COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Professional Services Review Scheme

(Public)

THURSDAY, 22 SEPTEMBER 2011

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 22 September 2011

Senators in attendance: Senators Abetz, Adams, Back, McKenzie, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

A review of the Professional Services Review (PSR) Scheme provided for under the Health Insurance Act 1973 (the Act) which is responsible for reviewing and investigating the provision of Medicare or Pharmaceutical Benefits Scheme services by health professionals, with particular reference to:

(a) the structure and composition of the PSR, including:

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

(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;

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

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

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

(e) the appropriateness of the appeals process; and

(f) any other related matter.

WITNESSES

Committee met at 16:33

CHAIR (Senator Siewert): I declare open this public hearing and welcome everyone who is present today. The Senate Community Affairs References Committee is inquiring into the Professional Services Review scheme. Today is the committee's first public hearing in this inquiry. The committee reminds all witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. The committee asks that witnesses avoid making adverse comments against other parties and warns that such reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage and witnesses may also ask that evidence be taken in camera, at which point we go over to another process.

WEBBER, Dr Anthony David, Private capacity

[16:34]

Evidence was taken via teleconference—

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

Dr Webber: It has.

CHAIR: Dr Webber, we have your submission before us, numbered 24. I invite you to make an opening statement and then the senators present will ask you some questions.

Dr Webber: Thank you, senators, for affording me this opportunity to address you this afternoon. I would like to make a very brief opening statement in general terms and I am happy to answer your questions. As you know, there has been an explosion in medical knowledge and technology since Medibank was first introduced in 1973 and, of course, the business of medicine has been altered forever by the entry of corporatised medicine practising for a third party profit. The Medical Benefits Scheme and the Pharmaceutical Benefits Scheme have essentially not changed in basic form and still operate on the honour system. There is probably no other area of Commonwealth expenditure which allows recipients of taxpayers' funds to determine their level of remuneration. The Medical Benefits Scheme has accreted many new items over its existence, many in response to clinical needs. However, these archaeological layers have come to resemble a fridge covered with sticky notes. The MBS has a very complicated document for clinicians to get right and also it is very difficult to audit it and to ensure that patients are receiving quality care and the taxpayer is not funding inappropriate practice.

Medicare itself administers over half a billion transactions every year and, unfortunately, it has a fairly limited ability to track inappropriate practice. It would be my understanding that it is relatively understaffed and has difficulty attracting medical staff in particular and this has resulted in, unfortunately, many areas of fairly blatant inappropriate use of the MBS which has continued for many years. I have certainly, as my time as director, come across many examples where this has happened. That is not a criticism of Medicare; it is the way that the audit process is structured and it does leave quite a few deficiencies, in my view.

The practitioners referred to PSR represent a very special group of practitioners: less than 0.1 of one per cent of all medical practitioners. They have been screened by Medicare Australia, given an opportunity to change their practice over a six-to-12-month period by Medicare and only those who have not changed their behaviour significantly are sent to PSR for a detailed examination of their behaviour. This generally represents about only 10 per cent of the people that Medicare has initially screened. The outstanding characteristic of the more than 350 practitioners I have reviewed as director is a remarkable lack of insight. These practitioners lack insight into the standard of medical care they have been rendering and also display a lack of insight as to how their conduct may be viewed by their colleagues. Despite this, I have been able to dismiss 20 per cent of those practitioners sent to me as their clinical behaviour, when examined, has been appropriate. Eighty per cent, however, have had a case to answer and in 35 per cent, on average, the behaviour is so egregious they are required to be reviewed by a committee of their peers who will forensically examine their clinical practice.

There have been complaints aired recently that the PSR committee process is stressful. Well, it is. At the first meeting with a practitioner I inform them that the process is long and very stressful. Any investigative process into personal or professional behaviour is personally very challenging and practitioners certainly find it so. However, I do believe the committee process is a fair one. Committees strive to give the benefit of the doubt to the practitioner where possible and the practitioner has many opportunities to put his or her side of the case throughout the whole PSR process and yet the inability of several practitioners to appreciate that they have been treated fairly is, I think, a reflection of their lack of insight generally.

The other criticism often voiced is that PSR is designed and run to claw back Medicare funds as its sole aim. Now, I reject that assertion completely. I have always taken the view that, if the clinical behaviour is appropriate and in the best interests of the patient, the dollars will look after themselves, and it is a perspective that all committees I have established have followed: concentrate on the medicine and do not be concerned with the recovery of money. Financial recovery is the role of the Determining Authority.

PSR has an important role to play in dealing fairly and transparently with those practitioners referred by Medicare Australia. It also has an important role in educating practitioners in general about the areas of practice where others have not met acceptable standards. PSR has always been willing to work with the AMA and other representative bodies to improve how the process operates. That has always been a part of the scheme, and

significant improvements have been put in place, certainly over the time that I have been director. As for the future, I can certainly see PSR—and this may be somewhat controversial—having an own-motion ability to investigate scams and unacceptable corporate behaviour, of which I have seen significant examples, to prevent an escalation of this sort of inappropriate clinical behaviour. Thank you. That is all I want to say initially.

CHAIR: Thank you. I will ask Senator Back if he wants to start with some questions.

Senator BACK: Thanks, Dr Webber. You may recall that, in estimates, I asked you a number of questions regarding the membership of the panels. Could you just remind the committee whether, in the case of a doctor being the person under review, members of the panel reviewing that doctor work part-time or full-time or are retired? I think you said to me at the time that you did not use part-time doctors. Is that the case? Or do you use some part-time doctors?

Dr Webber: There are some doctors who do practice part-time. In general, the criterion would be not so much part time or full time but active practice. People are required to be in active practice. Many of the doctors that serve on panels, on committees, are fairly senior and have a lot of experience and often perform other functions—sitting on medical boards, college boards et cetera—so they have restricted their practice to a part-time situation because they wished to diversify their interests. But, certainly, people are selected for a committee on the basis that they are in active practice and have an understanding of how practices run in Australia.

Senator BACK: Without wanting to know names of doctors, would it be possible for you to take on notice, if you still have access to those who could provide the information, to give us some understanding of the remuneration that panel members would get if they were actively involved over a 12-month period? I do not expect you to answer that now—if you could take that on notice. Could you also tell me: with a panel constituted to examine one person under review, is it likely that, for example, two members of the same practice or indeed a couple who may be married or in a relationship could both be members of a panel for the same person under review?

Dr Webber: Just to clarify the first point, my having retired and now being back in private practice, I think it would be best to ask Dr Coote tomorrow for that information that you require on notice, Senator, because I do not have access to that.

Senator BACK: Sure.

Dr Webber: In general terms, the answer would be no, because generally people come from individual practices. To my recollection, there is only one practice which has two members of the panel in the same practice—that is to my recollection—and that is in Tasmania.

Senator BACK: That is the one in Launceston, is it?

Dr Webber: That is right, yes.

Senator BACK: In your submission I think you refer more than once to committee members being reappointed dependent on their performance. Could you tell me what that means? What is their 'performance'? Is it based on the number of scalps that they achieve, or is it based on their capacity and willingness to participate in panels? What is that 'performance'?

Dr Webber: Essentially—

CHAIR: Senator Back, could you rephrase your question, please?

Senator BACK: Certainly. Could you explain to us your comment in the submission about members being reappointed dependent on their 'performance'? Could you explain it to us what you mean by their 'performance'?

Dr Webber: There are a couple of criteria. If their performance in a committee is not seen to be fair to the practitioner—if people are asking inappropriate questions or clearly have displayed an inability to act fairly—then that would preclude them from further use for a panel. It does not happen very often, but it has happened.

Another criterion would be if a particular doctor was too busy to devote enough time to the process and was tardy in getting back documentation and so forth. If someone was prepared to work well with the committee in general, was not displaying bias, asked appropriate questions, was being cooperative and was not making the practitioner feel any more stressed than they otherwise would be, then they would be asked to serve again. But people who do not meet those criteria I would not use again.

Senator BACK: In your submission you have made the observation that doctors under review can call witnesses to give evidence. Just going back to the answers I thought you gave during estimates, it is my understanding—or perhaps you can correct me—that it is not until after the issuing of a draft report some months after the hearing is concluded that the doctor is actually aware of why he or she was being called before a panel. If

I am correct in that assumption, I just wonder how a doctor would know the sorts of witnesses that they might call to give evidence on their behalf if indeed it is not known until sometime afterwards what the matter was.

Dr Webber: The doctor would be fairly well aware of the issues in general to be discussed following a preliminary meeting with me. There would also be, in the referral document, an indication of the sorts of issues that I was concerned about to refer that person. Also, when the committee met for the first time with the practitioner, they would be talking about the issues that were to be discussed. So I suppose the issues in general would be known fairly well upfront. As for the findings, they probably would not be known except during the course of a hearing. But a practitioner would certainly be able to present evidence or have expert witnesses present or giving evidence at any time in that process.

Senator BACK: I think the claims has been made that PSR committee members are experts and that outside expertise can be called in. Could you explain to me how often outside experts would be called in to assist panels in terms of their expertise to then assess a person under review?

Dr Webber: Generally, not very often; and the reason for that is that common things occur commonly, and the sorts of issues that generally are investigated for most doctors are the standard sorts of consultation items and so forth that do not require any particular expertise. However, if a practitioner was involved in, say, plastic surgery, and other general practitioners on the panel did not have that expertise, a plastic surgeon might be called in. If there was some other particular area of expertise and the committee felt that they did not have the required level of expertise themselves, it would certainly be at the discretion of the committee to get a consultant to give them an opinion. Also, in discussing the case at the formation of a committee, I have sometimes included a specialist practitioner to sit on the committee and be part of the committee. Sometimes they are part of the committee; more often they are used as a consultant.

Senator ADAMS: I would like to continue in that vein. Looking at your definition of practitioners, if you had a midwife or a nurse practitioner, would you have somebody on the committee with nursing expertise or would they be assessed by medical people?

Dr Webber: If the person were a nurse practitioner, the committee would have a chair plus two nurse practitioners. If they were a podiatrist, it would have two podiatrists. Each individual specialty being examined is always examined by its peers.

Senator ADAMS: I just wanted to clarify that. I was a little bit worried. My second question is on your submission, where a chart shows a number of years and the number of practitioners referred to the PSR. In 2008-09 there was a huge rise—you had 136 practitioners referred. I was just wondering what happened then. It then went to 39 practitioners over 2009-10 and 56 in 2010-11. Have you any idea why that was such a large jump?

Dr Webber: Yes, and it does not reflect an increase in inappropriate practice. If you looked at the figures for the two years prior to that big jump, they were quite low—in fact, they were down to seven practitioners in a year. The reason for that is that we rely exclusively on Medicare for our referrals and Medicare had changed its practice and introduced a two-step review practice. That resulted in our work drying up almost completely over an 18-month period or so. That was clearly a problem, so Medicare's practices and the way it went about things were altered. The large number of practitioners basically represents a catch-up by Medicare. If you average out the number of practitioners over the last six to seven years, it hovers around the 50 mark. So it is an aberration.

Senator ADAMS: I was just wondering why it dropped from 136 down to 39 the following year.

Dr Webber: Between about 40 and 60 would be our working average per annum.

Senator ABETZ: I will try to keep my questions brief, and could you keep your answers brief. In your opening statement you referred to corporatised medicine and unacceptable corporate behaviour. Has the PSR prosecuted any person who is an officer of the body corporate?

Dr Webber: Sadly, no, because the legislation makes it very difficult to do so. It talks about the ability to take action against an employer of a practitioner if that employer has directed the employee to practice inappropriately. However, it is silent about a contractor. Because many of the practitioners working in the corporatised medical field are working under contracts, the owner of the practice is not able to be followed up.

Senator ABETZ: The answer was no. Is it correct to say that, given the methodologies you use, a low-volume, inappropriately practicing doctor would probably not be identified using the Medicare auditing methodology?

Dr Webber: That is correct.

Senator ABETZ: What about doctors who are innovative in their medical practice and are at the forefront? They as a matter of course must therefore be thrown up as a result of the auditing methodology. Is that correct?

Dr Webber: That is correct, or possibly so. But they tend to be sorted out fairly quickly. If they have been practising inappropriately and they have just been caught by the methodology, that can be sorted out quite quickly and easily.

Senator ABETZ: We do have cases where an associate professor, without mentioning names, has the specialist support of two cardiologists but was still determined to have been practising inappropriately by GPs who were not specialists in the field. If a doctor is in the innovative space, how on earth can you get a PSR panel that is also in that innovative space?

Dr Webber: The person being reviewed has to meet two criteria. The first one is that they are practising within the rules of the MBS and PBS. It is fairly straightforward to work out whether people have fulfilled the item descriptor. The second criteria is whether their behaviour would be seen as appropriate. While no-one wants to burn Galileo at the stake it is my belief that committees have quite a large experience and expertise and, if there is doubt about a particular innovative procedure or so forth, they have the ability to source information to judge it correctly or not.

Senator ABETZ: In relation to that which you told us about 'appropriate peers, genuine peers' reviewing, why is it that the AMA, AIMA, MIPS, MDA National and the ADU all raise doubts in their submissions to us? It seems that every organisation does not support that which you are asserting in relation to peer review involving genuine peers, or that external expert opinion provided by the person under the review is not taken into account, or that there is no right of reply et cetera. It seems that all the medical organisations are basically of a similar view and yet you are asserting an alternative view. Are you able to offer us an explanation for that?

Dr Webber: In forming a committee, PSR has to follow the legislation, and the legislation requires peers to be appointed to a committee. The peer is defined by the practicing group, as defined by Medicare. So we have always followed the legislation. We have also tried as much as possible to fit particular expertise with a particular doctor. There are always going to be people who do not think we get that right. In my view we have got that as right as is possible to do so.

Senator ABETZ: I indicate that a number of the submissions, and I think the AMA submission—I hope I don't do them a disservice—basically say there is no real problem with the legislation—it is more the administration and the personal conduct of these review committees that is causing a problem—and that natural justice does not apply et cetera. It is more in the administration of the PSR rather than the legislation under which you operate. What would you say to that?

Dr Webber: I would reject that. The administration of PSR and the committees, I think, always strive to give the benefit of the doubt where that is possible. Regarding the sorts of behaviours by practitioners in these special interest groups, the ones that come to PSR are really quite at the extreme end. It is not minor behaviour by any means. It is quite clear, I would think, to any objective observer that their behaviour is inappropriate.

Senator ABETZ: Case does not make you reflect on that answer?

Dr Webber: I missed that, sorry.

Senator ABETZ: The Tisdale case does not make you reflect on that answer?

Dr Webber: No, it does not. I believe that the committees have always strived to get it right for practitioners.

Senator ABETZ: If I may, didn't the court find a lack of evidentiary support for the PSR committee's conclusion in that case?

Dr Webber: This is the Tisdale case?

Senator ABETZ: I beg your pardon?

Dr Webber: Tisdale. Is that the case you refer to?

Senator ABETZ: That is the one.

Dr Webber: That was a completely separate issue and not to do with clinical practice. That was due to a breach of the 80-20 rule. You are right. That is the case's finding but it does not go to the clinical behaviour.

Senator ABETZ: I will not argue the law.

Senator McKENZIE: Dr Webber, as the past director, now no longer, do you think there is too much power vested in the director of the PSR's role, especially given the three stages in the process for reviewing a case? The first stage is obviously that the director makes a decision as to whether it proceeds or not. Do you think that is too much power in the hands of one person?

Dr Webber: That is a difficult question for me to answer, Senator. Any case that proceeds from a decision of the director—in other words, either a negotiated agreement or a decision to send someone to a committee—is

overseen by other people. If I, as director, were to enter into an agreement with a practitioner, that agreement and all the documentation that supported it is ratified. It has to be ratified by the determining authority—a completely separate body. If I send someone to a committee, the committee obviously has oversight of that, which is then also reviewed by the determining authority. The only absolute discretion I have is to dismiss somebody.

Senator McKENZIE: On page 51, the decision on whether to refer a case in either place seemed to sit with the director. I must have misread that.

Dr Webber: That is right. It does. The decision to do that does sit with the director, yes.

Senator McKENZIE: That would suggest that the role itself has some decision-making process on where the practitioner ends up. That is fine. One final question: in your opinion, given the feedback thus far, do you think the PSR retains the confidence of the medical profession?

Dr Webber: I think overall it probably does. I think this process, the Senate process, is a good way of airing the washing. I do not have any problem with that, because I think it is a fair process and the people that I speak to are supportive of it.

Senator McKENZIE: Thank you.

Senator MOORE: Doctor, the PSR has been in place for how long?

Dr Webber: Since 1994.

Senator MOORE: Have there been any changes in the way it operates in that period, between 1994 and now?

Dr Webber: Yes, there have been quite a number of different legislative changes over that time. The ability to enter into a negotiated agreement was not in the original legislation, nor was the independent determining authority in the original legislation. They have been improvements in the scheme over the years.

Senator MOORE: Has that been reviewed in that period?

Dr Webber: Yes. There was a significant review of PSR in 2007.

Senator MOORE: In terms of the processes, have there been significant changes to the way peer review operates?

Dr Webber: Not since about 2004. There are some changes being considered by the department to go before parliament but they have not done that as yet.

Senator MOORE: The peer process has been operating in much the same way since 2004—that is your position?

Dr Webber: Yes. The committee process has been operating all the time, but there have been significant changes subsequent to that.

Senator MOORE: I would imagine you have had a look at some of the evidence we have received?

Dr Webber: I have.

Senator MOORE: As you have heard from other people from the panel, a lot of people have put in criticism. Was there any of this criticism that you were unaware of before this particular inquiry started?

Dr Webber: No.

Senator MOORE: So, as to the people who are putting in the evidence, are these cases that you are aware of?

Dr Webber: They are individual cases and individuals that I am aware of, yes.

Senator MOORE: The organisation the Australian Doctors Union—had you heard of them? Had they been in contact with the PSR when you were director?

Dr Webber: No, they have never been in contact with me.

Senator MOORE: I am sorry; I missed the beginning of that.

Dr Webber: They have never been in contact with me directly.

Senator MOORE: And there had been no communication between that organisation and you in your role as the director?

Dr Webber: Not at all, no.

Senator MOORE: As to the process with the AMA: there has always been a close association with the AMA; had the kinds of issues raised by the AMA in their significant submission been raised with you previously?

Dr Webber: Yes, we have been talking about those and many other issues since the PSR was instituted.

Senator MOORE: And the process between your position and the AMA was a regular kind of discussion?

Dr Webber: Yes it was.

Senator MOORE: Thank you.

CHAIR: Can I just clarify—

Member of the audience interjecting—

CHAIR: I am sorry, we cannot take evidence from the floor. Dr Webber, can I just follow up on a question that Senator Moore asked in terms of contact from the Australian Doctors Union. Have you had contact with members of the doctors union?

Dr Webber: No. I do not know who they are or who they represent.

CHAIR: There are some doctors who are appearing tomorrow, so you might want to have a look at that list and see if you have had contact from any of those doctors.

Dr Webber: Some of those doctors have been through the PSR process, but that would have been my only contact.

CHAIR: Thank you; I just wanted to clarify that.

Senator ABETZ: In fairness, I think the Australian Doctors Union was set up specifically because of the concerns with PSR and matters arising. We can ask them tomorrow about that.

CHAIR: Yes, obviously. Are there more questions? We have seven more minutes.

Senator BACK: I will just ask a couple. I think, Dr Webber, that when you were kind enough to appear at estimates you told us that people fell into one of three categories: firstly, having met with you, there was no further action; or, secondly, you were able to reach with them a negotiated settlement; and then, thirdly, there were those who went on to review. Can you tell us again: in a negotiated settlement, I guess by its very nature, they were resolved to your satisfaction; what proportion of people who went on to the final, review process panel subsequently were actually found to have acted incorrectly, and what proportion were found by the panels to have no case to answer?

Dr Webber: I cannot tell you off the top of my head the numbers of committees, but I think there was, in my time as director, one committee where the committee found no inappropriate practice. Indeed, before I was director I was also a panel member, and at one of the committees that I sat on the person was found not to have practised inappropriately. But the practitioners referred to committees have been through a very significant screening program, and I would think that—well, as it has proved—most of them have a significant case to answer. I think that is why there are very few who come out with no inappropriate practice being found.

Senator BACK: Is one of the options available to you to refer these people back to a medical board—is that the case? If that is the case, is that because the panel would not feel able to undertake the review? Would that be the reason why you would refer them back to a medical board?

Dr Webber: No, it is a separate process. At any stage of the review process of the committee or indeed the Determining Authority, if there is a suggestion or evidence that there has been danger to the health or life of a patient or if there has been significant unprofessional behaviour, we have a legislative obligation to refer that person to a medical board, and that is a separate process. The PSR process continues, as well as, potentially, the person being referred to a medical board.

Senator BACK: This is my final question, then. Can you tell us in what proportion of cases, if ever, the PSR process has found disciplinary cause where the medical board in fact did not—in other words, the medical board may have perceived that they did not act inappropriately. Has that happened?

Dr Webber: Yes, it has, but it is comparing apples with oranges. As an example, a practitioner may have been found by a PSR committee to have practised inappropriately in relation to, for instance, prescribing narcotics. Whereas that behaviour would certainly be referred to a medical board because it is significantly unprofessional, there have been occasions where the medical board undertook rehabilitation of the doctor and did not find a need to take any disciplinary action. But it is a different process.

Senator BACK: Thank you.

Senator ABETZ: Dr Webber, in relation to negotiated agreements under section 92, can you indicate whether you have ever had feedback that a lot of these so-called negotiated settlements were simply commercial decisions by practitioners to cop it sweet to avoid the legal costs and time away from practice et cetera. As I understand it, the widespread view is that if you take on the PSR they will go for you, so it is a lot better to plead guilty, to use that term, even in circumstances where the overwhelming majority feel aggrieved by this and it is seen more as

go-away money that you pay to get rid of the problem. Has that view ever been expressed to you; and do you think it has any validity?

Dr Webber: It has certainly been expressed in the medical media. No, I do not think it has much validity. Most of the people that are before the PSR are represented by their MDUs with legal advice. It is almost universal that submissions in the review process are constructed and sent by their legal representatives, with the doctor's input, and it is not uncommon for the concluding paragraph to request a section 92 agreement if I am not going to dismiss somebody. So, in fact, these section 92 agreements are asked for almost universally. However, it has been my practice to offer a 92 agreement only where there has been relatively minor inappropriate practice—certainly, inappropriate practice that has not put anybody at risk—and where the practitioner had insight into their behaviour and had demonstrated a change in behaviour. Under those circumstances, a negotiated agreement is an appropriate course to take. It gets people back to practice quickly; they can get on with their lives. However, if significant inappropriate practice has been found early on, then I would not entertain the idea of a 92 agreement with the practitioner at all.

Senator ABETZ: You told us that people could be represented by their legal adviser. Isn't it rather that they can be accompanied by their legal adviser, as opposed to actually being represented by their legal adviser at these hearings?

Dr Webber: It is not a legal process. It is not the same as a court process, because the committee focuses on the clinical relevance of their behaviour. The legal person with the doctor being reviewed is certainly able to comment on points of law or procedure, or procedural fairness, but because they are not medical practitioners they do not have the ability to talk to the problem at hand.

Senator ABETZ: Though they are 'accompanied', not represented—in fact, that is the terminology you use on page 10, in the very last line of your submission.

Dr Webber: That is right, yes.

CHAIR: Dr Webber, they are all the questions we have for you. Thank you very much for appearing tonight because you could not appear tomorrow; we appreciate it. Thank you.

Dr Webber: Thanks very much, Senator.

Committee adjourned at 17:15