ISSN 085 7033

THE UNIVERSITY OF SYDNEY
FACULTY OF LAW

PROCEEDINGS of the INSTITUTE OF CRIMINOLOGY

No. 50

CRIME AND THE PROFESSIONS: THE PROVISION OF MEDICAL SERVICES

REGISTERED IN AUSTRALIA FOR TRANSMISSION BY POST AS A BOOK

INSTITUTE OF CRIMINOLOGY
SYDNEY UNIVERSITY LAW SCHOOL

Address: 173-175 Phillip Street, Sydney, N.S.W. 2000

The Institute of Criminology is an organization within the Department of Law of the Sydney University Law School for teaching and research in criminology and penology.

STAFF

Acting Director
Associate Professor G.J. Hawkins, B.A. (Wales) (*Criminology*).

Acting Deputy Director
Associate Professor R.P. Roulston, LL.B. (Sydney), LL.M. (Tasmania).

Senior Lecturers
J. Oxley-Oxland, B.A., LL.B. (Rhodes), LL.M. (Yale).
P.G. Ward, M.A., B.E. (Sydney) (*Statistics*)

Lecturers
G.L. Certoma, Dott. Giur. (Firenze), B.A. LL.M. (Sydney).
G.B. Elkington, M.Sc., Ph.D. (Warwick), LL.M. (Sydney).
Dr. P.B. Shea, M.B., B.S., B.H.A., M.P.H., D.P.M., Dip. Giur., Grad., Dip. (Health Admin.), Dip. Env. Stud., F.R.A.C.M.A., F.R.A.N.Z.C.P., L.H.A., A.F.A.I.M. (*Forensic Psychiatry; Part-time*)

Senior Research Assistant
Mary Elliot, M.A. (Cambridge), M.A. (Sydney).

Publication Officer
D.M. Langley, M.B.E., B.Sc., Dip.Diet. (Melbourne), Dip.Crim. (Sydney).

Secretary
E. Bohnhoff, J.P.

N.S.W. ADVISORY COMMITTEE

Chairman
The Honourable Sir Laurence Street, Chief Justice of New South Wales.

Deputy Chairman
The Honourable Mr Justice J.A. Lee, a Justice of the Supreme Court of New South Wales.

Members

K.S. Anderson, Dip.Crim. (Sydney), Deputy C.S.M.

C.R. Briese, B.A., Dip.Crim. (Cantab.) C.S.M.

Dr J.S. Blow, M.B., B.S., D.P.M., M.R.A.N.Z.C.P., Consultant Psychiatrist, N.S.W. Department of Youth and Community Services.

W. Clifford, Director, Australian Institute of Criminology.

Dr J.H.T. Ellard, M.B., B.S., D.P.M., M.R.A.C.P., Consultant Psychiatrist; Member, Corrective Service Commission.

F.D. Hayes, A.M., M.A., Dip.Soc. (N.S.W.), Dip.Soc.Stud., Dip.Crim. (Sydney), Dip.Ed. (M.C.A.E.), Director of the School of Community and Welfare Studies, Milperra College of Advanced Education; Commissioner (Part-time), Corrective Services Commission.

Dr W. Hemphill, M.B., B.S., D.C.H., Principal Adviser, Bureau of Maternal and Child Health, Health Commission of N.S.W.

The Honourable Mr Justice R.M. Hope, C.M.G., a Justice of the Supreme Court, N.S.W.

The Honourable Mr Justice M.D. Kirby, Chairman of the Law Reform Com mission, Deputy President of the Australian Conciliation and Arbitration Commission.

W.C. Langshaw, B.A., Dip.Soc.Stud. (Sydney), Director, N.S.W. Department of Youth and Community Services.

John Mackinolty, LL.M. (Melbourne), Dean, Faculty of Law, University of Sydney.

J.A. Morony, F.R.I.P.A., President, Repatriation Review Tribunal.

H.F. Purnell, Q.C., LL.B. (Sydney), Senior Public Defender of N.S.W.

R.N. Purvis, Q.C., Dip.Crim. (Sydney), F.C.A.

M.S. Robertson, B.A. (Sydney), Director, Probation and Parole Service of N.S.W.

Emeritus Professor K.O. Shatwell, M.A., B.C.L. (Oxford).

Mrs B. Shatwell, B.Com. (Tasmania).

The Honourable Mr Justice J.P. Slattery, a Justice of the Supreme Court of New South Wales.

His Honour Judge J.H. Staunton, C.B.E., Q.C., LL.B. (Sydney), Chief Judge of the District Court of N.S.W.

INSTITUTE OF CRIMINOLOGY
SYDNEY UNIVERSITY LAW SCHOOL

Proceedings of a Seminar on

CRIME AND THE PROFESSIONS — THE PROVISION OF MEDICAL SERVICES

CHAIRMAN:

The Honourable Sir Laurence Street
Chief Justice, Supreme Court, New South Wales

16th September, 1981
State Office Block, Sydney

TABLE OF CONTENTS

INTRODUCTION

Rodney N. Purvis Q.C.

> For the conspirators there had necessarily to be a conjunction of factors before they could participate in the violations. First, of course, they had to perceive that there would be gains accruing from their behaviour. Such gains might be personal and professional in terms of corporate advancement towards prestige and power; they might be vocational in terms of a more expedient and secure method of carrying out assigned tasks. The offenders also apparently had to be able to neutralise or rationalise their behaviour in a manner in keeping with their image of themselves as law-abiding, decent and respectable persons . . .
>
> (Geis, White Collar Crime, page 116).

When a Criminologist speaks of crime, he is seldom thinking of any act which affects him so directly as, for example, a blow to the head. More likely he is thinking of the immense costs to a community of white collar crime, of occupational offences generally, of organised vice and of business racketeering.

Identification of criminality, whereby activities the like of those just mentioned are clearly indicated to society at large as criminal, is necessary and too long delayed. The importance of knowledge of familiarising a community as to the "standards of commercial, moral behaviour" which will, and which will not be the subject of criminal sanctions, is essential if respect for and compliance with the law is to be achieved.

The environment in which a person carries out his daily endeavours can well be conducive to acts not being regarded by the individual as criminal, or even wrong, in a professional, commercial or financial sense. The individual may well regard such conduct as being in the ordinary course of his profession or business, and no more than a "common sense" professional activity.

Human deviance is closely associated with social problems and social control. In the absence of self-imposed control, control imposed by one's peers, or control imposed by legislation, an individual must look to his own tenets before committing any particular act. It may be more difficult in the latter case than in any one of the former. That is, where a person has to make his own assessment of commercial morality without guidelines provided by his peers, the choice may well be more difficult. If guidelines are provided by some other person, then it will be easier for the individual to say that the parameters have been set by such guidelines—anything within such parameters is permissible. If he himself has to make up his mind, then the limits may be more extensive than those that would be defined by his professional organisation or legislation.

Peer group support for occupational and commercial deviance invariably widens the field of misbehaviour.

For some time past, the Institute of Criminology of the University of Sydney, through its Advisory Committee, has been minded to conduct a number of Seminars on the subject of White Collar Crime. The decision to hold a Seminar

on Crime and the Professions was as a consequence of the Institute having held the earlier Seminars, there considering legal principles applicable to the particular kind of criminality, the procedures appropriate for investigation and prosecution of white collar crime, the role of the Corporate Affairs Commission in this regard, and whether the procedure presenlty followed in our Courts is adequate to the task.

The cause of white collar crime had, to a limited extent, been considered.

In order to obtain a more complete appreciation of the nature of the acts being committed and, if possible, some understanding of the forces that were leading otherwise morally conscious persons to perpetrate acts of criminality committed against their fellow professionals, as well as the community, the Committee turned its attention to those sections of the community in which difficulty is being felt in overseeing the conduct of members and disciplining deviance. The matters of immediate concern were seen to be the apparent increase in the incidence of this type of white collar crime, and why, accepting that there had been an increase, such acts take place.

The professions of particular moment in this regard are the accounting profession, the legal profession, and the medical profession. Each of the professions by their executive members enthusiastically supported the proposal, and so this Seminar.

The persons asked to present papers, whilst all very experienced in the conduct of the medical profession, were known to hold views somewhat diverse from one another. It was thought that the interplay could result in valuable information being brought forth.

If there has been an increase in the incidence of breaches of professional morality and conduct of a criminal nature in the professions, then why has this taken place in our society as it is to-day? Why has it, if it be so, taken place amongst those who otherwise are well endowed with intellectual capacity and a measurable degree of financial security?

These were the questions that demanded to be answered at the Seminar.

THE PRACTITIONER: CRIME AND/OR ETHICS, THE MORALITY OF OVERPROVISION OF MEDICAL SERVICES.

Dr Noel Van Dugteren,
Medical Secretary,
N.S.W. Branch of the
Australian Medical Association

The medical profession in New South Wales is controlled by many Acts of Parliament, both at Commonwealth and State levels. Examples in the Federal sphere are the Health Insurance Act, the National Health Act, the Commonwealth Workers Compensation Act and the Trade Practices Act; while at State level there are the Medical Practitioners' Act, the Workers Compensation Act, the Consumer Claims Tribunal Act, the Public Hospitals Act, the Poisons Act, the Crimes Act, the Child Welfare Act, the Industrial Arbitration Act, the Arbitration Act, the Ambulance Transport Act, the Birth Deaths and Marriages Act, the Coroner's Act, the Venereal Diseases Act, the Mental Health Act, the Inebriates Act, the Coalmining Regulations Act, the Partnership Act, the Supreme Court Witnesses Act, the Minors (Property and Contract) Act, and the Anti Discrimination Act. Additionally, medical practitioners must be aware of Case Law or the Law of Precedent, and the Defamation Act when considering confidentiality.

The introduction of the *Health Insurance Act,* commonly known at the time as "Medibank" introduced a system of funding medical services which, while not entirely new, was an open-ended invitation to over-utilisation and fraud to both the community and the medical profession. Previous experience with the Pensioner Medical Service under the National Health Act gave very solid evidence that where the patient was not financially involved in the fee for a service, demand was high and abuse occurred. The Australian Medical Association's advice was not heeded and the media has given full publicity to the end result.

It is essential that breaches of the *Health Insurance Act* are categorised. In the main, there are over-utilisation which is covered by Divisions 3, 4 and 5 of the Act and fraud which is dealt with under s. 129. Another possible abuse causing concern to the Commonwealth Department of Health is known as "polyitemisation".

The major difference between over-utilisation and fraud is that over-utilisation is the supply of services that may be seen to be not clinically necessary while fraud is rendering an account for a service that has not been supplied. "Polyitemisation" means listing in an account every possible service that may have been provided during an episode.

A judgement on over-utilisation based on clinical need, is dealt with by Medical Services Committees of Inquiry with appropriate systems of appeal. Medical Services Committees of Inquiry are composed of five members. One is the Commonwealth Director of Health for the State or his representative and the other four are appointed by the Minister for Health from a panel nominated by the Australian Medical Association. Of the four, two are general practitioners, one a procedural doctor, such as a surgeon and the other a non-procedural doctor such as a physician or psychiatrist.

In brief, the computer printout indicates those doctors whose profiles show a higher utilisation rate than those of their colleagues in similar disciplines and circumstances. If a profile shows a questionable pattern of servicing in the view of the Commonwealth Department of Health the doctor concerned is counselled by a medical practitioner employed for that purpose by the Department. Normally there is discussion between the counsellor and the doctor under review about his pattern of servicing and relevant matters relating to his practice. If indicated, the doctor's profile is reviewed some six months after the interview and then may possibly be referred to a Committee of Inquiry.

The Committee of Inquiry examines the doctor's pattern of service and decides whether an inquiry is indicated and, if so, seeks clinical notes. The Committee may subsequently request the presence of the doctor at one of its meetings. On the basis of the clinical evidence available to it, the Committee then determines on the need for each item of service under review and makes appropriate recommendation to the Minister. The Minister, on the basis of the recommendation, determines whether any action shall be taken and, if so, whether there should be a reprimand, the retrieval of monies paid or the non payment of fees billed.

At appeals against the Minister's determination, many problems have been met due to legal interpretation by the judiciary of the Committee's procedures and the Commonwealth is still concerned as to how they can best function. Currently it is necessary for the Committees in N.S.W. to examine every item of service supplied and billed and they cannot utilise a sampling technique to establish a pattern on which to base their recommendations to the Minister.

Fraud is mainly covered by s. 129 of the Act which states;

129 (1) A person shall not make a statement, either orally or in writing, or issue or present a document, that is false or misleading in a material particular and is capable of being used, in connection with or in support of, an application for approval for the purposes of this Act for payment of an amount under this Act.
Penalty $10,000 or imprisonment for five years.

129 (2) A person shall not furnish in pursuance of this Act or the regulations a return of information that is false or misleading in a material particular.
Penalty $10,000 or imprisonment for five years.

The essential factor in fraud is that a bill is issued which can gain a medical rebate for the patient, or through assignment for the doctor, for a service which was not supplied. An example of actions for fraud against doctors by the Commonwealth police recently has been alleged billing by doctors for services of a longer duration than actually supplied. The allegations known as the "Greek Conspiracy" involve charges that to a large extent fall outside the *Health Insurance Act*. In the main they involve the Department of Social Security.

How **"polyitemisation"** can be dealt with is difficult to assess but it is alleged that some doctors show a pattern indicating that when they perform a certain procedure they invariably add other procedures to it. Additionally their profile of service is quite distinct from that of their colleagues in the same discipline.

It is impossible to determine whether in fact the additional services were supplied, or, if they were supplied, whether they were clinically indicated. Decisions would require specialised knowledge and an elaborate record keeping system. The degree of this form of abuse, if in fact it does exist, is problematical and the establishment of a system of investigation and control might not merit the end result. I have no knowledge of the percentage of the profession that has consciously or unconsciously accepted the blandishments of Medibank.

It must be understood that medical practitioners are registered in N.S.W. though they have not had instruction in their obligations under the law. Universities claim that within the five year training programme there is little available time for sessions on such matters. Once graduated, it is difficult to arrange for formal education as interns are scattered throughout the State hospitals system and have duty rosters to fulfil. It seems wrong to train doctors to the standard of clinical excellence that is sought by the community while leaving them ignorant of the laws introduced by politicians for the funding of medical services. Similarly it is quite wrong to allow the registration of overseas graduates and give them work permits when they are unfamiliar with the system of supply of medical services in this country. This was recently demonstrated when English graduates were found guilty of fraud.

There are many reasons for over utilisation and fraud some of which are due to ignorance, some to clinical expediency and the circumstances of the moment, and some to defensive medicine. It is accepted that, as in any occupation, there are a few rogues and strong measures need to be taken to remove them from the medical profession for both the sake of the profession and the community.

However, the community through the Government needs to see how the others, i.e. the ignorant and the foolish, may be educated and persuaded. At times it would appear that some politicians would prefer to have the profession make enough rope to hang itself and are reluctant for that reason to take firm action that would act as a deterrent to the ill advised. It is obvious from inquiries received at the A.M.A. from patients and members of the profession that there is a degree of fraud at a comparatively minor level that is due to ignorance on the part of the doctor supplying the service.

In the *Health Insurance Act* professional attention is defined as meaning, amongst other things, a medical or surgical treatment by or under the supervision of a medical practitioner. The Commonwealth Department of Health holds the following attitude in respect of professional attention.

1. A medical benefit rebate only appertains for services listed under Part 1 (attendances) in the medical benefits scheduled when there has been a physical contact with the patient and only for the period of time when the medical practitioner is in personal attendance upon the patient.

2. For all procedures listed in the schedule book a rebate appertains when a procedure is fulfilled by a person who is under the supervision of the medical practitioner billing for the service. For some procedures the supervision can be somewhat distant as long as the person acting on behalf of the doctor is an employee or agent. However the wording of some items impose a finer meaning to the extent that the doctor (with particular recognition) must be present.

From that attitude it may be assessed that the Commonwealth Department of Health would consider an account fraudulent for a prolonged consultation on the basis of time spent by a physiotherapist giving a patient physiotherapy when the general practitioner himself was occupied elsewhere.

Additionally this has particular relevance when a doctor supplies a certificate or repeat prescription at the request of a patient by telephone and the doctor does not have any form of attendance on the patient during the supply of the service for which the account is rendered. This does not imply that the fee may not be merited but the rebate is not available. The important point is that any account or receipt issued should not be in a form that could lead a fund into incorrectly paying a benefit for an attendance which has not taken place.

Insofar as **over-utilisation** is concerned there are factors that are difficult to control. We live in an advanced and highly educated society. The expectation of patients now are that they shall have a high quality of living and many make demands of their medical attendants with that view. Many services are supplied on patient request to overcome symptoms and fears that in other circumstances might well be tolerated.

The continual intrusion of the Department of Consumer Affairs into the disciplining of professions and the loud voice of consumer organisations must inevitably force the medical profession into "defensive medicine". Diagnostic services and consultative services may well be used, not as a clinical need, but as a defence against future possible litigation or investigation. If consumerism continues as it is going medical services must become more expensive.

One of the anachronisms of over-utilisation is the busy doctor. A doctor with a packed waiting room and behind in his appointments may tend to hurry patients through. Because of that hurry he is concerned he might have missed something of importance in the patient's clinical picture. He brings the patient back in the hope that next time he will have the opportunity for a more thorough examination and consultation. He may order additional investigations to ensure that something is being done but the end result is that the patient is brought back again and again and his waiting room remains just as crowded if not even more crowded. That is a chain reaction of over-utilisation which at times can be extremely difficult to break.

It must not be forgotten that when the word over-utilisation is used it does not necessarily mean that the additional services are for the financial benefit of the medical practitioner ordering them. A medical practitioner who refers a patient to a consultant or orders diagnostic tests is himself making no personal profit out of those things he has requested. If he were to seek some profit he could well place himself in danger of deregistration under the *Medical Practitioners Act* while the *Health Insurance Act* is most firm concerning kick-backs of any kind to referring doctors in the field of pathology.

The New South Wales Branch of the Australian Medical Association has submitted to the Minster for Health that there should be an Act to control lay organisations and companies entering into the field of medicine in a similar manner as medical practitiones are controlled under the *Medical Practitioners Act*.

The entry of lay organisations, companies, commercialism and entrepreneurs into the field of supply of medical services is raising many problems within the master-servant relationship as to where responsibility lies for the service supplied. While a medical practitioner supplies the medical service that attains a medical benefit he may well be acting under the instructions of an employing authority who is not answerable under the *Medical Practitioners Act* or the *Health Insurance Act*. This is another area causing concern to the Commonwealth Department of Health and the organised profession.

The Australian Medical Association has had many consultations with the Commonwealth Department of Health as to how breaches of the *Health Insurance Act* may best be controlled and minimised. Proposals that appear to be eminently reasonable are seen as legally difficult to implement by the Attorney-Generals' Department. Essentially however, it would appear that the only true answer is for universities to ensure that their graduates are not only versed in matters of a clinical nature but are also adequately taught their ethical and legal obligations to their patients, the community and their colleagues.

PRESENTATION OF PAPER

Dr. N. Van Dugteren

The point that I would like particularly to speak to from my paper concerns the people who judge their colleagues when looking at over-utilisation. One of the biggest areas of criticism that the profession as a whole receives is that it is not prepared to act (or can't or won't) in a peer review situation, and that the A.M.A. won't do anything about its membership. We want to know why we should do anything about our membership other than look at the clinical services they supply in a manner that is reasonable. That is being implemented in many ways. The medical profession has been frightened of the word "peer" review for a long time—quite understandably when we look at overseas precedents.

The papers presented at this Seminar show, on the one hand, that the A.M.A. is accused of living in the pocket of government in its cooperation with Committees of Inquiry and, on the other hand, of being unduly under the influence of the profession and not being prepared to take any action.

There is a big difference between fraud and over-utilisation. Both may well be in ignorance and in fact—s. 129 of the *Health Insurance Act* which refers to fraud gives ignorance as a legitimate plea as a defence.

The Association goes to considerable trouble when it is proposing a series of names to the Commonwealth Minister of Health from whom he will choose those who will sit in judgment on their colleagues. These people are selected not just for their clinical knowledge, which is important because they must be practising clinicians, but they must be people who are actively involved in seeing patients and have some knowledge of what clinical practice is all about. They must be people whom we think will not be prejudiced one way or other but will look clearly at the issues involved and the clinical services supplied.

There are avenues of appeal against their decisions. All the Committee of Inquiry does is to recommend to the Minister that all is well, that the clinical services supplied were necessary, or that certain services were *not* indicated on a clinical basis and it is up to the Minister to determine what he will then do. There is a system of appeal by a doctor who is unhappy about the determination by the Minister. There is no system of appeal by the Committee of Inquiry about what the Minister does on their recommendation and, in fact, it has been known where a Minister on a political basis has rejected what a committee has recommended.

In my paper one of the problems I referred to is "do governments really wish to see the rogues within the profession properly suppressed?". We are talking about matters of a political nature, and I must apologise if I sound political in this particular context, but a striking example is that one week before an election campaign in New South Wales the Minister for Health attacked doctors who are supplying services at Nowra on a "fee for service" basis. He put forward figures that need to be validated, and on experience I do not give them all the credibility that you would anticipate. We have known about what is happening in Nowra for 18 months or longer and, in fact, the local doctors, who were not wealthy North Shore doctors but happened to be Registrars mainly from St Vincents and

Prince Alfred Hospitals had contacted me some time ago asking my advice as to how they could manage the problem that was happening there. I hoped that it had been quietly settled, but one week before an election campaign it is raked up and thrown against the medical profession as a whole. In my view, it is frequently the position where a government, who needs something to deflect the public's view of their own shortcomings whether it be in the health area or any other, would prefer to have a tame set of rogues available to utilise in a political manner. Whether they are rogues or not does not matter as long as they can be made to appear rogues.

The medical profession has a difficult row to hoe. It has difficulty in gaining the respect of the community because of rather harsh treatment by the media. It has difficulty in gaining the cooperation of government when it endeavours to institute quality assurance programmes to ensure that the profession is fully educated, clinically, legally, and ethically, and will continue in that position for ever.

THE AETIOLOGY OF MEDIBANK FRAUD

Dr Denis P. Mackey,
Past President,
The General Practitioners'
Society in Australia

. . . the State . . . has converted the practice of Medicine from a noble and honourable profession into an ignoble and dishonourable one.

Alexander Solzhenitsyn.

What makes a doyen of the medical profession yesterday, a petty criminal today? Why is it that in New South Wales alone, according to the Commonwealth Health Department, one doctor per week is arrested for allegedly defrauding the National Health Scheme? The Commonwealth Health Department has stated that every week 4 to 5 doctors in New South Wales could be successfully prosecuted for Medi Fraud. What has changed the once noble profession into a bunch of crooks?

The government has recently legislated that the Profession's own Star Chamber, the "Medical Services Committee of Inquiry" is to have more power; power to demand that a doctor come before this "Kangaroo Court" or pay a fine of $10,000; and power to demand that the doctor's medical records be presented to this body. The Medical Services Committee of Inquiry is a group set up by the Australian Medical Assocation in accordance with s. 79 of the *Health Insurance Act* to investigate overservicing by doctors.

Overservicing is not defined, but is determined by a computer print-out of medical services that deviate from the norm. If the doctor does more of a particular kind of medical service than the area average, he could be regarded as an overservicer and he and his patients investigated. If a doctor does more home visits on his pensioner patients than the area average or counsels more of his underprivileged patients than the area average, then that doctor and his patients will be visited by officials from the Commonwealth Health Department. If the doctor's computer profile is in any way irregular by comparison with his colleagues, he is open to prosecution. If the doctor does not conform to that marxist doctrine of equality, action can be taken against him.

I am not here to defend any doctor found guilty of fraud as defined i.e., "using false representations to gain unjust advantages" but to point out that there is a vast difference between the undefined overservicing, and Medi Fraud. Recently in a Morgan Gallup[1], doctors topped the ratings for ethics and honesty. Federal Politicians scored badly on both issues, and rated just above used car salesmen and union leaders. I don't know about union leaders, but I personally reckon this is a slight to the used car dealer.

The present medical scheme is analogous to a situation where the Police Department build a long wide flat stretch of road, then restrict the speed limit to 50 km/h and set speed traps along the road daily. Practically every motorist

1. Public Opinion Poll, *Bulletin,* June 9th, 1981.

would be found guilty of speeding. The open-ended medical scheme with undefined parameters is in itself a fraudulent system that requires reform. It is fraudulent in that it falsely claims to offer a high quality medical care to all irrespective of the patients ability to pay. The government simply cannot guarantee quality and probably has no role to play in private medical practice.

Recent media releases by the Federal Health Department[2] as quoted in the press could have the public believe that widespread medical fraud exists throughout the profession. A bureaucrat, with no partiuclar expertise in any field of medicine, has played around with his toy computer and made some preposterous conclusions indicting the medical profession. He is quoted in the *Melbourne Age* as saying "The Federal Health Department believes doctors services could be costing the government and health funds $100 million a year more than necessary". "The payouts" he said "are because of fraud and doctors providing more services than necessary". A smear campaign against the medical profession has been instigated by the bureaucrats—one wonders why? As the smoke screen spreads a bit, the Minister for Health, Mr MacKellar, is quoted by the same source: "Since 1975, more than 30 doctors had been prosecuted for making false claims for Federal medical benefits, and more than 1 million dollars had been recovered".[3] A far cry from the bureaucrat's claim.

The bureaucrats have set up a "Schedule of Fees" showing the rebates a patient can obtain from registered insurance funds. The schedule has nothing to do with doctors fees, but has a lot to do with the amount of money a patient can receive as a rebate, provided the doctor itemizes his receipt with the appropriate number. The "Schedule of Fees" has in itself become a racket.

Item 3 is a short consultation, i.e., less than 5 minutes, and attracts a rebate of $8.10.

Item 14 is a consultation (which is regarded as a routine G.P. consultation) between 5 to 25 minutes and attracts a rebate of $11.20.

Item 25 is a consultation longer than 25 minutes but less than 45 minutes and attracts a rebate of $21.

The difference between 24 minutes 59 seconds and 25 minutes i.e., that 1 second, is worth $9.80 and if the rebate in any way affects the fee charged by the doctor then this 1 second becomes very significant and the scene is set for baiting the trap for the medical profession.

In an article written for *The Australian G.P.*,[4] Dr Gary North, an economist from the U.S.A., wrote about a 4 point strategy used by bureaucrats in an attempt to socialize the practice of medicine. The 4 part strategy consists of:

1. Baiting the trap
2. Setting the trap
3. Springing the trap
4. Skinning the victims.

Baiting the Trap

The government sets up a medical scheme promising to help all those in need provided the doctors co-operate. The short term benefits of government

2. *Melbourne Age,* 18th June, 1981.
3. *Melbourne Age,* 16th June, 1981.
4. *The Australian G.P.,* April 1978 "A Trap for Professionals".

subsidy to the medical profession as with the Medibank scheme are usually too great for the organized medical profession to resist. Organized medicine as represented (incorrectly) by the A.M.A. steps in and concludes (incorrectly) that government support will permit them to serve the public body better, while making them a tidy profit to boot. The A.M.A. as a "trade union" representing its members cannot resist the offer of subsidies. Medibank Mark I (1975 edition) promised the doctor a secure income backed by the Treasury. The doctor would have no longer to worry about bad debts as the government would guarantee the fee, provided the doctor stuck to the scheduled fee. The doctor would no longer have to dispense charity as the government would guarantee payment of bills by pensioners and the disadvantaged. This bonanza to the medical profession was safe so long as "official spokesmen" for the profession continued to have "meaningful dialogue" with the bureaucrats, and co-operate by sitting on committees of inquiry and thus gaining status by their participation. The profession gets used to having these distinguished members speak out in the name of the profession, but these distinguished gentlemen are simultaneously speaking out for the government, for it is now the government which enforces standards.

Setting the Trap

The Health Department, after establishing this scheme must by law account for every dollar spent. It has to be sure that no one is receiving any money or benefits who is not conforming to basic government standards. The government must always uphold the public interest. That is the theory of democratic government. The reality is simpler, the politicians create a system of bureaucratic control over the whole economy once the subsidy system becomes widespread. The official purpose of any expenditure is "the public interest". The real purpose is the expansion of political power. He who fails to grasp this point will miss the meaning of the twentieth century.

The government having thus granted a monopoly by way of subsidies to the medical profession now prepares for controls. The government now warns about possible abuses of this monopoly position. The government with help of the "official spokesmen" of the medical profession now sets up guidelines so as to reduce the likelihood of such abuses. In spite of the bedroom cooperation of the A.M.A., the government finds abuses anyway. So we conclude that the primary purpose of the monopoly to grant power, from the government's point of view, is to create opportunities for abuses. The system is established so that someone will milk it.

The government finds doctors more easy to control through the "official spokesmen", and therefore appeals to the profession's sense of fair play. The "official spokesmen" agree with the bureaucrats that professional standards should be established and a "peer" review committee is envisaged to enforce these standards.

Costs rise inevitably as expenditures rise and the "Schedule fee" remains stationary. However, the "official spokesmen" (incorrectly) participate in the government inquiry into 'medical fees' which is a misnomer because the inquiry deals only with patient rebates and has nothing to do with medical fees. The "official spokesmen" from the A.M.A. hope that by increasing patient rebates they have done something towards increasing medical fees. The A.M.A. has

continued to partake in the Ludeke Tribunals, and now the Isaacs Tribunal, without realizing that it is helping to set the trap. Sooner or later the government will advise "the Tribunal" that there is to be no increase in the "Schedule fee" and in spite of protests from the "official spokesmen", the trap is set.

Springing the Trap

Eventually the government or news media will discover someone who is milking the eminently milkable system of government subsidies. Someone is ripping off the public. Someone is making too much money. Someone is being greedy. The public's interest is being threatened. Something has to be done.

No one is actually breaking any law, you understand. The open-ended system allows for exploitation. Twenty-five minute consultations will proliferate in the practice of a not too busy doctor—after all he is not breaking the law. Nevertheless, the politicians smell blood and votes. The news media smell blood and headlines. The stories continue. Reports of flagrant violation of standards, meaning abnormally high incomes for a few doctors, continue to be featured in the media. The A.M.A. is told to police its ranks, but this is impossible, since no laws are being broken. So the stories continue. Of course, they continue. Why do you think the system was created in the first place? To create scandal. Scandal is ideal for the expansion of government power. Even if the scandal is manufactured. Even if the scandal is not really illegal. In fact, especially if the scandal is really legal. A legal scandal if based on profit can safely be expected to continue. The profit motive will do its work. What is that work? To create a crisis that demands further government intervention.

Eventually the hierarchy of the medical profession is alarmed. The stories of scandal keep coming. The "official spokesmen" are impotent to do anything. They know that only a few doctors are involved in the scandal and are ready to allow the government to step in temporarily and clean up the mess so that the honest men can practise in peace. They miss the whole point. The government's goal is to control and reshape the practices of the honest men. The government does not care a hoot about the scandals. The scandals are the excuse for intervention, not the cause.

Conferences are called. Control boards are established. The government, in cooperation with the "official spokesmen" from the A.M.A. delegate the medical services committees of inquiry more power in an attempt to halt the abuses. Amazingly, the abuses increase. There are more headlines. The closer the government and reporters look into the scandals the more there are. The "partnership" between the government and the "official spokesmen" of the A.M.A. is not working. The medical profession is not cooperating. Stronger medicine (to coin a phrase) is needed—government medicine. The trap is now sprung. The bureaucrats from the Commonwealth Health Department take over.

Skinning the Victim

Huge amounts of government money are spent policing the profession. The Commonwealth Health Department expands its bureaucracy with "computer experts" and details counsellors to advise the profession on the spirit of the National Health Scheme. Paper work proliferates to vindicate the expansion of the health bureaucracy. Doctors are now compelled to send forms to Canberra to authorise certain prescriptions. Government referral vouchers are required if

patients are to receive higher rebates for specialist attention. Referral patterns are investigated by the "computer experts" to see if G.P. Dr X is referring "too many" patients to gynaecologist Dr Y for hysterectomies, which they regards as unnecessary. Commonwealth police are called in to investigate overservicing which is designated as fraud.

The G.P. who visits the old age home every week to see his patients is regarded as doing a "milk run". The old folk should not be seen so often. Peer review standards of visiting homes suggests that these people need to be seen only every month. The young doctor setting up practice and spending greater than 25 minutes on his patients is regarded as an overservicer by comparison with the established G.P. down the road—this practice must stop. Counselling the socially disadvantaged with prolonged consultations is regarded by the Commonwealth Health Department as unnecessary, yet this department encouraged this style of medical practice as a form of preventive medicine, and set up bulk billing processes to attract doctors to this scheme.

The sports conscious doctor who regards respiratory function tests as an integral part of his medical consultation is also the target for officers from the Commonwealth Health Department because the average doctor doesn't bother with such tests. With continued "muck raking" the whole medical profession becomes a scandal. At this point the government ceases to discover any new scandals. It cannot afford to do so, since the government now operates the delivery system. Besides, standards are so low by now that the investigators have trouble in locating visible scandals that stand out from the general practice.

I hope never to witness this final bureaucratization of medicine where the whole profession is regarded as crooked with a public rating equal to that of politicians. But I do understand why certain inadequate doctors abuse the system by accepting government money in a bulk-billing situation. Any doctor who bulk bills must be regarded as a potential criminal.

If the Commonwealth Health Department wished to cut down abuses (but I am sure it has a vested interest in making sure abuses do occur—jobs are at stake) it would strive to abolish bulk billing and assignment of benefits. Computer print outs show that 85% "overservicing" occurs in this area. It is amazing to find that the top bureaucrats have campaigned their politicians and ministers to maintain bulk billing in spite of the obvious abuses, and in spite of the findings of the Razor Gang.

In researching the "Aetiology of Medibank Fraud", the medical bureaucracy come under close scrutiny. Why did the Commonwealth Health Department allegedly overpay the chemists $235 million over the past 5 years? Was this criminal negligence or incompetence from the Commonwealth Health Department—or was it blatant fraud? Is someone covering up for a top bureaucrat caught with his hand in the till. The advent of computers and the increase of white collar crime[5] with programmed embezzling would suggest that in looking at "Crime in the Professions" we may be looking in the wrong direction.

If I were a detective investigating Medibank fraud and I was told that $235

5. Report from head of the Australian Computer Abuse Research Bureau, Mr Kevin Fitzgerald.

million was allegedly overpaid to chemists by the Commonwealth Health Department and that $22 million was allegedly overpaid to Nursing Homes by the same department, then I would be looking for reasons for this misappropriation of government money by a government department. I would also check on how many top health bureaucrats own apartments in Surfers Paradise, either individually or with family trusts. How many top health bureaucrats own huge land holdings outside the State in which they live? How many top health bureaucrats have large and expensive farms in the State in which they live and how many of them own and/or breed top class racehorses? I would also check every computer technician for the same reason.

To date the Commonwealth Health Department has misappropriated hundreds of millions of dollars of taxpayers' money and has not been asked to give any accountability. In defence it has accused the medical profession of costing the government and health funds $100 million a year more than necessary and offered no proof of these allegations. In this confused situation I think that the due process of law will unravel the truth of Medibank fraud and point the finger of blame back where it belongs—the true criminals in the situation—the health bureaucrats.

"There can be no moral form of Socialism"

Alexander Solzhenitsyn.

PRESENTATION OF PAPER

Dr D.P. Mackey

When I walked into the room this evening Dr Arnold came from the front, tapped Dr Van Dugteren on the shoulder and congratulated him for looking after the A.M.A. in New South Wales. Dr Van Dugteren said "I don't look after things here" and Dr Arnold said "Well, somebody has got to take the responsibility for the mess we are in at the moment". We are in a mess at the moment, and I think a lot of our problems are due to the A.M.A. and the A.M.A.'s cooperation with the government, negotiating with the government on non-negotiable issues such as peer review, quality assurance etc. and many other matters that provide a direct pipeline from the Treasury into doctors' pockets.

There has been some confusion as to the role of the General Practitioners' Society. I have also heard it mentioned that the General Practitioners' Society is similar to the Doctors' Reform Society. I must reassure you that they are poles apart. At least, the Doctors' Reform Society is probably honest in certain aspects of its policy—that it is a socialist organisation and claims socialist objectives, while the G.P.S. is towards free enterprise medicine.

To reduce the confusion I think I should define some of the terms in private practice that we use in the society. "Private practice" is defined as a fee for service contract exclusively between patient and doctor with no third party involvement. We want to practice without any third party, it is a one to one contract. The patient pays the doctor directly and the doctor then issues the patient with an itemised receipt and the patient, if he is insured, will claim from the insurance company, i.e. as a re-imbursement. At the moment there exists a re-imbursement fallacy in that although it is the patient who is insured and it is that patient that claims back a certain amount, it is the doctor who is regarded as being the prime mover of a particular service. If there are excessive services the Department of Health comes to the doctor and says "We have defined this as unnecessary surgery so would you please pay us back for unnecessary operations or over utilisation, pay back this, this, and this" instead of going to the patient and saying "You have seen your doctor too often according to our computer print-outs therefore you, *the patient*, should pay back to the Commonwealth Government X, Y or Z".

This confusion can be exemplified from the experience in Great Britain with the British National Health Service. In 1970 the incidence of hysterectomies in the U.K. was published. There were X number of hysterectomies done on a particular population of patients over a particular age, whereas in Australia there were two X hysterectomies done on patients in the same age group. In 1970 the conclusion was this: Great Britain has a rotten health service—the patients are not getting the proper treatment; e.g. just look at the incidence of hysterectomies. Of course, there were other examples; in Great Britain there were waiting lists of years, e.g. a couple of years for a hip replacement, a year for a hysterectomy, and I heard there was a 10 months waiting list for abortions! Today the interpretation is a little different. The statistics are exactly the same: X number of hysterectomies in the U.K., two X in Australia and the United States; therefore we are doing too many hysterectomies, as in the U.S.A. We are a fee for service group and we are exploiting our patients, we are over-servicing them, and we are ripping out the collective uteri of all the women around just to get a few bucks

to pay the tax man. This is the opinion that has been brought forward by certain academic sophists in the community that at present grab the ear of the media.

There is a story of a doctor taking a social history from a patient for a particular job and the doctor was asking the patient for his answers to the question on the form provided: "Do you smoke?", "Yes. Twenty cigarettes a day". "Do you drink?", "Yes. About ten beers a night". "What about sex?", and the patient replied "Infrequently" and the doctor said "Is that one word or two?". This typifies, in a lighthearted manner, the confusion that can occur in the medical profession today when terms such as "over-utilisation", which is a computer term and is undefined, and "unnecessary surgery" are bandied around. If somebody is breaching these undefined terms they are brought before Committees of Inquiry. Recently in Hobart a counsellor from the Commonwealth Department of Health came to address a group of doctors. This question of over-servicing arose and the counsellor said "We look at the computer print-out and we can tell by the resulting histogram if a doctor is doing too much of a certain procedure, or seeing the patients too often". He was asked "What happens then?" and he said "I go and see the doctor and I counsel him. Now, if he agrees that he is doing the wrong thing and he agrees to change his ways then nothing further is done. If he doesn't I make sure he goes to a Committee of Inquiry". Here we have the counsellors judging these doctors guilty until proved otherwise, and that seems to be the opposite of our concept of British justice.

MEDICAL BENEFITS FRAUD AND OVERSERVICING—PRIVACY—DOCTORS AND PATIENTS. THE INTERESTS OF GOVERNMENT AND THE HEALTH FUNDS IN THE PATTERN OF SERVICING.

R.J. Findlay, B.Ec.,
Assistant Director-General of Health,
Commonwealth of Australia

A major objective of any Government underwriting a health insurance program must be to contain the cost of that program. The Australian medical benefits system is an open-ended one—there is no limit on the total amount that is payable—and, without the constant monitoring of costs, there is a risk that it could absorb an ever-increasing proportion of our resources without any real increase in the health standards of the community.

The total cost in 1980-81 of services attracting Commonwealth Medical Benefits—including amounts paid by registered medical benefits organisations as fund benefits and the amounts that patients had to meet—approximated $1,450 million in respect of some 86 million private services. The cost to the Commonwealth of medical benefits payments was $529m in 1978-79, $621m in 1979-80 and $683m in 1980-81. In the current year it is expected to be $820m.

The Government's principal thrust against runaway medical benefits expenditure is through the procedures that have been fixed for the settlement of the schedule of fees for medical benefits purposes. Another is in the area of medical manpower studies and another—the concern of this paper—is in the development of procedures to combat fraud and overservicing by doctors.

The term "fraud" is used here, for brevity, to refer to an offence under s. 129 of the *Health Insurance Act* which provides, *inter alia*, that a person shall not make a statement that is false or misleading in a material particular in connection with the payment of an amount under that Act. The section is obviously breached by practitioners who, *inter alia*, bill for services that were not provided or for services attracting greater medical benefits than those services that were actually provided.

"Excessive services" are defined by s. 79(1B) of the same Act as services for which medical benefits are claimed, and which "are not reasonably necessary for the adequate medical care of the patient concerned". Thus, while the identification of fraud may be a relatively clearcut matter, the question of whether or not services are excessive is clearly one for subjective professional judgement. This is provided by formally established committees comprising five medical practitioners, four of whom are in private practice, reflecting a wide range of general and specialist practice.

The Government believes that the medical profession should as far as possible be self-regulating in its participation in the Commonwealth's health delivery system recently. As the Minister for Health, the Hon. M.J.R. MacKellar told the Australian Medical Association:

> The medical profession is well respected within the community and the Government will work with the profession in maintaining these high standards of ethical conduct. As a corollary to this, members of the profession who abuse or defraud financial arrangements put in place by the Government should realise that they can expect no sympathy . . .
>
> . . . The participation of the profession, collectively and individually, in controlling abuse is essential if the current arrangements are to survive in the long term.[1]

The Extent of Health Insurance Abuse

Every so often, the media report the case of a doctor who has been found guilty of a number of charges of health insurance fraud. The relative infrequency of these reports, and the number of charges involved in each case, may also imply that such fraud is relatively minor in extent. Similarly, there are occasional media reports concerning doctors who have been found to have provided excessive services. It could reasonably be concluded from these reports that overservicing is neither widespread nor significant.

Such conclusions may be incorrect but as yet there is no certainty in the amounts involved. Recently, there have been many figures bandied about by many organisations and it has been claimed that fraud and excessive services are responsible for the loss of millions of dollars to both Government and health insurance organisations. It is emphasised that, as yet, there are no hard figures on this although it is obviously an area of great concern to the Government and the Department of Health.

Current Methods of Detection and Control

The Department of Health has recently introduced a computerised fraud and overservicing detection system (FODS). Previously, detection of fraud and overservicing was possible only by following cumbersome and time-consuming manual procedures. It should be stressed that the Department is concerned only with those services that attract medical benefits. It is not concerned with services provided outside the medical benefits scheme such as those associated with cosmetic surgery or health screening.

Under FODS a statistical summary, known as a scan profile, is capable of being produced each quarter for each doctor who has had claims lodged during that quarter for medical benefits for a medical service which he provided. The scan is a one-page summary of a doctor's servicing pattern, as compared with that on average of a selected peer group, as indicated by claims for medical benefits over a three-month period. There is no suggestion that doctors should be required to conform to an "average" pattern of servicing. A profile does no more than highlight a different pattern of practice which may warrant a special review. Where fraud or overservicing is suspected, the profile should assist in directing investigations to specific areas of concern.

Investigation of fraud or overservicing can be initiated in a multiplicity of ways. These are too many to list but certainly include Departmental clerical

1. Address to the Federal Assembly of the Australian Medical Association, Sydney on 15 June 1981.

checking of claims for benefits, particularly bulk billing, both in processing centres and the offices of the Department itself; complaints from patients (and these are the most difficult to assess); complaints from health insurance funds; complaints from other doctors (or surprisingly, on occasion, from partners); complaints from staff of the doctors concerned. No complaint can be ignored but the Department is well aware that many, particularly from dissatisfied patients, are either frivolous, malicious or without foundation.

If the examination of a doctor's profile and any other relevant information suggests that fraud may have occurred, the case is listed for an investigation which may include the examination of original claim documents and, possibly, the interview of patients. This procedure is explained later in the context of consideration of a hypothetical case. If the examination of the profile indicates that excessive servicing may have occurred, it is probable that the doctor concerned will be invited to accept counselling on his billing practices.

Counselling

The Department of Health employs seven doctors as medical counsellors. It is their general function to facilitate communication on medical benefits matters between the Department and members of the medical profession. A principal duty of these counsellors is to visit doctors and advise them on acceptable billing practices. It is not the role of counsellors to tell doctors how to run their practices, or to intrude into doctor/patient relationships, but they do indicate, in the circumstances of any particular practice, the level of servicing that is considered acceptable where medical benefits are claimed.

Counselling is usually provided in three situations:

a. advising new graduates and doctors from overseas on the operation of the Medical Benefits Scheme;
b. routine visits to doctors; and
c. remedial counselling, where there is evidence of excessive servicing.

Counsellors visit as many practitioners as possible to discuss their patterns of practice and to obtain an understanding of the causes of any special pattern of practice such as would be associated with a practice having a higher than usual proportion of elderly patients. The counsellor is careful to ascertain the reasons for any different patterns of practice, and, if there are not adequate reasons, the counsellor will advise the practitioner that a variation of his pattern of practice may be advisable.

Remedial counselling, including the giving of "warnings", is undertaken by medical counsellors in an endeavour to prevent overservicing. By agreement with the Australian Medical Association the Department will not ordinarily refer a doctor to a Committee of Inquiry unless a warning has first been given. It is emphasised that the major role of the counsellor is early intervention, discussion and *prevention*. If there is already clear evidence of fraud, the counsellor has little role.

Medical Services Committees of Inquiry

The medical profession has co-operated with the Government in establishing a Medical Services Committee of Inquiry (M.S.C.I.) in each State for the control

of excessive servicing. These committees are made up of five doctors—four are nominated by the Australian Medical Association (A.M.A.), the fifth is the Commonwealth Director of Health for the State. A second committee has recently been established in New South Wales to assist overcoming the backlog of cases.

These committees are not courts; they are professional review bodies instituted under the Act to advise the Minister for Health on cases of suspected excessive overservicing. They are not empowered to impose material penalties. Where they do find clear evidence that a doctor has rendered unnecessary services, committees may recommend to the Minister that medical benefits should not be payable for those services. In addition, they may recommend that the doctor be reprimanded or that he be formally counselled.

As members contribute their efforts on a part-time voluntary basis (with remuneration only for expenses), hearings are normally held in the evenings. The adversary procedure is avoided, and every opportunity is provided for the doctor or his representative to call witnesses, question witnesses, and address the committee. Hearings are held in private and with as little formality as possible. The M.S.C.I. process in each instance is particularly time-consuming. The main impediment to a speedy resolution of the cases is the apparent requirement that each individual medical service must be considered in detail so that a determination can be made as to whether or not it was an excessive service in the terms of the *Health Insurance Act.*

M.S.C.I.'s commenced operation 3 years ago and have carried through to completion 25 cases of possible excessive servicing. In 11 cases they have found excessive services totalling about $185,000. There are 20 cases currently before M.S.C.I.'s and another 30 waiting to be referred.

A doctor dissatisfied with a determination by an M.S.C.I. has a right of review by a Medical Services Review Tribunal under the chairmanship of a President who is or has been the holder of a judicial office or who is a legal practitioner of the High Court or of a Supreme Court of not less than 5 years standing.

Doctor X—A Hypothetical Case

A hypothetical case, deliberately one-sided, may be helpful in demonstrating the issues confronting the Department in investigating an individual case and bringing it to finality.

Doctor X, a general practitioner, decides to vary his billing practice so that charges for the more lucrative services become more frequent. For general practitioners, the most common item in the Medical Benefits Schedule is *Item 14*—a standard consultation during the day of between 5 and 25 minutes, and the recommended fee is $11.20 in N.S.W. Dr X could charge his patients any amount he liked, but $11.20 is the figure on which benefits are based and, if his fee is significantly higher than this, they will probably look for a doctor who charges at a more reasonable level.

Instead he bills the patient for a different item from his book of schedule fees—one with a higher medical benefit. For example, *Item 51* (standard home visit, with a recommended fee of $16.20) *Item 25* (long consultation of 25 to 45

minutes at $21) or *Item 19* (after hours standard consultation at $17). If the patient is a pensioner or a person in need, all that is required is the patient's signature on a claim form, and Dr X is paid at 85% of the schedule fee by the Department of Health. If the patient is insured his health fund will reimburse all or most of the doctor's bill. In addition, Dr X advises his patients to return frequently for observation, tests, pills or injections. Patients who can be persuaded that more treatment is better treatment regard him as a good doctor.

Dr X can therefore charge for a large proportion of his services at a fee level which, if operating in an unsubsidised, competitive market, would drive most of his patients to other doctors. The public and private underwriters (that is, taxpayers and contributors to health funds) pay his fees at a higher level and more often than his patients would tolerate. There is no obvious incentive for them to object to practices which benefit both parties to the doctor/patient relationship. It is probable that for many, the signing of a form in a busy waiting room is done with less than informed consent.

A facsimile of a simulated profile report on Dr X's billing practice is on page 36. The main table of the profile lists the thirteen most common services of the doctor. In respect of those items, details of the number performed, the number of patients involved and the income (schedule fee) derived are listed. In addition, the ratio of services to patients is calculated and a breakdown of the patient's insurance cover and the way they are billed is provided. All this data is printed beside equivalent data for the average of the doctor's peer group. The lower section of the profile includes histograms for the doctor and his peer group, showing a percentage distribution of the number of services per patient in the three month period. These histograms enable a quick visual comparison between the doctor's servicing pattern and that of his peers.

It is apparent from the attached profile that Dr X's practice is considerably different from the average for his peer group (that is, general practitioners in N.S.W.). He performs significantly more *Items 51, 25* and *19* than average, and few *items 14*. His income for the quarter from medical benefits is over $25,000 compared to the average of $17,500. Fifty-three per cent of his services are provided to disadvantaged patients, compared to the average practitioner's ten per cent. The histogram in the lower left corner indicates that Dr X saw more than 25 per cent of his patients at least five times between July and September, and 1.2 per cent were seen more than 24 times. The average G.P. in N.S.W saw only 8.5 per cent of his patients five times or more in that period.

The profile of Dr X's pattern of services is sufficiently unusual to warrant examination, so Departmental investigators proceed to collect a number of original claim documents. The laborious examination of hundreds of these documents turns up instances of suspected forged patient signatures, assignment of benefit forms which appear to have had items added after being signed by the patient, and other irregularities which support the hypothesis of fraud on Dr X's part.

Departmental investigators call on some of the patients involved and ask whether they can recall being treated by Dr X on the days indicated. Investigators in such situations do not represent themselves as police officers, nor may they call into question the professional competence of the doctor. Any statement made by a patient must be voluntary. Not unexpectedly many patients refuse to co-

operate as witnesses against their family doctor. However, a number of Dr X's patients state with certainty that Dr X's claims for medical benefits on their behalf are false. The Departmental investigators report that there is sufficient evidence to discard a hypothesis of inadvertent error on the doctor's part, and refer the case to the Australian Federal Police for compilation of a prima facie case.

After conducting formal interviews of patients and obtaining sworn statements, the police successfully apply for a warrant which authorises them to copy Dr X's accounting and patient records. These records indicate that Dr X may have falsely claimed medical benefits in more than one thousand instances. In most cases, these claims involve misrepresentation of the duration or circumstance of consultations for the purpose of receiving a higher medical benefit, but it appears that a proportion of claims were made for services which were not provided at all. Dr X is arrested, appears before a magistrate's court where he enters a plea of not guilty, and he is released on substantial bail.

The police prosecutor's case against Dr X is based on a selected fifty charges of making false statements for the purpose of obtaining money, in contravention of s. 129 of the *Health Insurance Act*. The amount of money involved in each charge is small, usually under $20, but each charge must be proven beyond reasonable doubt. It is obviously not feasible for the court to hear evidence on over a thousand charges; even fifty lead to a prolonged trial. But as far as the court and the public are concerned, the case against Dr X is a minor one, involving less than $1,000. The evidence against Dr X on thirty such charges is sufficiently strong for the court to find him guilty. Although some courts have imposed gaol sentences in such cases, Dr X receives a sizeable fine and is ordered to repay $500 in benefits falsely claimed from the Government.

Prosecution and Recovery

Offences in particular cases under the *Health Insurance Act* may involve amounts ranging from several thousand dollars to a hundred thousand dollars or even more. Almost invariably these total amounts are made up of a large number of similar instance offences involving $5 to $50 over some years. In other words the same offence—for example, the exaggeration of the length of a consultation—is committed many times, usually in relation to a number of services for perhaps several hundred patients.

The nature of these offences therefore presents problems regarding both detection and subsequent action by the Department either in instituting a prosecution or arranging an appearance before an M.S.C.I. Prosecutions and actions for recovery are necessarily limited to a manageable number of charges. The Department has found that for practical purposes approximately 50 instances of an offence are the most that can be handled although preliminary inquiries may suggest that hundreds of offences are involved.

It will thus be seen from the hypothetical case of Dr X that, in a high proportion of authentic cases, the Department is confronted with great difficulty in achieving at law an effect that it believes would properly reflect the totality of the offences that may have been perpetrated. On the one hand, the limited resources of the Commonwealth mean that it can pursue only a manageable number of instances of a series of suspected offences no matter how many have

apparently been committed; on the other, it seems that the capacity of the legal system to deal appropriately with a case of systematic fraud involving a multiplicity of relatively small amounts does not match the new levels of administrative sophistication that are now available for the detection of such offences.

One possible approach would be the adoption of a procedure that would permit generalised evidence—based on profiles and supporting documentation—to be placed before the court when reparations are sought. Alternatively reparations could be determined by a peer group which would have before it similar material.

As regards overservicing, an M.S.C.I. could be authorised to base its assessment of its extent in a particular case on the "blowing-up" of the result of a sample to a conceptual full practice. Another possibility is that services provided by a doctor found to be overservicing could be precluded from medical benefits for a set period. Such a measure could, of course, have serious implications for the doctor's patients. The usefulness of these and similar proposals would require extensive exploration and, in any case, would need legislative backing. They are certainly not part of Commonwealth policy at this stage.

Privacy

The issues of medical privilege and the privacy of patients are currently being considered by the Australian Law Reform Commission as part of a wider investigation into privacy and the law. In particular, a discussion paper entitled "Privacy and Personal Information",[2] and two addresses[3] by the Hon. Mr Justice M.D. Kirby to conferences of the General Practitioners' Society in Australia and the Australian Private Hospitals Association have been helpful in identifying the issues in relation to patient records. The proper balance between the interests of the individual and the interests of the community where issues of privacy are in question has always been a matter of concern to the Department.

As far as much of the work of the Department is concerned, the following passages of Mr Justice Kirby's address to the General Practitioners' Society are of particular interest:

> In advance of the delivery of the Law Reform Commission's report, and indeed of the relevant decisions, I cannot inform you of our final thinking on these topics. But two things stand out. First, the day of the medical 'lone ranger' seems to have passed. The price of public funding and escalating health and costs is inevitably pressure to monitor to some extent the conduct of medical practitioners as this conduct impacts the revenue: whether by frank fraud or, as is much more difficult, by eccentric prescription patterns. Secondly, the privacy of the doctor/patient relationship is still important for its success. Intrusions upon it should be few. When they occur they should be handled sensitively and always with respect for the intimacies of the patient, given usually upon an expectation that normal privacy and confidentiality will be observed . . .

2. Australian Law Reform Commission: *Privacy and Personal Information* (Discussion Paper No. 14), 1980.
3. *Law Reform and the General Medical Practitioner*, a paper delivered at the 14th annual conference of the G.P.S.A., Sydney, 21 March 1981. *Doctors, Hospitals and the Courts, or the View from the Witness Box,* a paper delivered to the 1st National Congress of the A.P.H.A. Sydney, 22 June 1981.

> When it comes to access by Commonwealth officers to patient records for the purposes of investigating frauds against the Commonwealth revenue or other offences provided for by Commonwealth law, some diminution of doctor/patient confidentiality seems inevitable. Even in the case of legal practitioners' privilege, so well entrenched and long established, the privilege may be lost in certain circumstances where the dealing between lawyer and client is itself fraudulent or criminal. It would appear to me to be too facile to say that a doctor's records should not be examined without his consent (or even his patient's consent) when investigating an offence alleged against the doctor or patient himself.
>
> Otherwise, we could be committing investigation and enforcement of the criminal law and breaches of statute to the consent of the very person under suspicion or other persons upon whom he may sometimes exercise influence.

At the administrative level, the privacy of the individual, doctor or patient, is well protected. This protection is derived from several sources:

- s. 130 of the *Health Insurance Act* provides legislative protection against unauthorised divulgence of material concerning individuals.
- with nearly all profiles, access to at least two sources of information held by the Department is necessary to identify a doctor. Once identified, considerable expertise is required to interpret the profile.
- complete profiles of patients are very difficult to produce, because information is stored by doctor rather than by patient, and very rarely produced. Again, access to at least two sources of information, one of which is not held by the Department other than for pensioners and the disadvantaged, is required to identify a patient.
- the authorisation of a Senior Medical Officer is required before profiles are produced.

The Department itself is jealous of the confidentiality of personal medical records that it holds. Correspondingly, the Department does not wish to have access to professional medical records held by private doctors, unless it is unavoidable.

In respect of suspected frauds relating to medical benefits access to personal medical records, if these are kept separate from accounting records, would seldom be needed. It is usually a question of fact that is involved in relation to possible frauds; that is, whether in fact a particular medical service was or was not performed. For these inquiries, access to account books would generally be sufficient.

In respect of overservicing which, as described earlier, is considered by M.S.C.I.'s, elaborate procedures are taken to keep the identity of individual patients private and confidential to the persons directly participating in the work of these Committees. Both the Department and the A.M.A. believe in the integrity of patient privacy and personal medical information. They are therefore both concerned to ensure that there is no breach of patient privacy through procedures associated with M.S.C.I. inquiries.

To cover those occasions where the Australian Federal Police are required to seize medical records from a doctor's premises, senior officers of the A.F.P. and the A.M.A. have agreed on detailed procedures for police to follow, so that any disruption of a doctor's practice and any intrusion into his and his patients' privacy is minimised.

These procedures are as follows:

1. All records seized are to be marked and entered as an exhibit and stored in safe storage.

2. All records will be photocopied, the photocopies being given to the doctor concerned as soon as possible. If before the supply of photocopies, a doctor urgently needed records for patient treatment, every effort is to be made to respond to the need by supplying photocopies of the required records.

3. A patient whose medical record has been seized may wish to seek information as to why his/her record was seized. A request for this information is to be directed through the Commissioner's office.

4. All original records are to be kept in lockable cabinets.

5. Keys to cabinets holding the records are to be restricted to no more than two persons.

6. Records which are no longer required are to be returned to the doctor as soon as possible.

7. The contents of all records are to be treated with the utmost confidentiality.

8. Any movement of the records is to be recorded.

9. A member or other person is to sign for records given into his/her possession.

The Department recognises the importance and sensitivity of the data to which it has access to in the performance of its functions and any relevant recommendations that the Australian Law Reform Commission may make in the matter of privacy will be helpful in its continuing review of procedures.

Conclusion

The medical benefits scheme is, in the words of the Minister for Health, based on trust:

> "the basis of the fee for service" system of payment is trust—trust between doctor and patient, trust between the profession and the community. The community and the Government assume that each individual practitioner, and the profession collectively, act ethically and honestly in the provision of, and billing for, necessary medical care . . .

> . . . Your continued participation in the development of these measures to control abuse, such as those measures designed to strengthen Medical Services Committees of Inquiry, has been well appreciated. However, further measures may need to be developed and your constructive participation in the development process will be essential.

The Department is therefore in regular dialogue with the profession to establish the nature and extent of problems and the solutions that may be adopted. It believes that co-operation with the profession itself is the most satisfactory way of minimising illegal and unacceptable practices in an area so critical to the well-being of the community.

SCAN PROFILE REPORT

Report 155240 SPECIALTY GROUP—SERVICE PROFILE—PROVIDER ( )BASED ON DATE OF CLAIM DATA PAGE
Run Date 09/03/81
Req. Date 06/03/81 PEER GROUP IS GENERAL PRACTITIONER POSTCODE IS
Job

From July 80
To September 80

EXPLANATORY NOTES

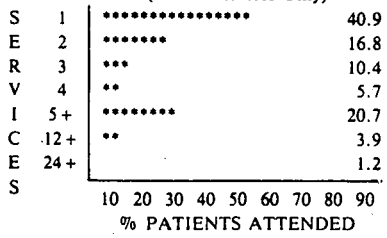
D1: Not Defined as yet
D2: Not Defined as yet
D3: (ABS X -1 / Y - 1) -1)* 100)
D4: Not Defined as yet
D5: "*" Shows group 1/Group 2 differs from average by at least 50%
MB: "**" When Used Indicates 100%

SPECIALITIES
GENERAL PRACTITIONER
PATHOLOGIST (APPROVED)

Prov. No.	P. Grp.	Item	Services Doc	Ave	D 1	No of Pat Doc	Ave	D 2	Serv/Patnt Doc (X)	Ave (Y)	D 3	Income Doc Amt	%	Ave Amt	%	Unins Dr	Av	% OF SERVICES BY BILL TYPE Pens Unins Dr	Av	Insrd Dr	Av	Pens Ins Dr	Av	Direct Bill PHB Dr	Av	Disad Dr	Av	D 4
		0051	758	93		242	46		3.1	2.0	108.0	11218	44	1367	08			22	05	13	25			07	65	58	04	
		0014	645	1047		279	654		2.3	1.6	118.0	6560	26	10645	61			13	02	27	55			05	32	55	10	
		0025	158	43		100	29		1.5	1.4	20.0	3058	12	823	05			32	02	38	33			04	42	26	21	
		0019	87	17		62	14		1.4	1.2	88.0	1355	05	263	01			09		22	53			01	24	68	24	
		0053	69	21		53	16		1.3	1.3	- 4.0	1449	06	445	03			06		32	43			32	48	30	10	
		0953	39	11		35	9		1.1	1.2	- 49.0	86	00	24	00			10		28	45				36	62	18	
		0033	29	6		23	4		1.2	1.5	- 48.0	841	03	183	01			48		45	50				33	07	17	
		8105	8	5		8	2		1.0	2.5	-100.0	93	00	42	00			13	20	13	40				20	75		
		3006	7	0		3	0		2.3	2.3	0.0	71	00	1	00			57						29		14		
		0921	5	2		5	2		1.0	1.0	0.0	74	00	36	00						50					50	**	
		Rest	26	234		24			1.0		0.0	614	02	3753	21													
		Tot.	1831	1479		492	793		3.7	1.8	214.0	25419	**	17582	**			19	03	22	53			06	34	53	10	

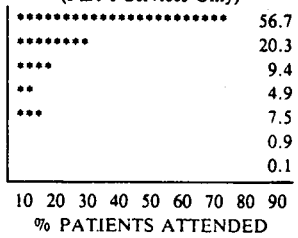
Histogram for This Provider

(Part 1 Services Only)



Average Histogram for This Specialty Group

(Part 1 Services Only)



PRESENTATION OF PAPER

R.J. Findlay

I hope that it is clear that the Department's paper is not directed to denigrating an honourable profession. On the other hand, I believe it is not in dispute that there are areas of abuse within the profession which are of a sufficient magnitude to justify community concern and the consideration of gatherings such as this. There are as yet no agreed hard figures on the extent of this abuse. Suffice to say for our purposes that the Minister for Health did tell the A.M.A. Federal Assembly earlier this year that concern was being expressed that the government could be losing tens of millions of dollars. Ethical implications aside, the extent of this abuse must have a serious impact on the level of our taxation payments and on the level of our contributions to health insurance funds.

In clearing the way for general discussion may I make several points:

First, the Department of Health is not concerned with how a doctor chooses to conduct his practice. The Department's sole concern in accordance with its statutory responsibility is with the billing by doctors for those services which attract medical benefits. The cost of these services in the current financial year is expected to be about $1700 million dollars. That is roughly twice the size of Tasmania's budget last year and slightly less than the whole Western Australian budget. It seems to me that it is quite unrealistic to suggest that the billing procedures of practitioners who are free to generate such massive expenditures, the bulk of which is met by the government and by the funds, should be largely exempted from monitoring or accountability.

Second, the Department of Health has no wish to initiate or promote a criminalizing or prosecuting campaign. It would very much prefer that breaches of the law did not occur and that any unsatisfactory billing practices that are seen to be developing are nipped in the bud at an early stage. Indeed, an assurance has been given that unless fraud or suspected fraud is involved a practitioner will not be referred to a Committee of Inquiry unless he has first been counselled and given an opportunity to adjust his billing practices where this is accepted as desirable. To pursue its preventive approach the department employs medically qualified counsellors whose business it is to advise practitioners in respect of their billing for services that attract medical benefits. A counsellor would normally seek to visit any doctor whose billing practices have given early warning that undesirable features may be developing.

Third, contrary to what has been suggested, the Department has no requirement that particular features of a practice should conform with the average for the same features in the selected peer group. However, a significant deviation from the average for a particular feature of a practice may indicate that some investigation of its billing practices is desirable. This investigation may show that fraud or overservicing has occurred. On the other hand the deviation may be quite easily explained by a characteristic of the practice that is not present in all, or some, of the other practices with which it is being compared.

Fourth, and turning to matters within the expertise of this gathering, the Department has found that there are difficulties in securing at law penalties which

it believes are commensurate with the totality of the offences that may have been committed. With the staff that is available for the purpose, the Commonwealth can investigate only a manageable number of suspected offences. This means that where the pattern of practice may indicate that a multiplicity of similar offences possibly all for quite small amounts has occurred, the Commonwealth may at the most be able to prosecute, say, only 50 of these. As a consequence the court would not be acquainted with the probable magnitude of the entire fraud and on the other hand the Department is criticized for prosecuting doctors for relatively trivial offences when in reality the amount of the total fraud may be many times the amount in respect of which charges have been laid.

May I conclude, where the Departmental paper began, by drawing attention to the need for all concerned to contain the cost of medical benefits? If that cost continues to expand to levels that our economy has problems in sustaining, then a continuation of our open-ended fee for service medical benefits system could obviously in the long run find itself under threat. The elimination of fraud and overservicing by those people who generate this expenditure would be one step in keeping the cost of our system within acceptable limits.

MEDICAL OVERSERVICING AS A CRIMINAL ACTIVITY

Professor Louis J Opit, B.Sc.(Hons), M.B., B.S., F.R.C.S., F.R.A.C.S.,
Professor of Social and Preventive Medicine,
Monash University, Victoria.

Any attempt to discuss the involvement of the medical profession in criminal activity requires a starting point which defines crime within the legal framework. It is a brave medical practitioner who debates matters of jurisprudence in the presence of his legal colleagues, but it is impossible to escape this task. My reading in this area has been provided by English law and English lawyers, so that if this creates a false framework I can only apologise for this document, it was composed in England. It is also obvious that, since doctors are also ordinary men and women, I do not wish to discuss criminality in the contect of ordinary human behaviour, but in the special context of the doctor as a professional person, with particular tasks, and particular power and responsibility.

In confronting this problem, namely selective medical criminality, I found myself between the realms of law and morality. Most legal authorities, although acknowledging that law and morals do not coincide, believe their demarcation is essentially impracticable and it appears to be necessary to understand some of these arguments in general before proceeding to disucss the medical processes themselves. It has been said that the seven deadly sins are not necessarily deadly crimes since sin dwells in the realm of thought and crime dwells in the realm of action. The law will not punish gluttony unless it makes a man drunk and disorderly, nor will it punish sloth unless it makes a man avoid his taxation responsibility.[1]

Law is said to be only the sum of rules of human conduct which the courts will enforce and criminal law is public law in which the Crown is one of the parties which set the law in motion. In para. 13 of the *Wolfenden Report* we find the following definition of crime and criminal law:

> Criminal law is to preserve public order and decency, to protect the citizen from that which is injurious or offensive and to provide safeguards against exploitation and corruption of others, particularly those who are vulnerable because they are young, weak in body or mind, inexperienced or in a state of special physical, official or economic dependence.[2]

Criminal law is based on a moral principle, and consent is thus never, or almost never, permitted as a defence. I believe, with Patrick Devlin, that private and public morality are not separable issues.[3]

I wish to argue that every contact between patient and doctor, or in the agency relationships between doctor, patient and paymaster (be it government or health insurance fund), there is potential for criminal activity within the

1. Hanbury, H.G. In *English Courts of Law*, ed. D.C.M. Yardley, Oxford University Press, London, 1967, pp. 1-3.
2. *Wolfenden Report: Report of the Committee on Homosexual Offences and Prostitution:* Command 247. HMSO, 1957, paragraph 13.
3. Devlin, P. *The Enforcement of Morals.* Oxford Univ. Press, London, 1965, page 28.

definitions of crime in the *Wolfenden Report*. In the main I am going to discuss what is euphemistically called private medical care, although some would say that it is merely uncontrolled public medical care, but that is another argument. In particular, I wish to discuss private medical care with third party financing since this is the prevailing mode of care in Australia and one which governments and the medical profession seem to desire above all else.

In this relationship the physician is expected to act on behalf of his patient in the latter's capacity of a benefit-receiver, while he is expected to act responsibly in terms of an agency relation with the health fund which acts as a cost-bearer. The physician retains all the decision-making power with respect to both patient and health fund. This framework is fraught with conflict of interest for the physician. It is obvious that in a fee-for-service payment system the physician has a stake in the consumption preferences of his patient—it creates his income. On the other hand, it is part of the professed ideology of private medical practice that vulgar considerations of cost ought not to be introduced into decision-making about medical care. We can observe that the patient has few, if any, alternatives from which to select his preferences and such preferences are acknowledged usually only at the end of the decision-making process.

This is the framework in which we must discuss "overservicing" as a criminal activity. I am loathe to use the term "overservicing" since it automatically assumes the concept of "sufficient servicing" or "underservicing". Instead, I would like to approach the problem by discussing the nature and purpose of health care service provision. The initial contact between a doctor and his client is usually initiated by the client, his friends or family and it is this case which I wish to discuss. Suppose a person feels unwell or unhappy and seeks the advice of a doctor. Once contacted, the doctor then controls the process of care for this patient onwards. We must assume that there is very little patient sovereignty, because the patient usually does not know what he needs in a technical sense; does not know whether the services he receives are those that he needs; nor is he able to evaluate the technical proficiency of any services he has received. In the world of commerce this sovereignty of the consumer exists to varying degrees and helps to keep the provider honest. It is even supported by independent state-financed mechanisms so that some uncertainty about expected quality may be resolved by reference to this body.

For a patient there is no such independent quality assurance. There are, furthermore, financial guidelines in the competitive world of commerce which help to obstruct fraud, albeit incompletely. We do not expect to buy a Rolls Royce for the price of a Mini Minor and if we are offered this opportunity then we may expect the reasonable potential customer to be suspicious. Patients, on the other hand, usually have no idea of the price differentials in medical care and in any case, if they are insured, the price which they pay is not equal or equivalent to the real cost of the services.

An even more important factor which renders the medical consumer vulnerable is that in many cases they are, to quote the language of the *Wolfenden Report* "young, weak in body or mind, inexperienced or in a state of special physical, official or economic dependence". In this state they are clearly not in a position to question or argue. The medical practitioner is thought to have the knowledge and practically has the authority to decide, and it is an unusual patient

in our society who questions this authority. In our third party financing system we can also observe that the doctor is paid for what he says he has done for the client. In most cases this is very difficult or impossible to verify, so that dishonesty may manifest itself by claim or by performance. Even when there is strong evidence that the fee schedule has been misused to create the doctor's account it is difficult to proceed legally against him, and most insurance companies are unwilling to do so. The Federal Government itself appears unwilling to act even on the suggestions of its own advisory committees and these are not notably courageous in their assessment of fraud.

It is necessary, then, to specify the way in which criminal activity can manifest itself within the notion of "overservicing".

1. Let us suppose that a physician persuades or encourages a patient to accept consultation, diagnostic tests or surgical procedures, the main purpose of which is to create gain for the physician. This gain may be financial but could also be reputation enhancement, a collection of cases treated in a certain way to be published in support of professional esteem. In my view this action, if it could be proved, and that's the rub, could lie within the definition of criminality both because of its injury to the person receiving the service and to society more generally through its effect on the contributors to the health fund who bear the cost of these professional services.

There has been some passionate public and private debate, for example, about "unnecessary" surgery. Those who deny that unnecessary procedures occur do so by assuming that everything which the doctor does is necessary and that it is the responsibility of critics to prove that some are unnecessary. This seems to me to be a complete inversion of the moral and technical responsibility of doctors towards their clients. The assumption should be that all procedures are unnecessary, except in certain circumstances, and thus "necessity" requires proof or argument. There are phenomenal differences in some surgical treatment rates between countries, such as the U.K. or Sweden, where salaried services predominate, and U.S.A. or Australia where subsidised fee-for-service medicine operates.[4] This suggests that the concept of necessity for surgery varies according to methods of payment.

The legal proof that an individual received "unnecessary" treatment is almost impossible to obtain. This proof will require the evaluation by expert medical witnesses already steeped in the same ideology, and adjudication by judge or jury, themselves potential clients of the same system. The verdict is always likely to favour the medical practitioner and the arguments become an inextricable mixture of technical and legal factors.

2. As I have suggested some crime comes about through the claim to have provided services which, in fact, were not provided. This is straightforward fraud at one level, but since it may injure the patient physically or psychologically as well it may be more than fraud. This fraud may entail

4. Opit, L.J. Submission to the Committee of Inquiry into the Efficiency and Administration of Hospitals. Department of Social and Preventive Medicine, Monash University, November, 1979.

using inappropriate (and usually more expensive) items to describe the procedure carried out. There are, for example, several different operations itemised as, say, hysterectomy. These are not described prescriptively in an unambiguous fashion but merely by title. A doctor may claim to have carried out a "radical hysterectomy" and instead have performed an ordinary "total hysterectomy". This will increase his fee and refund and it will be impossible to detect such a difference even where access is provided to the report on pathological material obtained at the operation.

3. There is another form of fraud related in part to that described under para. 2. This fraud appears to be widely practised on anecdotal evidence, and it known as the "numbers game". It consists of itemizing procedures carried out, or said to be carried out, in a way which maximises the refund. For example, a straight PA film of the chest can be described as an X-ray of the chest and of the mediastinum. This entails, then, billing for these items separately. This would effectively double the fee and refund value of the X-ray.

An operation for which specific item numbers exist, such as Keller's operation for hallux valgus, may be itemised as six different consecutive procedures, being the separate parts of the procedure, and this can triple its fee or refund value. There are many such tricks available and few of them are specifically excluded by the refund regulations. The detection of this moral or legal fraud is also made difficult by the immense complexity of the Schedule and the lack of enforceable guidelines with respect to its use.

4. Finally, there is another type of fraud which may occur. In this case, medical practitioners treat one another or the families of another doctor. The purpose of these treatments may be either to legitimise and subsidise specialists' training or as a bare-faced attempt to increase income by conspiracy. These types of fraud have been widely suspected as occurring in some psychiatric practices and action by peer groups within the College of Psychiatrists has not been completely successful in preventing the possibility of such fraud.

Once again, even when there is good evidence that such behaviour is occurring, the difficulties associated with legal proof and the considerable cost of failure to prove, have inhibited preventive action.

More recently there has been a change in the way people have been persuaded to view the use of medical services. Our society is based on continuous and rising consumption and the medical profession itself has joined the bandwagon of promoters. Some persons now use medical care in a way that seems more akin to conspicuous consumption of other goods and services (like restaurants, clothes or cosmetics). The significance of this alteration in the view of the role of medical care is profound. There is ample evidence that some persons are requesting their own treatment and this need is directed at satisfying their own convenience rather than for objectively verifiable illness. Since, in a third party subsidy system, this consumptive convenience medicine is paid for by someone else, it is clear that such actions, with the doctor's compliance, can deprive other persons of the means of financing their own private medical care. In this way we could regard this as a form of exploitation and corruption.

In some respects it may be analogous to burning down your own shop, after having first insured against fire, for the sole purpose of financing the acquisition of another shop. I am not certain what the moral position of the doctor is in this case. People may have the right to decide on treatment, such as cosmetic surgery, for entirely narcissistic reasons. It is not clear, however, that this type of service use should be forcibly financed by others and this increasingly common approach to medical care, encouraged by the medical profession who clearly benefit, may need philosophical, political, administrative and legal examination to maintain our notions of equity in medical care provision.

The operation of our so-called voluntary health insurance system depends on the assumption that doctors know best, not only for individuals but for society generally. It also assumes that their honesty, competence and integrity are all that are needed to protect the individual or the state from predatory clinical practice. The mounting conflict between medical care as social welfare and private consumption has not even been considered explicitly by government, health insurance funds or the health care professions.

We can see, therefore, that declining standards of honesty and competence could lead to the development of private medical entrepreneurs, subsidised from the communal or public purse. This is manifest by rising utilisation and cost far in excess of objective, determinable public gain. When, at the same time, the legal processes may be more likely to act to protect those engaged in this type of activity rather than the victims of such activity, ordinary citizens have cause to be concerned.

It must be clear, then, that I believe there is a substantial amount of crime perpetrated by medical practitioners in their relationship with their clients or pay masters. I view some of the actions associated with overservicing as *mala in se* not merely *mala prohibita* since they infringe the essential moral code. Patrick Devlin observed, in writing about these:

> crime means to the ordinary man something that is sinful or immoral, not merely an offence which is a piece of misbehaviour.[5]

Unfortunately, the existing administrative and legal framework will almost certainly maintain the difficulties in detecting and punishing these crimes. No matter how much the legal framework of our health care system is straightened (and it certainly needs a lot), the determination of how much overservicing is criminal activity by the medical profession will depend substantially on the framework of moral consensus. Tax avoidance provides a salutory analogy. If robbing the public purse can be construed as worthwhile and legal for some, then effective change of legal definition requires the capacity to view the action morally as well as legally; namely, that it is a form of theft.

The accountability of doctors to the community generally, or control of their capacity to subvert the intention of law needs to be considered in structural, administrative or political terms before the law can be used effectively to inhibit fraud. We have no idea of the scale of such fraud and, indeed, it is part of the

5. Devlin, P. *The Enforcement of Morals.* Oxford University Press, London, 1965, pp. 31-33.

fraud that we cannot easily find out. In my view a good deal of the debate about confidentiality relates to the desire of some members of my profession to maintain this uncertainty.

It seems likely that whatever changes occur in the law, some doctors acting as expert witnesses will have considerable influence over any evaluation of criminal intent in others. In determining questions of, say, overservicing, we will have to concede to whether such and such was "good" medical practice. Medicine, unlike the law, is based on catechism, not argument. "Good" or "bad" medicine is a convention which depends on the doctrine of our high priests. As I have observed elsewhere, good medicine is now regarded as lots of medicine. Quantity has been institutionalised as quality. Thus, good medicine is defined as the practice of good doctors and good doctors are those who offer plenty of medical care. Good doctors are also those whose prestige is obtained by setting the standards of good medicine. The profession appoints it own peers through professional bodies and thus we complete the circularity of our standards of assessment. It is clear, then, that our expert witness evaluator will almost always be ideologically committed to maintaining the status quo and is unlikely to see overservicing as more than a minor misdemeanour.

These evaluators will also be under enormous moral pressure from colleagues to favour the profession at the expense of whomever is plaintiff. I must confess that I do not believe that legal changes alone can materially reduce the type of malpractice or fraud that I postulate. The existence of predominantly fee-for-service private practice, coupled with a complex schedule of refunds subsidised by a third person, provides an irresistible incentive for some doctors to maximise utilisation and to perpetrate fraud. When this is coupled with changing public expectation of the role of medical care, and while the public is being exhorted to act narcissistically by expecting unrealistic outcomes from medical care, the forces resisting change must triumph. The medical profession, through its various professional bodies, has refused to even acknowledge the possibility that some doctors act in a criminal way within our health care system. The Federal Government and many health insurance funds also appear to wish to maintain this myth even when there is, at least, some evidence to the contrary.

There is no doubt that a clearly articulated, legally rigorous agency relationship defined between cost-bearer (government and health funds) and the doctor decision-maker would reduce overservicing but there needs to be evidence from government, health funds and the profession that such legal mechanisms will be used without favour. At present the law probably provides more protection for the professional medical criminal than for his victim.

The changes which we will need to detect and punish the medical criminal within our present system may not be attainable without substantial loss of clinical and personal freedom. They will certainly require the risk of some loss of confidentiality between physician and his patient. The enforcement of moral behaviour is made difficult when there is no specification of the moral values which underly certain actions. There is, I believe, a famous comment made by Cicero to the effect that in the end we are all slaves to the law for that is the condition of our freedom. I suspect we will have to change markedly the administrative system in which these criminal activities are encouraged before the detection and punishment of medical crime is possible. This legislative action

itself would be an expression of public moral values about the use and payment of private medical care.

Unfortunately, we can expect a high level of resistance from the medical profession to anything which interferes in its freedom of choice or its capacity to earn income. In the past Australian governments have been unwilling to provoke the antagonism of my profession even when they have suspected that benefits for many ordinary Australian citizens would accrue. We may have reached the point where we should consider whether a free society can afford to bow to the dictates of a professional oligarchy and should perhaps consider an assertion which Patrick Devlin made in his essay on Democracy and Morality:[6]

> What makes a society is a community of ideas, not political ideas alone but also ideas about the way its members should behave and govern their lives.

6. Devlin, P. *The Enforcement of Morals.* Oxford University Press, London, 1965, page 89.

PRESENTATION OF PAPER

Professor L.J. Opit

In the papers of the first two speakers (both doctors) there is the assumption that the only sort of criminal acts are those which take place by patients. They convey a picture of hordes of patients conspiring to make their doctors rich by various sorts of fraud in the suburbs. Exactly what benefit accrues to the patient from this action has not in fact been made clear to me but perhaps will be clarified later. They seem to be unable to accept the notion that the medical profession, because it has power, also must have responsibility to act morally and legally. In addition, Dr Van Dugteren wants to lay the responsibility on lack of education.

In Australia we are constantly being informed about the excellence of medical practitioners, about how Australian medical practitioners are the best in the world. Nowhere in the world are there better doctors and yet, at the same time, we are now forced to recognise that this implies that the excellence includes neither intuitive notions of probity nor a capacity to understand quite simple existing regulations. I find that this viewpoint reveals something worrying about the value system of our professional bodies.

Dr Mackey also supports the notion that patients are to blame for fraud and he asks the question "Who changed the once noble profession into a bunch of crooks?". This could be irony, but I doubt it. The answer seems to be that there is a giant conspiracy between crypto-communists in the Department of Health and patients, and the real purpose of health insurance is the subversion of the moral principles of doctors.

The paper is concerned with overservicing and the issue as to whether or not it is criminal. It is very dangerous for doctors, especially an ignorant doctor like me, to discuss jurisprudence in front of lawyers but I have found it absolutely essential for myself to discover what crime is, and I want to avoid the term "overservicing". It is a bad term. I want to itemise, as I have done to some degree in my paper, the illegal and immoral actions which can and which do occur, as Mr Findlay indicates, in our third party fee-for-service medical system. This is not to exclude bad actions from other systems, such as the salaried service, but I want to comment particularly on the problems which our particular financing and administrative structure creates.

In my paper I outline seven sorts of actions which can and which do take place. That is not escape into any fantasy—all of these things occur.

The first action which would be encompassed by overservicing is where there is a provision of medical services concerned mainly or exclusively with the welfare of the provider. There is enormous discussion about "unnecessary" surgery. I claim that this subverts the whole logic. In my opinion we should assume that all medical procedures are unnecessary, and the onus is on the doctor to prove that some are necessary—not the other way around. It is not only the money, which may be the gain when a doctor does something mainly for his own benefit. This wasteful provision is by far the *most important* group of overservicing states, and it is the most difficult, almost the most impossible, to prove convincingly before a court of law.

The second group of actions is the misclassification of procedures. The Commonwealth Schedule is mainly non-prescriptive. It provides titles and associates a particular fee with the particular procedure and title. For example, there are about seven different kinds of hysterectomy but it does not actually state what any of these are. So that it is possible to note that in one year 30% of all the so called "radical hysterectomies", as remunerated, occurred in a State with less than 10% of the population. There could be a logical, moral reason for that, but personally I doubt it.

Thirdly, we have what is called the "numbers game". I see it is called "polyitemization" but all doctors know about this. When I used to be a practising doctor I even may have done it but then it was called the "numbers game". In the "numbers game" you maximise the number of items, i.e. you reconstruct a procedure which is given as one item and one fee by taking parts of the procedure and constructing a much larger fee. I actually have with me genuine accounts sent to me by general practitioners where this procedure has taken place. There are hundreds and hundreds of possibilities, and they are very hard to discover unless you know a great deal about the Schedule and about medicine. Even when discovered, establishing that this action is deliberate is incredibly difficult.

Fourthly, another sort of overservicing occurs when there is a straightforward conspiracy between doctors to treat one another or their families. To detect this we would need fleets of private detectives. In some instances those cases that have been detected have been discovered by that method.

Fifthly, there is the straightforward fraud, which is claiming to have done something you did not do. This is the most obvious example of fraud, but is also amazingly difficult to detect.

Sixthly, and I suppose one could regard it as in the terms of my brief, there is the case where, in fact, doctors use hospital beds wastefully in a hospital which they own themselves. That is a situation fraught with the possibility, at least, of a criminal act.

The seventh type of overservicing and one which belongs to a very interesting group, relates to the circumstances in which we have changed the way in which medical services are presented and used by patients. It appears that, increasingly, medical services are not being provided for illness but are being provided to satisfy convenience and conspicuous consumption, and I believe that this phenomenon will continue to be an important issue. There is no question that people have a right to have done to themselves what they want; what is at issue is whether other people should be forced to pay for that convenience.

Having declared the possibilities that can occur, our problem is that we need knowledge of the frequency with which these actions occur and of that we have very little knowledge. The computer methods are hopeless for finding individual cases, but useful statistically for finding the phenomenon. There are appalling difficulties in detecting and proving the things that we know to be happening in a manner which will stand up to the rigour of the courts. As I have indicated, in many respects the courts protect the criminal, hence the fear of failure in prosecution by health insurance funds or by other agencies. The Attorney-General himself in a note reported to *The Age* indicated an unwillingness to involve the

Department in prosecution on the grounds that it might lead to actions for defamatory libel.

We have in our country an assumption that doctors know best for the disease, for the individual, and for the State generally and I think we really now must challenge this. Reliance on universal honesty, competence, and integrity of the physician may, unfortunately, be unwise. We must not confuse a failure to detect and a failure to prosecute with a lack of frequency. It is like trying to count the murders by counting the convicted murderers, or the theft by the convicted thieves. White collar crime is detected at much lower rates almost everywhere in the Western world and it is part of the social economic bias of our whole criminal system that we are much more worried about breaking and entering than quite massive financial white collar theft.

I began my paper by trying to find out which of these actions is really criminal, and I apologise to all the lawyers present because as a scholar of jurisprudence I would not rate many marks. It seemed to me that if these actions injured the individual directly or indirectly, or if they injured other persons indirectly as a consequence, particularly as in most cases the victims are mainly vulnerable to the power and authority of the practitioner through their state of health or their state of mind, we would have to consider that at least some of these actions are criminal.

Finally, in my opinion, the detection, conviction and punishment of much of the criminal activity is impossible, within the existing legal system. We have lack of information because of the complexity of the Schedule and, in many cases, because of a quite deliberately contrived legal mechanism designed to protect the confidentiality of the patient but which actually maintains the secrecy of the doctor. Proof, as I pointed out, requires adjudication by experts. The adjudicator himself will be a man, a doctor, a peer member, likely to have the same ideological basis. He will also be susceptible to pressure from his own professional colleagues. In addition there is an unwillingness of the vital "third party" to participate for reasons which I have indicated. We definitely need changes in the law but, in my opinion, most of the changes that are needed are administrative and political.

Some legal changes which seem possible are those which can define in a rigorous way the agency relationship between a paymaster, be it government or health fund, and the provider. This would tighten up the responsibility of the doctor to the fund, a step which is badly needed. We also need vastly more publicly available information about what is actually going with respect to the utilisation of medical services. We need recognition that there are changes in the role of medicine and in the nature of provision of medical services. I know that in many respects what I am asking for (and one important outcome) will entail a loss of the doctor's clinical freedom, but in many respects the community's preservation of freedom may require the doctor to give up some of his.

DISCUSSION PAPER

P.G. Ward, M.A., B.E.,
Senior Lecturer in Criminal Statistics,
University of Sydney.

As a person who has no particular interest (pecuniary or otherwise) in defending the medical profession, I feel that I should make some comments upon the present methods of computer screening used by the Commonwealth to detect fraud and overservicing. In the example given of Doctor X the computer shows that he treated only 492 separate patients compared with the average general practitioner who treats an average of 793 in the same period. Whereas the average G.P. sees each patient on average less than twice this doctor saw his patients more than three times on average and charged for greater numbers of home visits and other more expensive services more often.

This information was used to detect that Doctor X was a suspect and further investigation proved that he was claiming fraudulently. This is fair enough. It is obvious that persistent frauds will be detected by this technique and that the should be detected and punished where possible.

The point with which I wish to take issue is: supposing that not one piece of evidence was found to suggest that Doctor X has made fraudulent claims, would he have been charged with overservicing? I wish to suggest that several G.P.'s may generate a profile similar to Doctor X's who would not be committing fraud and might also not be overservicing.

Consider an area such as the Central Coast of New South Wales or the Gold Coast of Queensland with a higher than average proportion of retired persons and pensioners in the community. Doctor X "squats" in a community previously serviced by Doctors A, B, C, D, and E. The local community discover that if they ring Doctor X complaining of chest pains or that somebody is unconscious, instead of being told to call an ambulance and be taken to a hospital in the city 10 miles away, they usually receive attention in a short while at their home. Doctor X thereupon develops a practice consisting of an abnormally high proportion of the aged in the district and a high proportion of pensioners. Because Doctor X is squatting the other G.P.'s do not include him in their week-end roster system so that he also ends up with a high proportion of week-end consultations. My Doctor X will end up with a profile very similar to the fraudulent Doctor X's and if the review committee who examine his case are professionals of the type A to E he may well be charged with overservicing. Is he?

This Doctor X's methods may be costing the Commonwealth services more and the State services less but it would be difficult to argue that his methods are costing *the community* more (unless one argues that it is better to let pensioners drop off with heart attacks as soon after retirement as possible). But the picture painted by Mr Findlay of a pensioner popping in to see the doctor for a cosy chat and signing a form to see that the doctor gets paid unnecessarily is not really justifiable when the caseload is more aged than normal.

The basic flaw, as I see it, in the present computer program is that it makes no provision for comparison by caseload type. As the present computer system

presumably detects the patient by some form of medical benefit number it should be possible to determine the age profile of the doctor's practice and to use this data rather than a peer group to determine the averages to compare his methods with others. Such a technique should be just as likely to detect fraud and be far less likely to falsely imply overservicing.

PRESENTATION OF PAPER

P.G. Ward

I just thought I would make the point that having looked at the techniques that are used, you could say that they could detect those people who are fraudulent and people whom it is very debatable whether they are doing anything wrong. I made the point that if you were to adjust the computer program you would probably be able to make a differentiation between a group who have a different profile because they have a different sort of case load or because they operate in slightly different ways which I do not thing are unethical.

I also think that this just chasing of overservicing can lead to various sorts of patterns of behaviour such as a doctor saying to every patient who has only just come in once during that three months "Oh well you had better come back in three months time for another check up" so he gets enough instances of one call only per three months on his histogram. Patterns of behaviour like that, that do not really save anybody any money, make the histogram more acceptable to bureaucrats. Also cutting out those people who by some definition are over-servicing on the basis of just looking at the computer will mean that in the next three months if most of those who have conformed, your average will move down. You will then have another group of non-conformists. I am not too sure if this mechanical application of a computer programme without looking at other circumstances is a good thing in the long run. I can see all these possible dangers of defining overservicing more and more strictly until doctors may actually be underservicing.

DISCUSSION PAPER

Dr Robert Stein, LL.M., Ph.D., A.Mus.A.,
Lecturer in Law, University of Sydney.

My major difficulties relate to the papers of Dr Mackey and Mr Findlay.

As regards Dr Mackey I would like to remark on what appears to be over-statements of the case presented. It is said that the profession now has its own court for the persecution of its members. I think it needs to be indicated that such procedures as these are not *new* to the law and that they have often been beneficial in some areas. I select as an example the most obvious case known to lawyers *The Legal Practitioners (Amendment) Act* of 1935 which made provision for the "Statutory Committee of the Incorporated Law Institute of New South Wales". Under this Act, and otherwise, there are wide powers over activities of the legal profession. Investigations may be conducted, warnings issued, and approaches to the court may be made. In addition, suspensions and exclusions from practice may be ordered. This has been shown to prevent the worst excesses in which only a small group of our profession participate and it ensures a proper regard for proper procedures.

I cannot see how a medical practitioner who conducts himself within the law has any more to fear than the lawyer who likewise conducts himself within the law which is *nothing*. Therefore, it seems to me that the accusations against the Medical Services Committee of Enquiry are misplaced.

I pass over statements on page 19 concerning the fraudulent nature of the system which to me does not appear to be demonstrated and the fact that it is Parliament rather than politicians which introduces procedures of the kind explained.

As to the reasons it just might be that it has been for the avoidance of abuses. Perhaps the truth is too simple to be accepted. Secondly, my substantial criticisms are that no answer seems to be provided in the paper, but I may have missed it, to the mild criticisms and observations of Mr Justice Kirby quoted in Mr Findlay's paper at page 32. They do point, in my opinion, to abuses by some members of the medical profession even if a small number of doctors only. A shortage of murders does not seek to justify the abolition of the penalty for murder.

Last of all no attempt is made to provide for Professor Opit's remarks concerning the "tongue in cheek" fact that medical profession knows the best treatment for the patient, and it is the patient's duty to accept the advice tendered, without question. In the case stated the advice happens incidentally to be to the financial advantage of the consultant and not necessarily to the advantage of the patient. The example of the number of hysterectomies in Australia as compared with the position in England, I believe, does call for an answer. This alone might justify the existence of the Committee. One could say that I suspect two people are being hijacked. First of all the patient, with unnecessary surgery and secondly, the public purse for Commonwealth payments or the fund contributors who must foot the bill resulting from an unnecessary treatment of a problem which may not exist.

As regards Mr Findlay, my difficulties arise here under the heading of "Prosecution and Recovery". There is a suggestion that generalised evidence be accepted against Doctor X on page 31. It seems to me that this might be guilt by guesswork. For example a percentage of abuses might be established which is quite wrong and I believe the example presented by Mr Ward points this out. In such a case Dr X would be paying for crimes which he has not committed.

My second difficulty relates to the same heading: to exclude a practitioner from medical benefits as a penalty for a set crime. I do not see the difficulties raised by the author rather I ask "What of country people?". In an area serviced by one doctor only and the use of this penalty, what would the patients do for medical service attention? Would government provide them with relief service, or would they have to pay the full price during the period of suspension?

Last of all, and in passing, under the heading of "Privacy". There is a great difficulty I believe in the use of words such as "as soon as possible", which appears in points 2 and 7 (page 34), "every effort is to be made". I think experience of the lawyer suggests that unless the duty on the complying body is mandatory compliance with a request for cooperation will not be forthcoming for a multiplicity of reasons such as:— "pressure of work", "every effort is being made", "the materials may be required in the future", or the standard form of one which I have run into on numerous occasions "we have lost the lot", to name a few. I think these and other issues require to be answered before the papers can be accepted as, I believe, a satisfactory comment and proposal upon servicing and fraud *and* the rejection of a committee of enquiry.

DISCUSSION

Dr. Peter Arnold, General Practitioner

I am particularly pleased to be here today, because when Medibank was mooted I wrote an article called "How to Rob Medibank Blind"[1]. That article was taken from our magazine and reprinted entirely in the Editorial pages of the *Sun-Herald*. As a result many people saw the article. I ended up by saying that a general practitioner who was a little unscrupulous could earn half a million dollars a year.

We had a very interesting reaction to that article. The Minister for Health, who had seen a preliminary draft, said it was written tongue in cheek, the A.M.A. said it was a terrible thing to do because it was going to be tempting doctors to be corrupt.

One of the wisest things that has been said at this seminar was by the last speaker who pinpointed something which has not been noted by the main speakers, that it is all very well wanting to catch the "crooks", to find methods of detecting them, to change the law so that we can penalise them and so on, but nothing has been said about prevention. I think this is really vital. The reason *why* we have fraud, the reason *why* we have overservicing is quite simply that there is a third party paying, and in most cases of overservicing and fraud the third party is paying almost, if not all, the entire fee.

When he was here recently Milton Friedman was asked what to do about this sort of thing and he said "It is simply a matter of insurance. Any decent insurance company will stop overservicing and fraud by insisting on co-insurance". Here we have the most ridiculous situation which we should have learnt from Canada—we have a third party paying everything. Specialists who charge high fees are quite happy to accept the patient's benefit rebate as full payment, because it is only about $5.00 off the fee anyway. We have a wonderful system which, as one of the speakers said, is totally open-ended and it gets abused because the patient is not paying a cent.

One of my particular unhappinesses is the Medicheck system in Sydney. When my patients ask for a referral I refuse. All our referral forms are stamped "Not valid for Medicheck" (it does not mean a thing legally). When I ask them "Would you go to Medicheck if you had to pay the full fee of about $120.00?" they reply "Of course not, but it is only going to cost me $3.00 if I go there and claim off medical benefits".

I think the answer to most of what we have heard today is co-insurance. The patient should pay something significant for each and every medical service. Where a doctor wants to give a free service to the patient he should not get the medical rebate either. Let it be a free service as it used to be in the days of honorary service and in the days before we had health insurance when we treated so many people for nothing.

---

1. *The Australian G.P.* January 1976.

The other point which I must take Mr Findlay to task for is, I suggest, that it is somewhat fatuous to say you are not concerned with how doctors practise medicine but you are concerned with their billing. In fact the two are pretty indistinguishable. Because if I see a patient for 5 to 25 minutes you tell me I *must* put down an item 14 if the patient is able to claim and it is not a health screening or similar procedure. In fact, you are very concerned with *how* I run my practice, and if I do decide to run my practice where I have lots of long consultations you are very concerned with the number of item 25's. I think that it is really not an acceptable comment that you make at all. In fact it was ruled out by the High Court in the B.M.A. case in 1949[2] because the financing of it is very much a factor of the way in which medicine is practised.

The last point I want to make concerns the question of accountability and confidentiality. It is very difficult to have a system which takes care of the patient's confidences to the doctor. We already have the police able (maybe they have been for a long time, as our lawyers tell us) to raid psychiatrists' and doctors' surgeries and take the records of their patients. We have a situation where the patients are not telling because they are scared records may be taken, where doctors are not writing down important information because they are scared records may be taken, which really makes a farce of the medical records system—you do not really know what the patient told you last time because you cannot remember everything. At the same time we have the auditor-general who wants to be sure, and quite rightly so, that his money is being properly spent. What we must realise is that we have to try to combine these two things. We must have respect for confidentiality. I can't see why the Health Department cannot get the patient's permission if they wish to know about the patient's records, and I can't see that a doctor can say, "No" once the patient gives permission. I think that would be a great help to them. I can't see why the Minister and his administrative officers could not have a system whereby patients, people in general, are told "If you wish to be eligible for medical benefits you must give authority to our Department to get confidential information from your Doctor". Every insurance company does that, e.g. if you take out a life policy, or a sick and accident policy, you sign a paper that says you authorise the release of confidential information. Something that has upset the bureaucrats is that in our practice, our prescriptions are over printed (we do not use the government ones) with a warning which says "The information on this prescription is processed by government computers and may result in invasion of your privacy". This is something that people must be made aware of. The government is giving them something but in exchange it wants confidentiality—let the government be honest and ask for the confidentiality.

Don Weatherburn, Mitchell College of Advanced Education

I would like to make the point that it is a curious feature of the medical profession that they would like the patient to pay to keep the doctors honest i.e. in order to stop the doctors ripping off the patients you arrange things so the patient has to pay. I think it is just typical of the way the medical profession tries to organize its ethics.

---

2. *Federal Council of the British Medical Association in Australia v The Commonwealth of Australia (1949)* (79 C.L.R. 201-295).

Dr H.L. Soper, General Practitioner, Revolutionary, Libertarian, Executive member of the General Practitioners' Society in Australia, Editor of the General Practitioners' Society News, Editor of the Libertarian Digest.

To reply to Dr Van Dugteren: The A.M.A. speaks with too many voices—how can it represent State salaried people and private practice? It is quite impossible and I think that it is overrun with what could be called crypto-socialists (crypto-communists are the same thing)—they are under every bed—the whole argument is political. These services are supplied to gain votes for politicians. Why apologise for it? They know what they are about, we know what they are about. The overservicing at Nowra sounded to me like a lot of damned hard work and apparently the Health Minister finds high medical incomes odious. The best thing to do is to put more doctors on—he has woken up to that fairly late.

In considering ethics of the medical profession and honesty: As much as the Morgan Gallup poll is worth we are now up 1% to 63% in probity and ethical behaviour, politicians at the State level are down 4% to 16%, at Federal level down 1% to 15% and lawyers are 38%, police are up 8% to 56%, union leaders 8% and car salesmen 3%. I do not make any apologies about the general view of what our probity is, in spite of the crypto-communists that have been speaking today.

To reply to Dr Mackey: The A.M.A. is definitely in cooperation with the government. The A.M.A. in asking for government subsidy abrogates the free market. There is only one arbiter of excellence and that is the free market. Anything that is worthwhile will survive and anything that demands government subsidy should go down. So we have theft of our resources, our life, liberty and property to pay for something so that the glad-handing politicians can get votes.

Computer print outs: Dr Mackey has had some experience with these. They are quite erroneous. We have forgotten the simple aphorism about computers—"garbage in—garbage out". And yet, you try to convict decent people who are held in high regard in the community. I know there are some bad apples everywhere, but let the patient look after his own financial affairs, as has already been argued against, and he wants to rob me to take my hard-earned dough to pay his rotten medical expenses. Next thing he will want food, then housing and so on, and as in the communist state the thing runs down and nobody does anything. You destroy capital, you destroy the country.

To reply to Mr Findlay, the government is losing tens of millions of dollars into the non-productive bureaucracy which is engendered by these political handouts—32% of the population work for the government, 10% are on pensions, 6% are on the dole. We have got an inbuilt system for crypto-communism and crypto-socialism where the government constantly robs the productive people of the community, and I include amongst those the doctors—the free-standing doctors who want nothing to do with the government. They do not go to the government for subsidy and support.

Only the truly indigent need State aid and then you have much less opportunity for fraud. People that are really poor, not some artificial poverty line, but people that have no money, no anything, are the only people who require State aid. This is the basis of the free market. Once you have got a key into the

commissary nobody wants to work. The penalties for the fraud against the government have been miniscule.

In reply to Professor Opit: Patients do initiate services by the simple law of supply and demand—where something is free the demand is infinite, and that is precisely what is happening.

Our probity is supported by the general public, but within the general public you do have "something-for-nothing merchants" who are encouraged in this by government. The government takes my property, your property, on behalf of those people and gives them handouts. Even that would be alright if it were a two-way street, but unfortunately there is a voracious intermediary and that is the bureaucracy. Therefore, the government in supplying you services always gives you a lot less than you could get yourself. Private medicine is not only better medicine, it is cheaper medicine. It has been proved many times. Fleets of private detectives are not necessary where the patient pays his own bills—he monitors his own expenses. The order of a free market comes from the simple contract, and the regimentation of the socialist governments leads to chaos.

Dr Joan Asher, Chairman of the N.S.W. Committee of Inquiry.

One question that has received little comment and was raised by Professor Opit, does concern me in my position. Professor Opit noted that in many cases when one is dealing with these allegations one exposes evidence of medical practice that is greatly to the detriment of the patient. There is no current mechanism by which we can act on this in any way. There are no official channels by which this can be referred on to the authorities who have the ability to deal with this situation. That causes us equal concern.

Dorothy Howe

I want to be a moralist. I agree with Dr Van Dugteren, the essential factor in fraud is that the bill is issued which can gain a rebate for services supplied and not supplied. The fund is open to be "milked". In my dental practice with my husband the normal way to make a claim from a fund is that the patient pays, a receipt is given, and the patient gets the rebate. If this was done we would not have a problem. The patient receives an account, presents it to a fund, the cheque is made out in the dentist's name, and the patient is asked sometimes to pay the difference. I have proof that the receptionists at the fund make the cheque out in the patient's name. Everyone knows how simple it is to join a health fund, no identification is required, no birth certificate is required, and legal or illegal people other than the contributor may be covered, so the funds leave themselves open to cheating in small and large ways. All you require to get an illegal rebate is a dental account form. A scheduled item number form is supplied by the Australian Dental Association, it is sent out with every account to explain to your patient what those numbers mean. But, the criminal who wishes to cheat can have this form printed.

I agree with Dr Mackey that in this confused situation of changing medical and hospital funding the health fund bureaucrat is the true criminal in the situation. I cannot get an article published which shows how much the funds can be cheated and how easily they can be cheated. How can we have an honest fund

for the people? We have to have insurance, and we have to have everybody's name registered who are eligible on that insurance policy.

Dr Jodhi R. Menon, Member of the National Committee, The General Practitioners' Society in Australia, N.S.W. Spokesman and Editor of "The Australian G.P.".

I wish to reply to the question "Why do we want to make the patient pay so as to watch the doctors?". One simple lesson that we all have to learn is that doctors are not gods, and patients are not angels. This is one of the fundamental causes of fraud, and we in the Society have no sympathy for fraudulent doctors. We admit that in any cross section of the population, including doctors, there are crooks. When I once made this accusation, the interviewer said "You are making a serious charge against your colleagues—your own kith and kin". I said, "We do not wish to count any criminal doctors as our kith and kin. We would rather have them found out and tried like common criminals". The Commonwealth policemen have all failed miserably. The A.M.A. policemen and the Committees of Inquiry have all failed miserably. The only effective policeman is the patient. I dispute with Professor Opit that no patient would dare question the doctor's authority. If a patient had to put his hand in his pocket he would want to know what he was paying for. When he does not have to put his hand in his pocket he doesn't really care what he is paying for or how much he must pay. In the same way, I know nothing about motor cars but when I am presented with a bill of $325.00 I want to know exactly *why*. If I did not have to pay that bill myself I would not be particularly interested.

Don Weatherburn

There is one similarity that strikes me between the medical profession and the used car profession, and that is they both deal in their respective concerns as if with objects which demand a particular price—I think that is about as far as it goes.

In my limited experience with doctors as a patient it is very rarely that I receive a clear answer to the question "What is it that you are giving me for the money that I am paying?". Usually some sort of obscurantism follows immediately. I hate to think what happens to people who are less articulate. In summary, I think it is quite false to say people respond to doctors as they would to people supplying a bill for reparation to an automobile.

Professor L.J. Opit

There is one point I would like to make because two of the G.P.S. speakers have referred to "proper insurance". I suspect that really none of them know what proper insurance is. Proper insurance, in fact, sets rates according to the risk; so if 65-year-old people wish to insure they would be paying something like ten times the premium of 15 to 20-year-old people. The speakers from the G.P.S. have also constantly failed to introduce the notion of probity, the idea that greedy doctors could have something to do with the overservicing. They may not see anything wrong, in terms of social justice, with a medical system which made old people pay ten times as much as young people, but most people, certainly most politicians and governments, would never accept such a scheme. I think it

would be sensible to get rid of the idea that proper insurance is what health insurance is about. Health insurance is, if anything, extremely improper insurance and will always be improper insurance.

Dr P. Arnold

I must rise to Professor Opit's bait and point out to him that he is really confusing two very different things. The one is "what people can afford" and the other thing is what governments would like to do so that they look good. I see no reason why a 92-year-old patient, if he is wealthy, should not pay proper fees. I think what we are seeing is that old disease—where there is a problem, there must be a solution. I come from South Africa originally. Whenever people have said to me over the 20 years I have been here "What is the solution?", I reply "There is none" but they say "There *must* be a solution", and they will not realise there is no solution. Similarly there is no solution to the Arab/Israeli conflict. There are a number of possibilities, a number of changes may take place, but there is no solution. Unfortunately many people, particularly in government and universities, believe that if there is a problem there *must* be a solution.

What we have been saying for a long time is that health insurance is like any other insurance, and there is no reason why if people cannot afford to have insurance they cannot get State assistance. You do not see the government assisting people to insure their houses or their motor cars or their clothes or jewellery, but health has got to be special. There is something sacrosanct about health, that we have to go overboard in a *stupid* system which allows *everybody* free access to government money regardless of their means. Why on earth should rich people be subsidised by taxes paid by poor people? It does not make any sense. Let them pay themselves. There are very few countries as wealthy and as affluent as Australia, and yet when it comes to health insurance we behave as if we are Kampuchea or some benighted South American republic where everybody is so poor that the government must help them all. This is sheer lunacy, and the relevance of it is that these same arguments arise all the time.

In reply to Mr Weatherburn's point that some doctors are dishonest—some lawyers are dishonest, some University professors and lecturers are dishonest, some staff of College of Advanced Education are dishonest. I am not denying that, and I wrote the article originally to expose this dishonesty. What we are saying is that it is stupid having a system which allows everybody to abuse it. One lady in Toronto went to 85 different consultant physicians before she found one who gave her the diagnosis that she wanted. If that isn't abuse then what is? We have the same thing here. People want to go to Medicheck, to specialists, to their gynaecologist, a routine yearly check, and so on. They come in and say "I want to take my child to a paediatrician because it has a sore throat". In general practice we get this *all* the time. Let us look at the abuse honestly. The abusing people say "I am entitled to it. I pay medical benefits. I don't care what it costs. I am going to the specialists". This happens all the time, with respect to Professor Opit. We have to realise the fault lies in the system. Let us help those who cannot afford health care and let us direct government effort at the small percentage in Australia who need help, but to spread it universally is just plain crazy.

Finally, concerning the question of the computer. I hope the Medical Board will forgive me for saying this, but in my practice, where I have been 15 years,

we accept no money at all from anybody except the patient. We will not accept cheques from insurance companies, from medical funds, from Medibank, from the Government Insurance Office, or from anybody other than the patient. We do not give out itemised accounts, we give out an itemised receipt. The patient pays us, they get a receipt, and they do what they like with that receipt. If they are insured they claim, if they are not insured they do not claim, that is their business. I recently had a discussion with the N.S.W. Health Department. I asked for my profile and found a lot of *item* 3's (short consultations—less than 5 minutes), and a lot of *item* 25's (long consultations—over 25 minutes). What has been happening to general practitioners is, they are told: "Your computer profile shows too many long consultations. You are writing down *item* 25 when in fact it was not 25 minutes. You are cheating", or they are told "You have too many *item* 3's, therefore you are charging for prescriptions". I do charge for prescriptions, $2.00 paid, receipt given, no item number. The reason why I have so many *item* 25's is that ever since the Department picked on a doctor in Western Australia (who subsequently committed suicide) and I wrote a facetious letter to the Bulletin about working to a stop watch, I have in fact done what my lawyer does—I have a clock on my desk. I write down the time that the patient walks in and the time the patient walks out. I have every consultation time and the amazing thing is that, in my ignorance, I thought that most of my consultations were under 25 minutes. I am now finding that a goodly proportion, far more than I ever suspected, were over 25 minutes, so I find I have a great many *item* 25's.

One must realise that where you have time brackets 0 to 5 minutes, 5 to 25 and 25 to 45, what does the G.P. do if, looking at the stop watch he sees that it is 24 minutes and not 25, or the consultation took 6 minutes not 5? Does he put down the item number according to the schedule he has been given, or is he decent and moral and say, "It was a pretty ordinary consultation, I will stick to the ordinary one". These are real problems, and I think many of these problems arise because doctors are not using a stop watch, and I would not expect them to. I have been doing it for fun. But most doctors are not using a stop watch. They are saying: "I *think* it was a long consultation", or "I think it was a *short* consultation". These "simple rules", that one of the speakers referred to, following "simple regulations" are not so simple. It is often very difficult to know precisely which of these literally thousands of item numbers to use. Professor Opit I am sure would agree that it can be confusing to know which one to use, because the items are not, as he said, defined in the schedule of benefits. What is a particular kind of operation or what is a particular kind of fracture? There are no definitions given and these vary from place to place.

I agree there are some crooks, I am not disputing that, but I think it is fruitless trying to chase them. We need to change the system so that patients bear more responsibility and *they* police the system because that is the best way of doing it. Where the patients cannot afford health care let them get assistance. So far as the doctors abusing the system is concerned, I think we have to live with some doctors doing it and we have to try and catch the bad ones and not allow them, as is the case of a couple in New South Wales who are well known to the Department and to the Minister, to be so clever as to get away with it.

Dr Van Dugteren

I have been called a communist—that is quite delightful. I think there are two or three matters that have come forward.

As regards Professor Opit's paper, I think I was taken to task for suggesting that doctors do need education in regards to the law for the control and supply of medical services. He felt that this should be intuitive, that doctors should automatically know what is right and what is wrong. I was interested to note that he himself had to refer to a law library to define crime, and goes to some considerable trouble in quoting this in the opening of his paper.

The laws controlling medicine have changed almost day by day, not only within the provisions of the *Health Insurance Act,* but at State level also. The last time I lectured to medical students I referred to a minimum of 35 Acts,and when we look at, for instance, the *Crimes Act* s. 83, which refers to termination of pregnancy, as to whether it is a crime or not depends on the use of the words "lawfully interferes". Nobody as yet has determined what is the level of "lawfully" in this State as regards an abortion, so we do not know what the law is. Intuitive feeling is far from sufficient in determining what the code of behaviour of a medical practitioner shall be. I think the fact that our universities have given up the previous practice of medical jurisprudence as an examinable subject is a tragedy. I also think that it is a tragedy that doctors from overseas are registered and allowed to practice in this country without the slightest idea of what the established medical system really is, and they are placed frequently in danger because of that very fact.

When it is stated that "Committees of Inquiry have failed" I consider that to be a statement without any backing to it. To what level overservicing would actually occur without Committees of Inquiry is something of which we have no knowledge. There is no true evaluation of what the position might be. It could even be better without Committees of Inquiry because doctors themselves might not be stimulated to try and beat the system. Mr Ward's paper refers to the feedout from the computer and how that in itself can be misleading. Let us hope that the day never comes when we have trial by computer. All the computer does is draw attention to certain people within the system, and nobody likes that being done to them. I did not enjoy it when I was investigated by the N.S.W. Department of Health about 30 years ago regarding a patient. Fortunately, apparently I got away with it. The essential thing, as we have said (and the A.M.A. is violently criticized by the G.P.S. for its attitude in that direction), is that the final recommendation to the Minister must be by medical practitioners with knowledge of clinical practice with a good level of discretion who are chosen by their colleagues—that is those of their colleagues who support my Association (which happened to be the vast majority). Those people judge, it is not just on a computer feedout. But on those factors that Mr Ward has raised, for instance the type of patients that are involved, e.g. at a practice from, say, Wyong up in the northern waters area where you have an enormous number of retired people, and pensioners, compared to the situation in the type of area where Peter Arnold practises, and within that area a particular doctor, because of a certain charisma he has as to older people, might have a practice that is totally loaded with retired people; or you can be practising in a suburb where you have an enormous number of disadvantaged people. It is up to the Committee of Inquiry, with their knowledge of the variation of circumstances and with their knowledge of the clinical entity of each practice, to make a recommendation to the Minister. There will be arguments as to whether that is a good or a bad system. My association supports that system. I know that the G.P.S. does not support it. We are all entitled to have a variation of opinion, but it is perfectly obvious from the respective

memberships that we do have a very high level of support from the profession, and they would sooner be judged by their colleagues than by somebody who knows absolutely nothing about our profession.

Dr. Raymond James, Psychiatrist (private practice), Brisbane.

As a Queenslander I am, of course, a member of the A.M.A. and other right wing groups!

I would like to speak to the proposition that patients can look after their own interests, or that actions by the patient can make the system honest. The patient can, of course, complain to the Commonwealth Department of Health which will then investigate or not investigate, and we have heard the difficulties of that.

What I would just like to raise are the difficulties encountered by patients who feel that they are the victims of medical malpractice. In those situations the recourse to the patient is to take an action for negligence against the doctor. This is enormously difficult in the present circumstances. Firstly, it is very difficult indeed for patients who become plaintiffs in civil actions for damages, to get doctors to give expert opinions in these matters. Secondly, the patient then has to take the case to court and he is up against the doctors who are defended by the medical protection societies which are very affluent and well organised "doctors insurance groups". The attitude of these societies is often to take the matter to court, and in that situation the plaintiff, who may be a middle class person, must run the risk of losing because of the difficulties of getting opinions in these areas. If a matter went to court over a period of perhaps three to five days and the plaintiff lost, he would be up for costs of perhaps $30,000 to $50,000. This really means that in bringing matters of medical malpractice to the notice of the public issues are not debated in the courts, and therefore, through the media, brought to public scrutiny because plaintiffs cannot afford the risks of losing. The only people who could litigate these matters with any confidence would be millionaires, whom I presume are not the victims of medical malpractice, or paupers, who could get legal aid, but presumably do not realise when they are the victims of medical malpractice.

Dr Van Dugteren

As far as legal aid is concerned we are obviously in quite different States. In N.S.W. it is now a State legal subsidy through the State Legal Services Commission, so, in fact, N.S.W. is in a somewhat different position. Previously in New South Wales this was run by the Law Society whereas now it is by the government.

However, the accusation of the "closed shop" is one important thing that emerges when the patient *cannot* get a medical practitioner to give an opinion. I know the G.P.S. is going to hate me because now we have guaranteed legal aid for the patients. If they have difficulty in obtaining an opinion in a matter under dispute, and where a patient is looking to obtain legal aid when they feel they have a case for damages against a doctor, we have guaranteed to obtain the cooperation of senior members of the profession in the particular discipline involved to assist in full examination and frank opinion upon that patient to legal

aid and if necessary to give future evidence in court. We are determined that there will *not* be a "closed shop" in that direction in New South Wales. In fact, we have also formed within the Branch a section of those doctors who are involved in giving medical evidence fairly frequently. We have supplied the Law Society (although we still have some gaps to close) with a list of those doctors who are prepared to give their time in examining patients and giving medical evidence. I know that some people do not have a very high opinion of the honesty of the profession but I can assure them that those medical practitioners are giving an honest and open opinion.

One hurdle that we have had to overcome is to ensure that there is a list of people available. In some of the smaller, more exotic disciplines we do have problems in finding an appropriate senior experienced person with the time to go to court, remembering that loss of time can be a serious disruption of your practice and your patients. I think we have covered that reasonably well and if we haven't covered an area we are doing our best to.

Pamela Routledge, N.S.W. Health Commission

My point might now be redundant but I would like to support the comment of Dr James about the viability of the notion of medicine operating in the market place. I think there is substantial evidence that consumers, in fact, are not able to operate in a market place medical situation, because they are not informed about what is involved in a medical practice and they do not have the knowledge or the skills to make informed choices.

My second point is that there is substantial evidence both from Canada and the United Kingdom that selective provisions to cover the very poor, such as we have recently introduced in Australia, simply do not work. The poor do not take up these selective provisions, and this is evidenced by the lack of take up of the new health care cards recently introduced by the Commonwealth. The number of low income families coming forward to avail themselves of that provision is way below the numbers estimated to be eligible to receive them, and the consequence of this is that the very poor just do not use health services even when they are often those most in need. It seems to me that for both those reasons government must act in the medical care situation to ensure that people do have access to health care and to protect the consumers who are not informed against the sort of malpractice we have been talking about. I was wondering whether the speakers could address themselves constructively to what sort of relationship they would like to see between government and medical practitioners.

Dr Mackey

I would prefer myself to see no relationship between government and medical practice. I do not think it is a proper role of government to be in medical practice, but, if you do want government there then there should be a two tiered system of medical practice, i.e. private practice with your fee for service doctors working in their private rooms with private hospitals, and salaried government doctors working in government hospitals. The two never meet—they will go along in parallel lines. That, I think, would probably satisfy the wants of people who think that private practice does not deal with the poor. That is quite wrong. The poor appear to be the "achilles heel" of the medical profession. What are you going to do about the poor? What are you going to do about the poor patient who cannot

pay the doctor? What is going to happen? That is when the profession usually goes to the wall because the poor are always going to be with us, some are going to be poorer than others, some will not be able to pay not only the doctor, but the butcher, the baker, and so on. But that does not mean that we should take the argument to a collectivist conclusion. We should not argue from poverty to collectivism to say doctors must be subjugated to government ruling on this matter. In private practice sometimes the right and proper fee is no fee at all, and that is the best way to practise.

His Honour Judge J.H. Staunton, Chief Judge of the District Court, N.S.W., and Chairman of the Medical Disciplinary Tribunal.

Perhaps I may be permitted to attempt to divert your attention back to the title of the seminar which is "Crime and the Professions" i.e. Medibank fraud and other problems. I do that with some diffidence because I know it is far less exciting than listening to polemics about the problems concerning health care, but the criminal aspect of it, of course, remains a very serious one.

The point I would like to take up arises out of Mr Findlay's paper in which he states that in prosecuting fraud the Commonwealth Department does not seek to attempt to prove or lay more than a selected 50 charges against one practitioner (see page 31), even though the pattern may demonstrate a multiplicity of charges. I do not wish to say anything about the problems of proving overservicing difficulties, or about morality or about the criminal intent that is involved in that action. I am more concerned with the straight out fraud because after all most people can understand that fraud involves straight out dishonesty. Most people expect that straight out dishonesty should be pursued and that it should be punished. It does not matter what part of white collar crime it is, whether it be solicitors or any other profession. It does not matter whether we are talking about a person who steals from a house or steals in any other way. Dishonesty is a terrible thing in this community as anybody who has had their house ransacked would know. So I am concerned, although not altogether surprised, to find that this should be the Commonwealth attitude. I do not think in the result that it is going to serve the public interest if the Commonwealth attitude is restricted to this somewhat narrow approach. I say that for two reasons. Firstly that the dishonest should be pursued and punished, and secondly, it would be in the community's interests that, in the words of one of the speakers, "the rogues in the profession be removed". This can only be done in the case of fraud by conviction and punishment.

To illustrate what I mean I take up a point made by Mr Findlay as to the difficulty of proving this fraud and the mechanical problems associated with presenting it through the courts. It seems to me that such problems should be overcome because we are dealing with a huge amount of public money in the system. It is well known, of course, that it is difficult to prove these matters. If I could give you an illustration that came to my attention recently:— a doctor was proceeded against in respect of, say, 28 charges of fraud and these charges were vigorously defended. Senior Counsel was brought down to cross examine the people who said that they had not had the treatment that he had billed them for in bulk billing, and, as you can imagine, with a lapse of 12 months or more it was very difficult for some of these persons to remember the length of time that the treatment took. Indeed this became very obvious during the proceedings,

and after three days of hearing in which the patients were cross examined from their cards as to what diseases they were suffering from, social or otherwise and why they were seeing the doctor, a deal was made in which he agreed to plead guilty to 16 charges of fraud in charging for after hours home visits which had never occurred and which, in several of these cases, the patients stuck by their guns and said they had not had them. So having pleaded guilty to that he was dealt with summarily. As you know under s. 129 he was liable to a $10,000 fine and five years gaol, as he was dealt with summarily he was fined a relatively small amount on each of the 16 charges. He had been convicted of about 50% of the charges that were brought against him, and convicted, as much as anything, because everybody was finding the whole matter a bit tiresome. I doubt whether the public's interest is served if the Department could have prosecuted him for 100 charges. I really think that, without changing the method of proof or suggesting proof by computer there is a very good case to be made for saying that the Commonwealth should provide the courts, facilities and the support systems necessary to police this very expensive system.

The second aspect of the matter is when that person comes before a medical tribunal he is there as a person who has committed 16 offences only and it would be improper for the Tribunal to deal with him on any other basis. If, of course, it could have been shown that he had been convicted of 50 or 100 such offences it may well be that he would be differently treated in respect of what happened to his practice, and it is in *that* matter I suggest the community has a very real interest. Bearing those two interests in mind—the proper punishment of those who have perpetrated frauds against the community and "rooting out the rogues from the profession" I would suggest it is time for those who have the power and authority to re-examine the manner in which these prosecutions should be attempted.

R.J. Findlay

I am sure there are people from the Department at this Seminar who draw great comfort from what has just been said. The limitation of the number of instances prosecuted to about 50 is not a firm policy, but 50 has been shown to be the maximum number that can be reasonably handled with our resources, bearing in mind also that as time passes memories of possible witnesses fade. Generally the investigation is undertaken not by the Department but by the Federal Police and, of course, they also have problems with resources, I am sure that there would be no disagreement between the Commonwealth and yourself on this matter. If we had the resources the Department would wish to act in accordance with your precepts, but in practical terms there are immense problems in pursuing possibly 500 cases.

Dr K.M. Doust, Chairman, Capital Territory Health Commission

A criminal intent can be quite obvious at times, at other times it may be much more difficult to recognise. The persons themselves may fail, even with reasonable argument, to accept that they are involved in an activity where there could be said to be criminal intent.

As far as Medibank is concerned, of course, it was a change in our whole system—universal health insurance system came in where a third party took over

universal payment for health care. This particular event changed the mentality of the entire medical profession, not the members of the public. I am quite sure that in the days before Medibank that some doctors' receptionists knocked off a few receipts and filled in a few claim forms and collected a bit of money. I am quite sure that patients obtained them also, and I am quite sure that, at times doctors slightly modified the itemisation which was then current. I am sure nobody really changed, but when Medibank came in a system of investigation was developed for the first time. Before that time no doctor had been convicted of any offences with regard to health insurance matters, subsequently there have been. A large number of doctors' receptionists were investigated and were convicted, and it is not surprising, of course, that the doctors' receptionists were dealt with much more summarily and much more quickly than the doctors subsequently were, as were members of the public who were found with fraud. People were physically held in claim offices until the police came, so the whole aspect of an "investigation system" was developed.

As this investigation system developed more and more publicity occurred, publicity such as Dr Arnold's "How to rip off Medibank". All of this tends to contribute to the general knowledge of what goes on, and certainly there have been some deliberate professional attempts to rip off the health funds. I am quite sure that a number of doctors have seen some of the activities that have occurred, and have deliberately avoided practices in which they may previously have been involved so there has been a prophylactic benefit, but, on the other hand where one evil person somewhere has done quite well you might say "I can get away with that".

To a certain extent the change in the publicity in the activities of the profession has modified the relationship of patients to doctors, and whether it is good or bad, I am sure that the changes all indicate that the community wants some form of protection for the costs that they incur in medical services. They want a generally community rated service where the sick person is helped by the person who is reasonably healthy, where the poor person is helped by the person who can afford to pay the taxes. The G.P.S., of course, have maintained a singular point of view, that you divorce yourself from government, you get the patient to pay, but they have been hitting their head against a brick wall ever since they started. The patient is still in a third party payment system, and it is naive to accept the view that because the patient only gets benefits on the basis of a receipt, manipulation cannot occur. For instance, I am well aware of one patient who got receipts from the doctor for services that he had not obtained in order that he could get a refund from the fund in order to pay his medical benefits so he could get the money to pay the doctor! The issuing of a receipt and the fact that you insist on only itemising receipts does not protect against fraud either by the doctor or the patient.

The community wants some form of system whereby they are given some support in their health costs, i.e. a third party payment system, and consequently the people who are involved in insuring the third party payment system give to the members of the community the best value for their dollar. There is a reasonable right that these people should have some degree of protection, and this is in part by the judicial processes and the investigative process.

Dr P.A. Tomlinson, President, N.S.W. Medical Board

Later on this year I will be attending my 45th graduation dinner, so I can look back on medical practice over quite a long period.

I would like to make a few comments on the written papers. I found that of the four written papers, two were straight down the centre, and two were very doctrinaire—one way out to the left and the other an almost similar distance to the right.

In respect to Professor Opit's paper I would like to state that a large proportion of what I read is not in accordance with the facts as I have seen them over the last 45 years. I take issue on several aspects with him. The statement (p. 44).

> The medical profession, through its various professional bodies, has refused to even acknowledge the possibility that some doctors act in a criminal way within our health care system.

That is about as far from being a fact as anything that has been written or said at this seminar. It is entirely untrue. There would be at least 90 to 95% of the medical profession who would be glad to see the criminal element in the profession removed from the profession.

In respect of Dr Van Dugteren's paper he mentions that fraud is mainly covered by s. 129 of the Act. This, of course, is factual in respect of the Commonwealth legislation but it might be of benefit to the meeting to know that under the *Medical Practitioners Act (N.S.W.)* which has recently been passed an infringement of s. 129 of the *Health Commission Act* becomes under the *Medical Practitioners Act (N.S.W.)* a defined portion of misconduct in a professional respect. This means that the time in which a problem can be dealt with has been expedited.

The problems that I see in respect of crime and doctors are, first of all, problems in delay in matters being heard. This is a matter in which I have endeavoured to be active. The Supreme Court has fortunately recently laid down a mechanism whereby any appeal from the disciplinary tribunal to the Supreme Court is now heard in a very much shorter time than previously. One tribunal matter that went to the Supreme Court on appeal before this new mechanism was laid down, and that doctor was permitted to practise for two years before his case was heard, and during that time, of course, he amassed a considerable amount of his legal fees.

There is a problem, also, in the time that is taken for the matters that are heard in the Courts of Petty Sessions. These may wait for some time, and recently an approach has been made to the Under Secretary for Justice in order that such matters can be dealt with a little more expeditiously by the courts. There is a possibility that they may be heard in one or two courts in the State rather than a variety of courts.

Another cause of delay is the time taken to produce the availability of the transcripts of evidence. This is a logistic problem for courts, and this delay impedes

the administration of matters that come before the New South Wales Medical Board and the Disciplinary Tribunal. It has not been made easier by taping, as they still have to appear in written form, because matters before a Tribunal after going to the Investigating Committee are in the way of a re-hearing, as are matters on appeal from a Tribunal to the Supreme Court.

Another matter under the new Act which is awaiting promulgation is that there shall be an appeal from the Investigating Committee by the complainant, as well as by the defendant, to a Disciplinary Tribunal, and there shall also be an appeal by the complainant on matters of law or of the severity of the penalty from a Tribunal to the Supreme Court.

In Dr Van Dugteren's paper I would draw attention to the problems of medical practice that are being revealed on a day-to-day basis by the practice of medicine by companies, businesses, foundations and persons who are not legally qualified as medical practitioners because it is not widely known that all such people may practise medicine in this State although they are not able to treat all diseases. I fully endorse the necessity for the teaching of medical jurisprudence and medical ethics at undergraduate level.

In Dr Mackey's paper I agree with the suggestion regarding bulk billing. Where doctors abuse it I believe they should have that facility withdrawn from them in respect of their practice. I will not comment any further on Professor Opit's paper, but on matters where I think he is in error and has misinformed the seminar I would be very pleased to discuss it with him in private on any occasion.

Dr D.P. Mackey

I was somewhat amazed at Dr Dousts' comments (pp. 65-66) supporting third party payment when, as Medical Director of Medibank, he saw the abuses that went on through bulk billing processes. I think that if we are going to root out the rogues from the profession we need to root out the cause of the roguery. Who pays the doctor is very, very important. When a third party pays for the service, it can be over utilized by the doctor and the patient alike, and the majority of offences, as we have heard, occur in the bulk billing process. The patient, as Dr Menon put it, is always the best policeman of services. In my opinion, any doctor who bulk bills the government should be regarded as a potential criminal. It would be a good idea if the government looked at this. They are trying to cut costs. Let the people who want to bulk bill, bulk bill, but follow Canada's lead, restrict it to say $10,000 per practitioner per annum and leave it at that. That does not stop the doctor's from seeing the patients, they can do so and not charge them.

P. Dougdale, Medical student.

I would like to ask what the effects of the recently introduced changes to health financing arrangements will be on the incidence of crime amongst the professions?

Dr G. Douglas, Medical Practitioner.

I spend a considerable amount of my time sitting on one of these Committees of Inquiry. I do not do it for fun—it is a lousy job. The pay is crook, the hours are worse and the coffee is usually cold by the time we drink it. I do it because, like a lot of my colleagues, I am perturbed at seeing members of my own profession doing things that I think are not right for a person in their position to be doing. We spend a lot of time in Committees of Inquiry in investigating allegations of overservicing against practitioners. The bureaucrats in the Department of Health, for all their expertise and for all the computers, sometimes miss out badly on deciding whether a doctor is, in fact, doing the right thing in his practice and in his charging of the Commonwealth. Nevertheless, it is perhaps good to see that a group of professional colleagues looking at the way a man practises, listening to him give evidence about his practice can very rapidly form an opinion as to whether the services that man has been giving have been done properly or improperly. A Committee of Inquiry can form an opinion as a committee of peers in a relatively short period of time. The problem with the Committees of Inquiry is the very cumbersome legal process under which they have to work. The only reason for having medical practitioners doing this work is because they are the only people who can recognise what is normal for people of their profession to be doing, but you negate that when you make a cumbersome legal process in order to pick these people out.

There is a further problem that has come out of Committees of Inquiry. This impotence which our committees have had forced upon them is not unknown to those members of our profession who are willing to overservice their patients and to get money from the Commonwealth government on their behalf. I believe that the way in which our committee system is running at present may well be doing a detriment both to my profession and to the people who are paying these bills as the Commonwealth Department of Health. I came to this seminar in order to learn what people who knew more about this interface between two professions might be able to suggest to make my profession work better and to be seen to work better. I am afraid the main thing I have learnt tonight is to lock up my account forms and my receipt forms, as well as the petty cash and the prescription forms.

Dr Van Dugteren

Briefly, His Honour was quite correct—we did move well away from the subject of crime. We looked into many areas which probably had nothing to do with the original intent.

In the eyes of the community health insurance is an entirely different animal to any other form of insurance. If you use your car insurance, if you use your householder's policy, or other similar policy you are a bit cranky. But if you do not get your money out of health insurance you are being robbed, and I think the average member of the community looks a lot more critically at what they get out of their health insurance than what they get out of any other type of insurance. The Association knows that in the *Medical Practitioners Act* there is a serious gap. The New South Wales Medical Board can look at professional behaviour and a number of other matters but they cannot look at the manner in which a doctor has supplied a service. We have been approaching the current

State government now for about two years to ensure that there could be a system of complaint without having to go to common law. Unfortunately at the moment that is unacceptable to this government.

Dr D.P. Mackey

The last speaker asked what changes would occur in the incidence of white collar crime with the changes to the National Health Scheme. I think the incidence of white collar crime will decrease significantly, because the changes to the scheme are going to prevent any doctor classifying any person he likes as socially disadvantaged. Therefore it is going to cut down the amount of bulk billing in this particular area. As we have mentioned before it is my opinion, and the opinion of a number of other doctors, that the great incidence of crime occurs in this bulk billing area and I think it should be policed.

Professor Opit mentioned "the community's preservation of freedom may require the doctor to give up some of his". I do not understand that, because in a truly free society people cooperate in a voluntary exchange with other people in the society. The basis of freedom is a lack of coercion—nobody should want to take away anybody else's freedom. I do not think Professor Opit should want to do that to the medical profession or to patients or to anybody else.

R.J. Findlay

I refer to Dr Stein's comments (pp. 52-53) in case there has been some misunderstanding. The suggestion that in a changing system it may be possible for the courts in considering reparation to take note of generalized evidence about a practice was merely the floating of an idea. I hope you appreciate that. We would have welcomed that idea, or some alternative solution to our problem of securing commensurate penalties, being picked up in discussion. Likewise we were aware, of course, of the adverse consequences for patients that would flow from the disqualification of their doctor from issuing accounts that would attract medical benefits and the cautionary note in the Department's paper was included to indicate that we were aware of it.

One matter that I understood was to be raised is the relationship between the Commonwealth and the funds. It can be expected that in the future there will be greater cooperation between the Commonwealth and the funds in the pursuit of fraud and overservicing, and what can be done in this regard is presently being discussed between the Department of Health and the Commonwealth Attorney-General's Department. The impetus for this increased cooperation of course is that the medical benefits provided since 1 September will attract a mixture of Commonwealth and fund monies.

The recent developments of the integration of statistical information from the claims handled by the funds with the bulk billed claims handled by the Department will also simplify the identification of practitioners who are engaged in fraud or the provision of excess services. I understand that before too long there will be some discussion on the most effective form of joint action between the Department and the funds, probably in the context of the Health Insurance Advisory Council.

Professor Opit

I would like to answer Mr Purvis' question because I consider it is very important. Has there been an increase in medical fraud or medical crime, and if so, why? Of course, nobody knows for certain. I can certainly state it has been happening in my experience and in my environment since 1962, so it is certainly not new. I would suspect that it has increased partly because the number of doctors has increased, partly because the total number of services have increased, and partly because I think there has been a loss of moral consensus in our society. I think an analogy would be tax-avoidance. We have abandoned rather old fashioned notions of consensus. In Australia and many other western societies consensus is based on the consensus of acquisition. It is now smart to get rich, and so I suspect that this problem has increased and will go on increasing in the short term. We cannot deny the existence of what is going on. I am very disappointed in this seminar because I had hoped to hear some comment from lawyers about, for example, whether or not it is possible to look at the law itself to see what changes could be made vis-a-vis defining agency relationships between the practitioner and the funding agent. Is there some way in which that relationship could be defined which would make protection and prosecution of defined fraud, at least, easier? I am very sorry, in fact, that this has not happened.

Chairman

We have to try and do the best that we can in our society to suppress criminal activities in the white collar area—in the provision of medical services equally with the other specie of white collar crime. But it is the moral fibre of the community which ultimately will dictate the extent to which we are free of crime, whether it is white collar crime or any other sort of crime. I agree with Dr Douglas that there is great benefit to be had from the mutual strengthening of recognition of professional obligation. We might with advantage conclude this seminar on a note of idealism—a note of emphasising the mantle of integrity that the community puts upon the medical profession and the obligation of the medical profession itself to see that that mantle is worn proudly and without tarnish. To a large extent I believe that the internal peer pressure amongst the members of a profession, as with any other group, is perhaps the most potent weapon for preserving integrity and proper standards. If adjustments in billing, to use a euphemism, are tolerated and laughed about at the golf club then they will become widespread. If those who do it are looked upon askance by their fellow practitioners, they soon become known and identifiable by the authorities and their opportunities become diminished. If we within our society demand integrity from those of whom we expect it, then I believe we will receive it.

D. West, Government Printer, New South Wales—1982

The following Proceedings have been published and are available for sale at the Government Printing Office, 390-422 Harris Street, Ultimo and the Government Information Centre, Cnr. Hunter and Elizabeth Streets, Sydney. All enquiries to The Government Printer, P.O. Box 75, Pyrmont, N.S.W. 2009, Australia.

1967	1.	Sentencing. Fitness to Plead.
1968(1)	2.	The Adolescent and the Law. Treat or Punish?
1968(2)	3.	Computers and the Lawyer.
1968(3)	4.	Drug Abuse in New South Wales.
1969(1)	5.	Judicial Seminar on Sentencing. Sentencing Project, Part I.
1969(2)	6.	Sexual Offences against Females.
1969(3)	7.	Bail.
1970(1)	8.	Abortion.
1970(2)	9.	Male Sex Offences in Public Places.
1970(3)	10.	Sentencing Project: Part II, Probation.
1971(1)	11.	Parole of Prisoners Act, 1966.
1971(2)	12.	Social Defence.
1971(3)	13.	Road Safety.
1972(1)	14.	Psychiatric Service for the Penal System.
1972(2)	15.	Armed Robbery.
1973	16.	Sentencing to Imprisonment—Primary Deterrent or Last Resort?
1973	17.	The Right To Silence.
1974	18.	Police Questioning and Confessional Statements.
1974	19.	Corporate Crime.
1974	20.	The Protection of Children.
1974	21.	An Examination of the Parole of Prisoners in N.S.W.—*out of print*.
1975	22.	Proposed Amendments to the N.S.W. Mental Health Act (1958).
1975.	23.	White Collar Crime—Can the Courts Handle It?
1975	24.	Motoring Offences.
1975	25.	Compensation and Restitution for Victims of Crime.
1976	26.	Parole in Practice in N.S.W.
1976	27.	Treatment of Children Associated with Crime.
1976	28.	Corporate Crime (No. 2).
1976	29.	Complaints Against Police.
1977	30.	Probation.
1977	31.	Bail (No. 2).
1977	32.	The Dangerous Offencer—prediction and Assessment.
1977	33.	A Diversion Programme for Drinking Drivers.
1978	34.	Rights of the Mentally Ill.
1978	35.	Sentencing (1978).
1978	36.	Unemployment and Crime.
1979	37.	White Collar Crime (No. 2).
1979	38.	State, Direction & Future of Corrections. Part II—Alternatives to Imprisonment.
1979	39.	State, Direction & Future of Corrections: Part I—Prisons.
1970	40.	Crime and the Family—Some Aspects of the Report of the Royal Commission on Human Relationships.
1979	41.	The Problem of Crime in a Federal System.
1980	42.	Problems of Delay in Criminal Proceedings.
1980	43.	Police Discretion in the Criminal Process.
1980	44.	Aboriginals and the Criminal Law.
1980	45.	Victims of Crime.
1980	46.	Index—Volumes 1-36.
1981	47.	The Old as Offenders and Victims of Crime.
1981	48.	Criminal Evidence Law Reform.
1981	49.	Child Welfare in the 80's.