To the Senate Community Affairs Committee:

Proposed Medicare Legislation

2009

From:

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This paper addresses, for the assistance of the Senate Committee, issues raised by the proposed changes to Health Insurance – Medicare – legislation.

This CLA paper addresses the draft legislation and explanatory material contained in:

(a)

EXPOSURE DRAFT

2008-2009
The Parliament of the
Commonwealth of Australia
HOUSE OF REPRESENTATIVES/THE SENATE

EXPOSURE DRAFT

Health Insurance Amendment (Compliance) Bill 2009 No. , 2009

(Health and Ageing)

A Bill for an Act to amend the *Health Insurance Act 1973*, and for related purposes

and

(b)

HEALTH INSURANCE AMENDMENT (COMPLIANCE) BILL 2009

EXPLANATORY MATERIAL

Recommendation: CLA recommends that the Standing Committee rejects the proposed amendments, for the reasons explained below, and requires Medicare to start from scratch developing a proposal that will meet Government and community expectations as to quality, that will be effective, and that will not cost the nation in terms of productivity and actual dollar amounts.

There are managerial, medical and legal reasons why the proposed amendments should not pass the Parliament, in CLA's opinion.

Managerial:

> *Explanatory material*
> *Summary and financial impact*
> ***Financial impact**: The implementation of the IMCA initiative will provide savings of $147.2 million over four years and will cost $76.9 million to administer, leading to net savings of $70.3 million over four years. This funding was included in Budget Paper No.2 2008-09 for the Health and Ageing portfolio.*

Financial claims illusory

There is no proof of the above claim, stemming from information provided by Medicare, and included in the 2008-2009 Budget. The Senate Committee should be made aware that Medicare has an abysmal record of making financial claims as to 'potential savings' that prove illusory.

CLA strongly recommends that, before making a decision based on Medicare's 'Financial impact' claim, the Senate Committee requires Medicare to produce all similar claims made over the past 15 years as to proposed financial savings, and the true outcome five years into the proposed period of savings for each claim.

In particular, Medicare should be asked to explain the $120m-odd of special funding requested in about the year 2000 for new IT equipment/systems that was, Medicare promised, going to save that much in four years, and then return positive funds to the Government in all future years. What has been the net result of that project, and why would the current financial estimate be any more accurate than that estimate was?

Should Medicare's track record prove to be, as CLA suggests, woeful in predictive financial terms, the proposed amendments should be abandoned strictly on financial grounds, in that they will not produce the financial outcome Medicare claims.

If the financial basis is flawed, due to over-statement, there is no sense in proceeding with legislative change.

Financial claims wrong

Accepting, for the sake of argument, that the financial claims are correct, they are still wrong...or perhaps 'wrong-headed' would be a better description.

The equation allegedly is: $147m savings, $77m administrative costs, $70m savings.

The Senate Committee is strongly encouraged to require Medicare to explain in detail how it will take an extra $19.25m a year ($77m over four years) to administer a program that is overwhelmingly driven by computer algorithms automatically identifying billing behaviour outside the average.

If the bulk of the grunt work is to be done by computers, where is the justification for spending $19m extra a year on the program?

The only way this money could practically be spent is if Medicare plans to have a staff of about 100 unqualified, not-medically-trained people poring over patients' private health records and clinical assessments by doctors to find millimetric errors in diagnosis and/or treatment. These 100 'auditors' would be making diagnostic and treatment assessments for which the Medicare staff are totally untrained.

(That is, 100 people by $100,000 annual salary including on-costs per person = $10m annually, plus an additional $9m unexplained extra expenditure...on just this program!)

Leaving aside the privacy aspects of such a move, is it not true that the savings identified by Medicare will peter out after four years, on Medicare's own figures, and that the additional 100 staff will simply comprise additional cost from then on?

Note: These Medicare administrative workers should be described as 'voyeurs' rather than 'auditors', as they will be looking through patients' private health records rather than 'hearing' information about them.

Secondly, in relation to being 'wrong...or wrong-headed', the claimed costs to administer the program of $77m take account of Medicare/HIC/Health Department costs only. **They take no account of the extra costs to be borne by doctors and society as a result of Medicare changing its procedures.**

Assuming that Medicare's administrative costs of $77m are accurate, it must also be assumed that there would be a cost to doctors and society of a similar amount 'on the other side', which would be at least equal.

The true cost to doctors and society of bringing in a new audit program that requires a 'paper' (and/or similar) trail from diagnosis to being able to provide proof, to a level of courtroom evidentiary standard, two years later is likely to be, in fact, much higher.

The cost is certainly likely to be more than the equal of the claimed cost to Medicare because of the nature of its impact: it is "inefficiently" spread across thousands of general practices and isolated workplaces, rather than by contrast being "efficiently" contained in a few core Medicare locations.

The program will take hugely additional amounts of time from doctors and their staff – time is the raw material required by doctors and their staff to give patients adequate care, so that this program will have the effect of cutting consultation time and therefore lowering treatment standards.

If so, there will be NO benefit to Australia and no benefit to the national bottom line, even on Medicare's probably erroneous, but favorable, estimates...other than money being taken from doctors and transferred back into Medicare/Government funds.

Based on Medicare's figures being accurate – and acknowledging the extra costs on doctors and society – the equation will be:

$147m savings, $77m administrative costs and $70m savings to Medicare;
$77m-plus costs to doctors/society
Net benefit: ($7m)

That is, based on Medicare's own figures and a reasonable estimate stemming from them, this proposal will cost the nation $7m over four years at the same time as reducing the number of hours doctors and their staff have to treat patients.

This is a sub-optimal outcome for Australia.

'Hit list' is at one remove from reality

> 1.11 The expansion of the program is enabling Medicare Australia to include in the compliance audit program Medicare services provided by allied health practitioners including aboriginal health workers; audiologists; clinical psychologists; diabetes educators; dieticians; exercise physiologists; mental health nurses; occupational therapists; psychologists; social workers; and speech pathologists.

This list is interesting. It appears to be Medicare's 'hit list'. At another level, it appears to be a list containing the services in most demand in Australia.

Is Medicare truly saying that it plans to target 'aboriginal health workers'! and 'mental health nurses'! These people are like gold, and their time is extraordinarily valuable because they are in such short supply, but Medicare apparently plans to single them out for special surveillance so that they have to spend more time on creating a paper trail, dotting 'i's and doing administrative work, to the detriment of their helping patients in enormous need.

Observers closer to reality sometimes wonder how erstwhile agencies at the end of the Government food chain, like Medicare, can conceive of such counter-productive 'initiatives'.

CLA proposes that the Senate Committee asks Medicare to go public with its program when it begins to target 'aboriginal health workers'. We believe the media will be very interested in Medicare's efforts to reduce the effective time that such workers can spend on helping Indigenous Australians improve their health. The Prime Minister's office is also likely to be very interested in the media publicity likely to occur.

Double-speak shows deficiency of Medicare's competence

> *1.12 The expansion is also enabling Medicare Australia to conduct more compliance audits on Medicare services provided by specialists. At the*

same time, Medicare Australia is continuing work to develop better risk identification processes for specialties and sub-specialties.

This paragraph is classic, bureaucratic double-speak. Translated, it means "we desperately want to conduct more audits on specialists because we really don't know what we're doing when it comes to specialists".

Specialists and Australian society should not have to pay – in doctors' and staff time – for Medicare to learn how to do its job properly. If Medicare doesn't know enough about 'risk identification processes' in relation to specialists, it should not be introducing legislation on the speculative basis that there might be something wrong in specialists' claiming. It should not be using the legislative hammer as a self-educational tool for Medicare managers and staff.

Medicare is here acknowledging that it is incompetent. Neither patients, nor doctors, nor Australian society, should have to pay extra – in terms of time and stress for doctors, and reduced care for patients – because Medicare is on a fishing expedition, chasing an intangible 'catch', like fishing for stars in the sea.

Medical

Grab for power

Until now, reviews of possibly inappropriate medical decision-making by doctors and allied professionals have been made under the Professional Services Review (PSR) program.

PSR is a separate statutory body, set up solely, precisely and entirely to carry out reviews of inappropriate medical servicing. The proposed legislation would fundamentally change how possible over-servicing is policed. It would give raw 'policing' powers to Medicare – which is a funds disbursement body – and take those powers away from the PSR, which is the designated policing body.

The PSR's very purpose is to do the work that Medicare is trying to take over by having this pseudo-saving legislation approved by the Parliament. Medicare's move is basically a grab for more power.

From the PSR website:

> The PSR Scheme (the Scheme) gives the Professional Services Review (PSR) authority to investigate whether health practitioners have engaged in inappropriate practice when providing Medicare services or when prescribing medication.
>
> **Professional Services Review**
> **Protecting the integrity of our public health schemes**
>
> Professional Services Review (PSR) exists to protect the integrity of Medicare and the Pharmaceutical Benefits Scheme (PBS). In doing so it also protects patients and the community in general from the risks associated with inappropriate practice, and protects the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

> The PSR Scheme is the process used for reviewing and investigating the provision of services by a person to determine whether the person has engaged in inappropriate practice.

This is how the scheme works:

> **Review by the Director**
>
> As set out in the Health Insurance Act 1973 (the Act), Medicare Australia may request the Director of PSR (the Director) to review the provision of services by a person during a specified period. The period specified must be within 2 years immediately preceding the request. The request must include reasons. Medicare Australia must give the person written notice of the request within 7 days.
>
> The Director may request further information from Medicare Australia to assist in making a decision whether to conduct a review, or for conducting the review. The Director has 1 month from receipt of the Medicare Australia request to decide whether or not to undertake a review.
>
> The Director must undertake a review if, after considering the Medicare Australia request and any other relevant material, it appears to the Director that there is a possibility that the person has engaged in inappropriate practice in providing services during the review period. The Director must notify the person and Medicare Australia of the decision to undertake a review.
>
> The person must also be provided with information about the Director's power to request medical records and other relevant documents under section 89B of the Act at this time.
>
> If the Director decides not to undertake a review, the person and Medicare Australia will be notified accordingly. The notice given to Medicare Australia must also include the grounds for the Director's decision.
>
> Where documents are required to be produced, the Person under Review (PUR) will be notified of the consequences of failing to produce them. These are that services rendered or initiated by the PUR will not attract a Medicare benefit until the practitioner complies with the notice (s 106ZPM). Refusal or failure to comply with a notice by a person other than the person under review is an offence under section 106ZPN of the Act.
>
> The Director may review any or all of the services provided by the PUR during the review period, may undertake the review in whatever manner is thought appropriate and is not limited by the reasons in the Medicare Australia request.

The most important aspect of this scheme, from the public's privacy perspective, is:

> The PSRC consists of medical practitioners and other health practitioners appointed by the Minister for Health after consultation with the AMA or appropriate professional organisations.
>
> – from PSR website, 1645hrs 090422

CLA suggests that the Senate Committee asks one simple, basic question: why should Medicare be given new powers to investigate doctors when a separate statutory authority – which uses 'medical practitioners' to do the investigating – exists with the prime purpose of doing exactly the same work? The PSR has proved to be efficient and effective, and appears to have the confidence of the medical profession and the Australian people.

If the answer to this question is that the new legislation will emasculate the PSR and put power into the hands of non-medical bureaucrats in Medicare, who do not enjoy the confidence of the medical profession or patients, it is difficult to understand what is gained by fundamentally altering how over-servicing is policed.

Special privacy of the doctor-patient relationship

> **@129AAD Notice to produce documents**
>
> *(1) This section applies if the Medicare Australia CEO has a reasonable concern that an amount paid, purportedly by way of benefit or payment under this Act, in respect of one or more professional services may exceed the amount (if any) that should have been paid.*

Under the proposed legislation, the person empowered to take any relevant action is the 'Medicare CEO'. The Medicare CEO is not required to be a medically-qualified person, and is not necessarily (nor customarily) a doctor.

Through delegation, the wording effectively gives any Medicare administrative worker the unbridled power to look through all health records of any Australian at any time of their choosing to assess whether the treatment history **may** be 'of reasonable concern'...as the proposed legislation says. In the past, in general only medically-qualified people have had legitimate access to the health records of Australians for such review purposes.

Effectively, the legislation abrogates – removes – the privacy of the health relationship between a doctor and his/her patient.

Until this legislation, Australians could see their doctors in confidence that what they told the doctor would only be known by a doctor, and the recorded information would only be seen by a doctor. Now, Medicare employees are empowered – and will be encouraged (if not compelled) by the Medicare CEO – to pry through health records to see if any treatments are 'of concern'.

This is a drastic and unwarranted intrusion into the patient-doctor relationship. On this basis alone, the proposed legislation should be abandoned and never re-introduced in any form or under any guise that will allow bureaucrats to pry into patients' private records.

Legal

All privacy safeguards abandoned

> **@129AAG Medicare Australia CEO may deal with documents etc. produced**
>
> (1) If a document, extract or copy has been produced under section

@129AAD in respect of a professional service, the Medicare Australia CEO may do all or any of the things mentioned in subsection (2) for the purpose of ascertaining whether the information contained in the document, extract or copy properly substantiates an amount paid, purportedly by way of benefit or payment under this Act, in respect of the service.
Note: If the information does not properly substantiate the amount, recovery action may be taken (see section 129AC) and an administrative penalty may be applied (see sections @129AEA, @129AEB and @129AEC).
(2) The Medicare Australia CEO may:
(a) inspect the document, extract or copy; and
(b) make a copy of, or take an extract from, such a document or extract; and
(c) retain the document, extract or copy in his or her possession for such reasonable period as he or she thinks fit.
(3) The person otherwise entitled to possession of the document or extract is entitled to be supplied, as soon as practicable, with a copy certified by the Medicare Australia CEO to be a true copy.
(4) The certified copy must be received in all courts and tribunals as evidence as if it were the original.
(5) Until a certified copy is supplied, the Medicare Australia CEO must, at such times and places as he or she thinks appropriate, permit the person otherwise entitled to possession of the document or extract, or a person authorised by that person, to inspect and make copies of, or take extracts from, the document or extract.
(6) This section is not limited by:
(a) any other provision of this Act; or
(b) any provision of the *Medicare Australia Act 1973* or any other Act;
that relates to the powers of the Medicare Australia CEO to deal with a document, extract or copy as described in subsection (2) of this section.

There is absolutely no doubt that clause (6) negates safeguards that have until now protected the privacy of patients' health information. Once the information falls into the 'of concern' category, it is open slather to Medicare staff to go through it.

The section clearly abrogates – that is, repeals or does away with – the provisions in the principal Medicare legislation that make it an offence for Medicare staff to pry into Nicole Kidman's health records, or to riffle through files to find out whether Quentin Bryce has received any unusual treatments, or to find out what medication Kevin Rudd, or their local Member of Parliament, is on.

Clause (6) means that Medicare staff may 'inspect, extract or copy' any information willy-nilly if that information is caught up in the 'of concern' category. Staff only need to claim there is an issue of 'possible concern' – whereas in the past they have been prevented from peering into private files unless they had a specific reason for accessing the particular record.

Undoubtedly, the incidence of inappropriate access by Medicare staff to the private information of high profile Australians (and neighbours of staff, and people from the local school, and prominent people, etc) will rise. The Senate Committee may decide to ask Medicare to list how many inappropriate accesses there have been over the past 10-15

years, and to give an estimate of what the additional inappropriate access is likely to be in future. If Medicare can give 'accurate' financial estimates, it should be able to be equally accurate in giving estimates of increased prying.

Creeping compulsion

There is a trend in government in Australia, evident at both the federal and state/territory level, to abandon the traditional rule of law in this country for the purposes of administrative ease.

It is as if public servants, or bureaucrats, are become the power in the land. New laws and regulations are being made to suit the public servants' convenience, to the detriment of the common citizen and to the abandonment of the Aussie 'fair go' principle.

So it is with this proposed Medicare legislation.

> **@129AAF Self-incrimination etc.**
> (1) A person is not excused from producing a document, extract or copy when required to do so under section @129AAD on the ground that doing so would tend to incriminate the person or expose the person to a penalty.

That is, if Medicare officer has a 'concern', a doctor is compelled to produce whatever document the Medicare officer demands if that document may have any relevance to any claim made on Medicare by the doctor. This provision is unfair, unreasonable and un-Australian. It should be struck out, and the common law should prevail.

There is a grave danger in Australia that laws being amended for the ease of administrators are warping the traditional rule of law and the rights of individuals. While individual Australians (doctors in this case) have responsibilities as well as rights, so does the State, as represented by bodies such as Medicare: the State's prime responsibility is to prove any legal case against an individual without compulsion on the individual to self-incriminate – this is one of the longest standing and most basic tenets of our common law system.

There is no cogent reason that doctors should be compelled to produce documents outside the legal traditions any more than bankers, or buskers, or pet shop proprietors or politicians should be. It is often useful in proposed legislation such as this for anyone considering the efficacy and ethics of the situation to consider how they would like a particular provision if it applied, solely, to them or their line of work.

Examples prove the legislation is not needed

> 2.11 There are a range of circumstances which might form the basis of a reasonable concern on which to conduct a compliance audit.

Example 2.1

> **Example 2.1**

> A medical practitioner has provided 10 services in respect of which Medicare benefit for item 31524 was paid. However Medicare Australia's claiming data appears to indicate that these services have been provided to male patients. As this item can only be used in respect of services provided to female patients, this could constitute a reasonable concern which may result in a compliance audit being conducted.

Example 2.1 is a clear example of administrative processing error, in which case education is required, or of fraud, in which case prosecution is required, or at least referral to the PSR.

If Medicare allows this type of error to occur 10 times without correcting the situation, then Medicare staff are incompetent, because it will be automatically identified by computer vetting algorithms at the first occurrence.

Example 2.1 does nothing to illustrate that the proposed legislation is required – the reverse, in fact.

Example 2.2

> **Example 2.2**
> Expenditure on professional services for Medicare items associated with heart checks unexpectedly grew from $500,000 in 2005 to $10 million in 2006. Analysis of claiming data indicated that the majority of these services were being provided by practitioners employed by corporate entities who advertised free heart check services.
> Medicare Australia became concerned about the risk to the Medicare scheme and conducted compliance activity focussed on practitioners who had provided significantly more of these services than their peer group. This example would also constitute a reasonable concern under this Bill.

CLA has field-tested Example 2.2 with a sample of average patients. Every single one responded by saying that: "Isn't having a heart check-up a good thing?" Every single ordinary citizen believed that providing providing preventative health check-ups is precisely what the Australian health system should be doing.

It is not Medicare's place to decide government policy.

If the rules permit doctors to provide 'free' health checks when a patient exhibits any 'at risk' indication, then it is Medicare's job to pay the benefits. This is a classic example of a bureaucracy growing above itself.

If a group of doctors wish to specialise in providing health checks – aimed at preventative medicine – then Medicare should pay the bills until the Australian Government changes the rules.

The only 'concern' evidenced here is that Medicare appears to believe it is a policy-setting agency, which it is not and has never been, and should never be. The Health Minister sets health policy, on the advice of the Health Department.

Penalty regime

The above highlights one of the problems with the proposed legislation: all the 'penalties' are on doctors. There needs to be a countervailing penalty regime – if there is a penalty regime at all – which imposes penalties on Medicare for incompetence or wrongdoings. See below for further discussion of penalties.

Example 2.3

> **Example 2.3**
> Medicare Australia's National Compliance Program (NCP) identifies a number of strategic risks which are the focus of compliance activities during 2008-09. One of the risks identified in the NCP is upcoding in relation to skin lesions. Upcoding occurs when a practitioner bills for a more expensive Medicare item than the service provided to the patient.
> For example MBS item 31215 is paid in respect of a service for the excision of skin lesions of up to 10mm in diameter whereas MBS item 31210 is paid in respect of a service for the excision of skin lesions of more than 10mm and up to 20mm in diameter.
> The size requirement relates to the diameter of the skin lesion, not any other skin excised with the lesion. However sometimes upcoding occurs because a practitioner considers the diameter of all the skin excised rather than just the diameter of the skin lesion.
> As the upcoding of these services has been publicly identified as a strategic risk to the integrity of the Medicare scheme, a reasonable concern may arise in relation to any practitioner who provides these particular Medicare services.

Example 2.3 is such a poor example as to be laughable, if Medicare did not – apparently – intend the example seriously.

As noted above, how other than still photography, probably at the professional macro level, could a doctor demonstrate that his/her treatment was of a skin lesion of 11mm rather than a skin lesion of 10mm?

Will the Senators please take a moment to draw on their pads the difference between 10mm and 11mm? And will the Senators consider how a doctor could prove that one lesion was 11mm rather than 10mm? Would the Senators consider that the cost of providing proof at the millimetric level would be monumentally unproductive in terms of national output, the health of patients, the administration of a doctor's surgery and the efficiency of Medicare?

Will Medicare be providing professional quality cameras, with tripods and flash, so that doctors can be assured of having to hand the documentary proof to the standard required by Medicare?

At about $1000 per camera, this will require a substantial expenditure by doctors which will ultimately have to be paid for by Medicare, either directly or indirectly.

The nonsense of this example again questions whether there is anybody within Medicare who has an ounce of common sense? Is it not obvious in the extreme that the cost – to doctors and the community – of providing documented proof to Medicare standards of 1mm will dramatically increase the time required per patient, and considerably increase the level of sophistication of recording devices: tape recorders, cameras, video cameras, flash units, lighting, etc? Then, of course, there is the cost of extra storage requirements to meet privacy principles for this documentation, in the doctors' surgeries and in Medicare.

Is it not obvious to anyone using common sense that the definition of size of lesion as currently administered, millimetre by millimetre, is an inappropriate way to apportion different costs for lesion treatment? Is it not obvious that Medicare, working with doctors, could come up with an entirely different and more appropriate recompense regime?

Making an example of the examples

The three examples given by Medicare as to why the legislation is needed are presumably the best examples that Medicare can give to support their case.

If so, it is clearly demonstrated that the legislation is not needed, and that Medicare needs to involve itself on fundamental staff attitude training and competence raising, particularly among whatever section or branches of Medicare were/are responsible for producing a document of such intellectual paucity as the Explanatory Material paper, and its quaint 'examples'.

Lowering the bar

The 'proof' level before a doctor's practice can be effectively 'raided' for total production of documentation is very low. All that is required is for one person within Medicare to hold 'reasonable concern'. We note that this belief standard is not defined (except by cumulative indications from the poor examples), leaving interpretation wide open and giving doctors (and later judges) no guidance.

The bar needs to be raised considerably. At the very least, there should be "reasonable grounds for suspicion based on a pattern of behaviour extending beyond three months".

The test needs to be far, far higher from simple 'reasonable concern'. At 'reasonable concern', one solitary billing event could trigger an entire investigation into a doctor's behaviour, whereas one solitary and genuine billing error could be all that occasioned the 'concern'.

The proposed 'reasonable concern' standard leaves it open for Medicare, and individual Medicare staff, to engage in witch hunts. Lest the Senate Committee think that government agencies do not engage in witch hunts, CLA wishes to remind Senators that the Government has recently – and so far – paid out $55m compensation to Jim Selim of Pan Pharmaceuticals because the Therapeutic Goods Administration engaged in behaviour which some commentators have described as a 'witch hunt' (it is possible that further court cases in relation to Pan will cost the Government an additional $100m or more). Where bureaucrats are given excessive power, it is almost certain that they will eventually use all the power available to them and, in some cases, will abuse that power.

CLA recommends that the Senate Committee – if it decides to endorse the proposed amendments at all – demands that a better bar/level of suspicion be described, and be defined.

CLA points out that the damage to the doctor is done ab initio. That is, on merely raising the 'concern', all the negatives of being required to prove his/her innocence are visited on the doctor, including the cost and turmoil within the practice.

From the bureaucrats' point of view, this is legislation which passes all the workload on to the doctors: pass the legislation, and the Medicare public servants can go out to a long lunch while doctors and medical professionals throughout Australia are forced to jump through even more hoops, continuously proving their innocence, whereas the common law usually demands that a 'prosecutor' proves a defendant guilty.

The hoops involve, at least:

- additional recording of reasons for making clinical decisions:

  No longer will a simple reminder note to the doctor be sufficient; the note must be fulsome enough to satisfy the prying eye of a public servant or, in extremis, the tight, legalistic interpretation of a judge.

- in some cases, photographic evidence:

  Doctors will have to change their method of operating, at least in the example given by Medicare of removal of skin lesions. To be able to prove that a lesion dimension requiring removal was 11mm, rather than 10mm, a doctor will have to take one or more photographs every time a marginal decision is made. Similarly, there will be requirements for photos in other diseases, ailments and treatments.

- in some cases, video evidence:

  It is likely that doctors will have to produce video – moving pictures – 'evidence' to be able to satisfy some of the proof requirements demanded to allay 'reasonable concern', such as a proving that a 'pre-existing condition' was present. For example, how can psychologists prove that their treatment was appropriate? We note that psychologists are on the Medicare 'hit list'.

Administrative penalty

Why should there be an administrative penalty? If there has been a genuine mistake, education is required. If there has been fraud, a criminal case should be mounted through the PSR, and criminal penalties should be imposed.

On what basis does Medicare believe that, alone among workers, doctors should pay administrative penalties? Will similar regimes be introduced for bankers – that would be extremely popular worldwide at the moment? For solicitors and barristers? For accountants? For politicians? For supermarkets who mark up prices excessively? For garbage workers who make too much noise early in the morning? For Australian cricketers who don't get runs?

Perhaps Australia could have the Medicare-led, Penalty-Based, Recovery We Have To Have? All workers could pay a penalty in advance, just in case they make a mistake.

If administrative penalties are to apply, then they should apply two ways. That is, if Medicare makes an error, or delays billing reimbursements, they should pay administrative penalties in keeping with the quantum of the proposed charges on doctors.

And any case 'of concern' brought to bear which proved to be erroneous should attract a penalty payment in compensation for the doctor and his/her staff's additional workload to prove themselves innocent when they were in the right all the time.

If a penalty applies if the 'concern' is proven, then a penalty should apply in reverse if the 'concern' is not proven.

Perhaps any penalty on Medicare should be double or treble that on doctors, so as to dissuade frivolous or malicious behaviour by Medicare staff; ideally, of course, Medicare staff making an error would have to pay personally, as it is proposed the doctors do.

Senators may wish to ask Medicare to provide details of how much of the $147m 'savings' are to be made by way of administrative penalties on doctors?

Apply prospectively

> 1.86 This Bill will apply prospectively. That is, the new provisions will only apply to professional services rendered once those provisions commence (currently expected to be 1 July 2009).

It is not true that the legislation applies only from the commencement date. The power exists in the legislation to demand documents up to two years old. Therefore, at commencement, Medicare will be able to require doctors to produce documents relating to events two years ago. It is highly likely that Medicare **will** demand documents two years old with a view to establishing a pattern of behaviour.

If the legislation is to apply prospectively only, there should be a two-year moratorium from the day the legislation passes Parliament until it becomes active. Otherwise, the Explanatory Material claim needs to be amended – again, in yet another aspect, the Explanatory Material is deficient.

Ultra vires

> 1.17 The CEO of *Medicare Australia* has broad responsibilities under various parts of the *Health Insurance Act 1973* (the HIA), the *National Health Act 1953* (the NHA) and other legislation.
> 1.18 While there is no explicit power that directs the CEO to conduct audits, it is reasonable to expect that the CEO may conduct audits in order to carry out a given function, and to ensure the honest and efficient use of public money.

If there is no specific power to conduct audits, this legislation will surely lead to a High Court challenge to the validity of the audit and of the 'of concern' regime.

The Senate should require the legislative drafters to include power to audit if this legislation is to proceed, otherwise the new legislation will only increase uncertainty.

Why should a doctor comply with an audit when the Medicare/Health Department's own Explanatory Material admits there is "no explicit power" to audit?

Privacy is shattered

> 1.19 Compliance audits of Medicare services are checks conducted by administrative staff to confirm that the practitioner was eligible to provide a Medicare service, that the service was actually provided and that the service met the requirements of the Medicare item paid in respect of the service.
>
> 1.25 A compliance audit is conducted by specially trained administrative staff that assess whether the service the practitioner provided to the patient met the requirements of the Medicare item which was paid in respect of the service.

No proper assessment can be made by 'administrative' staff unless the clinical circumstances are included. The example of the millimetric distinction proves this point. Hence, all assessments will invade the privacy of patients.

Rather than NOT notifying patients of situations where their health records are caught up in 'reasonable concern', it should be mandatory for Medicare to notify patients that such is the case. This would ensure full and proper disclosure to patients, who would be able to take whatever action they determine is needed to safeguard the privacy of their health records.

The Senate Committee should require of Medicare a scheme that includes notifying patients in all cases, with details of how it will operate (and how much extra it will cost to the already-calculated costs given). Why should investigation of their health records be kept secret from patients?...unless Medicare, rightly, fears a massive public backlash.

Spinning the facts and figures

> 1.41 Across a range of audits conducted during 2006-07, this non-response rate ranged from 4% to 70%. The average non-response rate for compliance audits of Medicare services during this period was around 20%.

This percentage analysis has all the indications of being heavily 'spun'. Senators should demand the raw material on which these two sentences are based to see if the impression given here is accurate or is in fact, as CLA very strongly suspects, heavily gilded.

The figure suggests non-compliance of 1 in 5 situations. It would be interesting for Senators to analyse the significance of the various issues at the heart of these situations, to see whether the Senate is being given relevant and accurately truthful information, or is being 'snowed'.

The comparisons should also take into account the dollar value of the situations, to give a proper indication of meaningful impact.

Existing powers are sufficient

> 1.48 Part IID of the *Medicare Australia Act 1973* provides Medicare Australia with the power to require a person to provide information or produce documents where there are reasonable grounds for believing the information or documents may be relevant to the commission of a criminal offence or civil contravention.
>
> 1.49 Part IID also gives Medicare Australia powers of search and seizure (which extend to clinical records) where criminal offences or civil contraventions are suspected.

As the Explanatory Material itself makes crystal clear above, Medicare has more than adequate powers already. No further powers are justified where there are "reasonable grounds for suspicion", which is a far more sensible test than 'of reasonable concern'.

Why additional training?

> 1.56 Information collected during a compliance audit will only be accessed by specially trained compliance auditors.
> 1.57 Compliance auditors will be administrative staff located at Medicare Australia's State, Territory and Central offices who will receive additional training in the use and storage of sensitive information.

If the training of Medicare staff in relation to privacy is adequate now, why would additional training be required for the audit program?

The only reason would be if administrative staff were to have open access to clinical data, which is precisely what the Australia people do not want, and to be making administrative decisions which attempt to second-guess the clinical decisions made by doctors.

Doctors' experience with Medicare officers is that they have no idea what goes on in consultations, or how complex the work/decision-making actually is. How could they have – they are medically untrained, which is why they should not be making judgements based on medical decisions made by trained professionals.

The doctor has a clear accountability to the patient for the patient's health (and, sometimes, life); where is the equivalent accountability or appreciation of clinical decision-making by a Medicare administrative officer? Of course, a Medicare administrative officer would have made a different decision in the circumstances, because the Medicare administrative officer is not capable of having a full medical understanding of the situation.

Of all data and personal information, Australians most highly value – and most want protected – their medical records.

There is no justification whatsoever for allowing administrative staff to have access to private medical records when any potential problems in terms of over-charging by doctors could be handled by the PSR, using medical practitioners to evaluate treatments/costs.

If Medicare truly believes it is not competently carrying out its mission, and that therefore it is paying out more money than it should, it should lobby government for more staff to be given to the PSR so the PSR can become more active.

Privacy is in limbo

> 1.63 A Privacy Impact Assessment (PIA) is being prepared on the IMCA initiative and is currently being updated to reflect stakeholder comments. This document is likely to be released for stakeholder consideration shortly.

The question of privacy in relation to personal health records is in limbo at the moment. The National E-Health Transition Authority is in the process of establishing what privacy regime will apply to personal health records for the sake of electronic data exchange of health records in the future.

The diminution of privacy standards which would be involved in this proposed legislation would create a very low-level basis on which that NEHTA ongoing discussion would be held. It would be far preferable for legislation such as that proposed to be complementary to any NEHTA developments.

The proposed Medicare legislation would do a grave disservice to the Australian people in terms of the privacy of their health records. Previously, only medical practitioners have had usual access to patient's health records; this legislation would, in one swoop, significantly extend usual access to low-level administrators and public servants. This would not be a positive development for health in Australia, or for Australians in relation to their health records.

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Addendum 1

CLA is not associated in any way with medical/health doctors; we wish to point out that we represent mainly the interests of patients/the community. However, in preparing our paper we have consulted with patients/citizens, and with doctors.

For the benefit of the Senate Committee, here is one piece of first-hand feedback to us from a doctor:

> Our experience with Medicare auditors – we were fully audited XX years ago, then again XXXXXXX – has been quite excruciating. Their processes are appalling.
>
> The PSR process is set out very clearly, and you know what is happening. But with Medicare audits – we were not told what was going on, why or how. We were asked to collect some information, then a woman turned up and told us she expected to audit a whole range of issues which we had not been informed of. While she was there she was asking us about what was going on with the patients in the centre, which was not her brief at all, she was just being a nosey parker. We were appalled by the whole experience.
>
> The next experience was when the government employed all these people to ring up GPs, asking them to examine their records to "check up" on what they had been claiming. The doctors were given 2 weeks to reply. The so-called "random" audit ended up with two-thirds of our doctors being singled out *(because of the nature of the service these doctors provide, it is alleged* - comment added*).*
>
> Again the process was appalling. In both cases, the doctors spent an inordinate amount of time looking at records (hours upon hours), which just shows that the people delivering services – the doctors – will be spending far more time, unpaid and uncompensated, on the "red tape" than anyone in Medicare.
>
> Us and other doctors have had the experience of Medicare ringing up our patients to ask the patients about the services the doctor delivered – and of course, our patient was the one patient who was absolutely adamant that she did not want people knowing it was a mental health consultation, yet it was identifiable by the item number, then Medicare rang her up!! *(underline added)*. And we have so many people asking us "are my records confidential" as GPs do so much counseling, what are we to write down now *(underline added)*? And the administrators will be able to look retrospectively, go on fishing expeditions etc.
>
> Re the "heart checks". It is my understanding that the Medicare rules forbid any preventive screening. This argument has been going on since the inception of Medicare. Medicare administrators since the beginning have made up medical rules – they said a Medicare benefit was not payable for "travel advice" or "preventive" or "health checks". So they introduced one specific item number for 40 to 45 year-olds who have to be "at-risk" who only are eligible for checks.
>
> They also introduced an item number called a GP plan to plan people's health needs, then proceeded to identify conditions which Medicare said were not "diseases" eg hypertension (so we hardly ever do those as the rules are too hard *(underline added)*, but the corporates do work those rules).
>
> And now, saying that they want to look at records to see if GPs are claiming a long consultation for "simple problems"... since when was decision-making in primary care easy?
>
> So they tie us in knots with rules of their administrative invention. But now they are not happy with the endless rules that they interpret differently from the doctors, they want to go further – they want more control.
>
> Yet the "deliverers" of the services are getting paid less and less over time.

...and, CLA says, having to do more paperwork, to satisfy Medicare administrative workers, which Medicare apparently believes (according to its 'Financial impact' claim) can be done at no 'cost', either in dollar terms or in time, to doctors!

Addendum 2

Doctors' representative groups suggest that the rate of suicide by male doctors in Australia is approximately three (3) times the rate of suicide of all males in Australia.

The corresponding figure for suicide by female doctors in Australia is reportedly five (5) times the female suicide rate in Australia.

A Senate Committee with the 'Community Affairs' responsibility might well ask whether the proposed Medicare amendments are likely to increase, or decrease, the rate of suicide by doctors in Australia.

If, as is likely, the amendments may increase the rate of suicide by doctors in Australia, they ought to be much better justified as to their managerial, legal and medical efficacy and need than they are by the very poorly-drafted proposed legislation, and the puerile Explanatory Material provided to the Senate.