be problematic and open to individual interpretation. Medical consultations take many forms that do not necessarily fit current Medicare item descriptors, e.g., counselling during a consultation does not necessarily require a physical examination, yet the descriptor includes/requires a physical examination.

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

- As previously discussed, currently one of the main criteria used to determine whether an alleged breach against the Act has occurred is to compare the alleged breach against what the general "body of medical practitioners" would normally do, but how is this determined? This should not be left to an individual reviewer's interpretation of what the body of medical practitioners would do.

- Currently, practitioner's notes are used as evidence in investigating alleged breaches under the Act. It is vitally important to keep good notes but it is unrealistic to expect that the notes taken fully reflect all of the consultation. Many of the psycho-social aspects of the consultation may be excluded, e.g., being empathetic to the patient sometimes excludes the taking of notes.

- Practitioners should only be required to financially repay Medicare where inappropriate billing (outside of the item descriptors) has been established, not where the doctors has practised medicine in good faith in pursuit of good patient outcomes (but not practised by others in the comparison peer group).

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

- Practitioners under review must be
    - Entitled to legal or similar representation to both represent and speak on their behalf
    - Entitled to mitigate the financial consequences of a breach where it can be demonstrated that the breach, rather than being fraudulent, was 'unintentional in the pursuit of good patient outcomes'

(e) the appropriateness of the appeals process; and

- There must be a right of appeal, and such an appeals process should be outside the domain of the PSR.

(f) any other related matter.

We trust this information will be of assistance in bringing about important and needed changes to the structure and operation of the PSR, in the interests of transparency and fairness to the medical and Australian community it serves.

Yours faithfully,

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President

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