- **1 ..Does Dr Ruse believe the sampling methodology used by Medicare is the most appropriate to**
    - **A. Find inappropriate practice;**
    - **B. Achieve value for money from Medicare's perspective.**
    -

1 .A Find inappropriate practice

I could not judge the appropriateness of the sampling methodology used by Medicare, as I am not a professional statistician. I don't know what it currently is, and how it got there. I don't know what else is available. However I do believe, from common sense, that it should be a tool to begin working through the assumptions outlined in my submission. They were rejected in his presentation by Mr Watt of the Australian Doctors Union.

These are my assumptions. There will be inappropriate practice. It will not occur often. Every doctor will have a bad day. Some doctors will have too many bad days too often. Statistical analysis will find a group within the total that lies to one side of the distribution. The distributions are NOT Gaussian bell shaped curves of the scatter of certain randomly distributed characteristics over which the doctors have no control (dog with bone). They are a snapshot of what doctors have chosen to do, in that part of their practices that is visible to Medicare. Here endeth statistical analysis.

Some of the outliers will be in terms of sheer volume. Others will be in terms of ratios , of long to normal length consults, complex to standard, patterns of testing or providing treatment, in patients with certain common demographic features.

Sheer volume outliers may be exemplary doctors, keeping good notes, providing good care and working a lot longer and harder than most. They have (well at least one case in the annual reports) been found by the Directors to exist. They may be doctors who can't say no, don't have insight into practice deficiencies, are trapped or exploited by unscrupulous medical or non medical employers and **could** be providing inappropriate or even dangerous care on a regular basis.

Ratio outliers may be exemplary doctors, with special interests or even emerging specialty pioneers, who do more Pap smears and Vitamin D estimations perfectly appropriately. They may have legitimate interests that require longer consults for more of their patients who have musculo skeletal, psychological or mental health problems. However they may have crackpot theories, sui generis, of disease causation. They may use a barrage of tests without discernment to make up for an unwillingness to take histories and do examinations. It's a lot easier to hear a word and press a button. They may "counsel" by just having a half hour chat ("We just talk about bananas in Carnarvon. They'd kill themselves without our chats". One of my cases). They **may** be practicing inappropriately.

If the Senate Inquiry accepts my assumptions, and also accepts, at least for the moment, that the process , both Directorial and Committee was and is as fair as it can be, could we consider the experience of the last 17 years a natural experiment ? Of those thrown up by the Medicare statistical methodologies over the years, and getting to the Director, about 1/3 have been found, at that first single peer review to "have no case to answer". It would be less traumatic for them if that finding could be made earlier in the process. Healing that trauma lies with the Medicare auditors.

One third accept an offer from the Director (not made to all) of a section 92 negotiated settlement. One third come to a Committee. Overall of the Committee hearings, about 15% (I think) have been found to have practiced appropriately. However, this proportion has dropped in recent years to zero.

One school of thought interprets this recent hardening as evidence of increasing injustice, from a change, either in the composition of the Committees, to more pliant tools of an avenging Director, or in the recently brainwashed mindset of long serving members. An alternative view is that the changing Medicare methodology, while still putting some good doctors through the mill as far as getting to the

Director stage before they are recognised, is delivering a “richer mix” of truly inappropriate practice to the Director and the Committees.

1 . B Achieve value for money from Medicare's perspective

Once again, I just don’t know the Medicare perspective, this time in terms of the values on which they are expending money. The sampling methodology is a microscopic cog in what I hope is not a catastrophic “plan”. I would like to use this question as a springboard for some wider thoughts. It begins to tackle question 2.

PSR Committee members are free from Ministerial control or suggestion. Medicare however is an active arm of government policy. I don’t know whether it receives directives to minimise increases in outlays. I don’t know whether at a lower level in Medicare there is perceived pressure to minimise those increases by slowing the total volume changes, and increasing the proportion of cheaper items.

I have been concerned with the evidence presented to you of the inability of working doctors and their practice managers to obtain answers, in writing, from identifiable Medicare personnel, to legitimate questions regarding descriptor usage. I note the concerns of Colleges that Medicare may be quite inappropriately directing such questions to them. As I note in my submission, the final descriptors are NOT submitted by Medicare to collegiate critique by the Colleges, doctors’ more industrial organisations, or PSR before they become “the law”. (As an aside: Item 30213 is for the treatment of non malignant “starburst” vascular lesions in the skin. They must be visible however from 4 metres. Whose eyes, what light, what record of this criterion being fulfilled before they are zapped forever? The non bureaucratic mind boggles.)

If it is the intention of Medicare to minimise increases in outlays by creating uncertainty regarding how descriptors should be used, and fear of how doing the wrong administrative thing could end up in the full rigour of a PSR Committee, then I do not consider it a worthwhile value. I would object to my “badge of honour” activities on Committees being part of an atmosphere of coercion.

Medicare medical advisers are currently prohibited from looking with the doctors they visit at their patterns of practice to the level of individual patient records. More value for money might be found in Medicare paying, in part or whole, for someone from AGPAL, or similar accreditation organisation, accompanying the adviser (with the consent, and perhaps financial contribution, of the doctor under audit) to look at a few appropriate records, and flag concerns AT THAT TIME, as an independent “honest (non Medicare) broker”.

Medicare would have a stronger case for subsequent referral to the PSR Director if repeat statistics were not changed after an independent quality adviser had pointed out that change should/could be made. It was only a suggestion, not a directive.

Is the PSR process “value for money”? Possibly not, in terms of dollar recovery and cost of the PSR office. However it must be remembered that as well as retrospective recovery, disqualification for periods in the future by the Determining Authority will also represent “savings”.

I have however been part of a process which has found dangerous practice before it led to disaster. As an adjunct to the Medical Board / APHRA structure this can only be of value to consumers and the profession. The doctors involved may be amenable to re education, but their problems have been identified and quarantined. If the money has to come out of a Medicare budget, then the value of those outcomes should also be credited in some way to Medicare.

- **2 ..Evidence received suggests that doctors have changed their practices as a result of the PSR and the changes recommended by the PSR. Where should the line be drawn between professional best practice and value for money for taxpayers?**

Antonio Mark you this, Bassanio,
The devil can cite Scripture for his purpose.
An evil soul producing holy witness
Is like a villain with a smiling cheek
,
Merchant of Venice Act I Sc iii

Glendower**:**
I can call spirits from the vasty deep.

Hotspur**:**
Why, so can I, or so can any man;
But will they come when you do call for them?

Glendower**:**
Why, I can teach you, cousin, to command
The devil

Hotspur**:**
And I can teach thee, coz, to shame the devil—
By telling the truth. Tell truth and shame the devil.

Henry The Fourth, Part I Act 3, scene 1, 52–58

As you can see, I feel an urgent need to first test the evidence you have been given before proffering my own opinion.

"Evidence" 1.
Mr Dahm and Dr Masters , in their written submissions both draw attention to an article published in the Medical Journal of Australia "Decline with a capital D". I attach a copy so you can test their interpretations and mine.

The article looked at changes in patterns of use of standard GP consults, and the degree of offset which might have occurred when special items were introduced. It tested Government assertions that they balanced out, to the advantage of consumers. It found those assertions were not, in the authors' opinion, justified. It looked at the period 2004-2009, found a dramatic decrease in the long consultations items C and D (hence the witty title), and increase in A but not B, and a weakening of the postulated offset in the last 2 years of their survey.

They wished to replace comparisons of crude service volumes with a longer term rate adjusted approach, and expand the offsets from just chronic disease planning to health assessments, service incentive payments and mental health care.

They mention in passing (which I suppose is really just hearsay) audit anxiety but the reference is to articles in the medical popular press, Australian Doctor 2008, and Medical Observer 2009. They note

that there is a posited one million drop in long consults in those articles. This is once again hearsay with references. I copy the articles here for your perusal.

****

6/5/08 is psr really on the level over c and d consults?

EDITORIAL by Australian Doctor Political Correspondent Paul Smith

APPARENTLY GPs are doing level C and level D consults wrongly. These consults are claimed more than 12 million times a year, but it turns out the widely held idea that they are routine consultation items in the standard sense of the word 'routine' is misguided.

It's not just about measuring the time spent with the patient, according to Medicare's watchdog, the Professional Services Review. To claim the consults legitimately, doctors should also be offering something extra and only to patients with complex problems.

If you don't believe it, the PSR says to look at the wording of the items in the MBSbook — which as a recommendation makes you wonder whether the PSR quite knows what it's asking. The text of the MBSbook reads like Swahili.

According to the PSR, "A patient seen for a repeat script for a stable condition, an ear syringe and a blood pressure measurement would not qualify as a level C consultation, even if the consultation lasted more than 20 minutes."

A 'genuine' level C consult apparently involves doctors taking "detailed histories, offering an examination of multiple systems, arranging investigations and implementing a management plan".

When I read those words last month I thought this was the PSR's attempt at a belated April Fool's joke.

The obvious problem for the PSR and Medicare Australia (if they are indeed serious about tightening up on this alleged 'misuse' of Medicare) is that they would be squashed flat by the sheer number of doctors who would qualify for investigation.

The current use of the items is so ingrained that it's impossible to go back to the strictures of the MBS book. Ingrained not because doctors have been eyeing an opportunity for early retirement, but ingrained because the items are supporting the viability of the business of general practice itself.

Looking back to the dark days — before more cash came into the profession in the form of management plans and higher rebates —you could argue level C and D items were one of the elements that kept general practice afloat.

The second argument for their use is also straightforward — if a GP is having to spend 30 minutes with a patient, it's not about getting government subsidies for a social chit-chat but that the patient's problems are sufficiently complex that they take 30 minutes to deal with.

Of course, GPs could submit to the written decrees of the MBS book and charge a string of consecutive level B consults instead — a classic bureaucratic solution in that it would add rather than save costs.

The PSR concerns about level C and D consults were outlined in its latest Report to the Profession. It comes out once a year and it always makes good reading — all those dodgy docs making merry on Medicare like they have hit the jackpot on an RSL pokie machine.

But we are talking about only a handful of doctors —27 in the past financial year — who are subject to censure by the PSR. That represents less than 0.05% of all doctors. Yes, 2007 included one GP who claimed 50 times the national average for longer consults — a claiming rate which makes you wonder if this doctor had to warp the space-time continuum to ensure there were enough hours in the day to fit everyone in.

But sometimes you suspect the PSR's perspective of the profession as a whole — and the advice and warnings it subsequently offers — is itself warped by the nature of the doctors it has to deal with. Certainly the typical doctor investigated by the PSR is not a representative sample of your typical Australian doctor — if it was, the Medicare budget would not last beyond a week.

I may be wrong in saying this, but you can usually read the PSR's pronouncements as a warning shot across the bow, one that is aimed at that small cohort of doctors whose claiming profiles flirt with deliberate fraud.

The one question that still remains is why so many of the investigations into Medicare abuse still seem to take little interest in specialists. The PSR says this has now changed — they've apparently caught a couple of ophthalmologists and a cardiologist.

But the focus on GP claiming still seems disproportionate and it is apparently wrapped up in the lack of both technology and formal powers available to Medicare Australia and the PSR to fully examine specialists' claims. It's almost four years since a Four Corners investigation found that specialists, particularly obstetricians, were ramping up their consultation fees to push patients onto the Medicare Safety Net where the Federal Government starts picking up 80% of the bill.

The continued financial pressures on the safety net suggest the PSR has got some way to go before you can argue that it's taking specialist rorts seriously enough for its existence to be considered a deterrent.

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If a consult is worth a Level C due to the time and the number of medical

issues dealt with, I'll bill it as such. And if I get audited I will happily tell the Medicare/PSR police that they will be personally and legally responsible for any adverse health outcomes in my patients as a result of them not being able to get an appointment as I will have been driven overseas to practise in a more appreciative environment.

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I would note that there is no reference here to one million consults, or audit anxiety. It only attracted one comment.. That does not suggest widespread concern amongst the readers.

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Audit fears undermine Government's prevention push (Medical Observer)

3rd Apr 2009 **Andrew Bracey** all articles by this author

ANXIETY over Medicare audits appears to be gripping the profession, with the number of Level C consults falling by almost a million. As GPs spend less time with patients, experts warn that the Federal Government is at risk of undermining its preventive health agenda.

Medicare figures reveal that around 4.55 million C consults were claimed in the six months from September 2008 to February 2009 – down significantly from the 5.53 million claims lodged for the same period in 2007/08.

Comparisons of claims for Level B consults for the same two six-month time periods revealed an increase of just over 2 million.

In the first two months of 2009 alone, there was a 21.4% drop in Level C consultations and a 28.9% drop in Level D consults compared with the same period last year.

The fall corresponds with the start of Medicare's ramped-up auditing campaign, and follows previous warnings from the Professional Services Review over correct claiming of long consults.

In the first quarter of 2009, Medicare received funding to initiate 625 audits, a 400% jump compared to the first quarter of 2008. Controversial new penalties for incorrect billing begin in July.

Professor Claire Jackson, professor of general practice and primary health care at the University of Queensland, said the figures reflected GP concerns over audits.

"The data indicates that GPs, sadly, are likely to revise their billing of consultations [longer than] 19 minutes to avoid the risk of investigation – either by decreasing the amount of time spent with patients or foregoing previous income from longer consultations," she told *MO*.

Health Minister Nicola Roxon has long advocated for preventive care. In her "Light on the Hill" speech, she voiced aspirations to fix MBS anomalies which led to disincentives for GPs to "provide the type of longer, intensive visit that prevention demands".

A spokesperson for the Minister conceded the drop might be partially attributed to confusion over Cs and Ds but said a 30.9% rise in enhanced primary care (EPC) items during the second half of 2008 showed the drop was being offset.

MO calculations for the same period showed a 1.03 million drop in C and D consults, overshadowing a rise of just over 385,000 EPC item claims.

AMA president Dr Rosanna Capolingua said the statistics revealed the government was undermining its own agenda.

“There is an absolute inconsistency between health policy, [which is] GPs spending more time with their patients... and Medicare on the other side auditing the use of Cs and Ds. It’s... two different messages,” she said.

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Here apparently is the origin of anxiety about audit, and the one million missing long consults, but based on the crude volume data decried by the “Decline” authors. Here is a professor of general practice, an ivory tower academic in other parts of this debate, offering her unsubstantiated opinion that these crude figure changes are “likely” to be due to GPs foregoing income or decreasing time spent with patients. All of which makes the headline and opening assertion fairly low grade “evidence”.

No one bothered to make a comment online regarding this article. This would be against it chiming with a chord of concern in the medical community.

Dr Masters states regarding “Decline”, the actual peer reviewed article in the “Medical Journal of Australia”:
“Recently the MJA highlighted research that has shown ‘audit anxiety’ is one of the major reasons for a drop in level C and D consultations in preference of (sic) the shorter A and B level consults (MJA 2010 193 (2): 80-83). One million less long consultations occurred due to Drs (sic) concerns about being targeted by the PSR – this does not bode well for people with chronic health problems”

This is not Evidence Based Medicine. The “Decline” article does not support Dr Masters’ thesis.

“Evidence’ 2.

The second published article is Appx 2 in Mr Dahm’s submission 4. It is a letter in which academic general practitioners from Notre Dame University in Fremantle report a survey they did of GP registrars. These are relatively young doctors with their careers ahead of them, actually investing time in preparing for a career in general practice. Sixty one percent of 147 trainees responded. An open question “What do you see as the major obstacles to general practice in Australia” had 6 possible responses (more than one could be checked). Fifty percent ticked a box that incorporated in one response “Increasing bureaucracy/Medicare/super clinics/disillusioned with medical system/isolation”.

The not yet fully fledged general practitioners did not say they suffered from, or were oppressed by, these factors. They just identified them, from the offered menu, as major obstacles to general practice in Australia, as they saw them from their particular perspective, at the beginning of their careers but after some exposure to older mentors.

Mr Dahm, p6, dot point 9 extrapolates this to “The current Medicare and bureaucratic system is a primary cause of this problem (not engaging in high risk professional activities, or leaving the profession altogether, leading workforce shortages (sic)), as research discussed in this article attached as Appendix 2 shows.

I do not believe the extrapolation is justified, or that the article he quotes shows any evidence of his thesis.

Evidence 3.

My reading of the submissions from the AMA, RACGP, RACP, MDAN, and MIPS is that they contain no reference to practitioners dropping out or markedly changing practice because of ‘audit anxiety’. Avant says it “has experience of ordinary appropriately practicing doctors so fearful that they perform for free, or a lesser rebate to normalise their statistical profile.” How they obtained and quantified that experience, and how large it is, is not stated. Avant does not say they have dropped out of practice or

seriously contemplated it. They are still performing the services they believe necessary, but under a self imposed financial penalty. Consumers have not suffered, only the doctors, financially.

“Evidence” 4

Dr Masters submission mentions his survey. It was publicised in his own LMA (Local Medical Association), where he is the Medicare Compliance officer and undoubtedly has a high and charismatic profile, and Medical Observer, a high circulation GP trade journal. It attracted about 210 replies, mainly negative. I would say the questions asked were leading and preaching to the converted, but I do not have to weigh that evidence as the Senate Committee does. It is evidence of a need for properly constructed and conducted surveys to explore the concerns, or lack of concerns, of the whole body of general practice.

‘:Evidence’ 5

His article to his LMA, attached to his submission, Dr Masters mentions “Anecdotally , there is evidence of rural pracitioners cutting back on work hours and doctors decreasing bulk billing due to recent increases in PSR activity”. No references , no numbers.

In the “Decline” article , they specifically mention that bulk billing has remained remarkably steady, after a transient drop in about 2003. His evidence for these assertions is unsupported. There is published evidence against his assertion on bulkbilling rates.

What follows may be thought to stray from the questions asked by Senator McKenzie. I therefore excise it from the body of my answer to assist the scrupulous.

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I would like to make a few comments here on “evidence” that doctors getting to the Director interview stage, and being offered a Section 92 agreement have received certain advice from lawyers and presumably their Medical Defence Organisations. It could be construed as “doctors changing their practice as a result of PSR activities.”

The joint skin Colleges letter, signed by 2 presidents, includes a case in which one (unidentified) was involved. A colleague in a busy clinic specialising in skin disease was a hard worker, with a high melanoma detection rate, who was subject to a Medicare audit, and came to interview with Dr Webber. His team of lawyer and barrister informed the college president that “PSR would not accept any arguments proposed on his billings because he was one of the highest earning GPs over the last few years”. He accepted this hearsay, as one possibly would from a respectable lawyer. We don’t know if the lawyer was employed by an MDO. The PUR is reported as feeling he was coerced into settlement, but was told by the lawyers that the only way to justice was through the courts. The lawyers reinforced in the doctor’s mind that natural justice would not prevail with the PSR.

This doctor is undoubtedly Dr D in the PSR report of 06-07. It is said there that the Director found claims for removal of malignant skin lesions where the pathology showed they were benign. This could be construed as fraud. Skin flaps were performed for the removal of tiny lesions, admittedly at least one on the finger where it is important that scarring not reduce function, but the justification in other areas might be difficult. The complex argument over his Number Needed to Treat could only be made to peers in a constituted Committee. It might backfire on him (if the melanomas were only found by removing every blemish that passed before him).

Dr Masters states, “this has led to MDOs advising doctors to accept settlements with the Director rather than face PSR committees as they consider the PSR committee unpredictable and acknowledge there is no practical appeal mechanism.”

I have myself had the one in a lifetime brush with litigation. I considered my case was strong. My MDO took expert advice, which was favourable to me. The opposition had advice that was not. Although my MDO would have let me have my day in court, their preferred position was to outlay $15000 in go away money. I agreed.

It used to be that MDOs were run by doctors, and “the bubble reputation” was a major priority. Now they freely admit they are in the business of insurance, and thus look to minimising expenditure on purely pragmatic grounds. Court cases and PSR Committees are expensive for an MDO.

No mention was made in any of the MDO submissions of such misgivings (as outlined above regarding PSR) that rolling over was now, with deep regret, their advice. I wonder whether difficult to defend cases are quietly misled regarding prejudice and unpredictability, and directed to a S 92 agreement so that outlays on Committee hearings where a legitimate judgement of inappropriate practice is fairly likely are not risked?

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At last, my opinion on where the line should be drawn between professional best practice and value for money for taxpayers.

Most institutional medical authorities, Colleges and AMA, recognise that modern medicine is expensive, and will get more so. The marginal health benefits are usually small increments, for quite high extra expenditures. There are formulae accepted by all to estimate the cost per quality adjusted life year, the current unit of account.

The debate then is for the consumers of health, and the taxpayers with their other demands for defense, education and rent seeking rewards as to how limited resources are to be allocated. We are all consumers and taxpayers.

The AMA code of ethics exhorts the ethical doctor to:

c. Use your special knowledge and skills to minimise wastage of resources, but remember that your primary duty is to provide your patient with the best available care.
d. Make available your special knowledge and skills to assist those responsible for allocating healthcare resources.

Best professional care sometimes is to watch, and go with the odds. All professional care includes assisting those patients who want to understand the doctor’s frequent uncertainty regarding probability of different causes for a set of symptoms. All patients must be aware of the risks of investigation or treatment, and assisted in assessing their own cost benefit ratio.

Different doctors, and different patients, have variable degrees of comfort with riding the odds, watching and waiting, and aggressive treatment for an individual when the total research flock on which the advice is based has not done that well.

Some doctors, and some patients, prefer early rather than later active investigations. That is recognised as part of the smorgasbord of acceptable practice. Doing everything to everybody every time is not.

I think there is no doubt that all doctors are these days aware of the likelihood of being sued by an aggrieved patient. Thanks to publications like Medical Observer and Australian Doctor doctors with a message get a pulpit. The message now includes beware the audit from Medicare and the chance of seeing a PSR Committee. Like flocks of terrified starlings doctors after law cases like O'Shea v Sullivan (1995) make transient changes in practice, returning after a few months to the norm, which slowly changes under more rational influences.

(In O'Shea v Sullivan the learned judged privileged specialist opinion on the perceived inappropriateness of a general practitioner's actions over the approval of a general practice expert witness. We are told that in the next few months referrals to specialists in terms of unexplained vaginal bleeding, a problem normally commonly and expertly dealt with in general practice, rocketed. There was great unhappiness,which has persisted, over specialists passing opinions on appropriate general practice.)

I don't think the evidence that I have seen, or has been seen in confidence by the Senate Committee, makes a case for the current PSR and Medicare auditing changing professional practice for the worse even for a minimal or unjustified saving to the tax payer/health consumer.

I do hope that after having considered all your evidence, you are able to say to the doctors involved, as observers, as persons under review and as PSR Committee members: "Do what you believe is professionally best for the patient and the community purse. We support you in that difficult endeavour. We believe that the PSR process is also fair and supportive, overall."

Thanks for reading this far, I hope it has answered your questions.