Medifraud and Inappropriate Practice

Health Insurance Commission

Performance Audit

Tabled 13 May 1997

Audit Report No. 31 1996-97

Abbreviations

ABS	Australian Bureau of Statistics
AFP	Australian Federal Police
AMA	Australian Medical Association
ANAO	Australian National Audit Office
APA	Approved Pathology Authority
CEO	Chief Executive Officer
CLEB	Commonwealth Law Enforcement Board
CMC	Case Management Committee
DHFS	Department of Health and Family Services
DPP	Director of Public Prosecutions
DPSR	Director, Professional Services Review
DRS	Doctors' Reform Society
DSS	Department of Social Security

DVA	Department of Veterans' Affairs
EDI	Electronic Data Interchange
EIS	Executive Information System
FASAC	Fraud and Audit Services Committee
GP	General Practitioner
GPD	Government Programs Division (of HIC)
HIC	Health Insurance Commission
HREOC	Human Rights and Equal Opportunity Commission
JCPA	Joint Committee of Public Accounts (Australian Parliament)
KPO	Key Performance Objective
MSCI	Medical Services Committee of Inquiry
PBA	Purpose Based Audit
PBS	Pharmaceutical Benefits Scheme
PGA	Pharmacy Guild of Australia
PRB	Professional Review Branch
PRD	Professional Review Division
PSR	Professional Services Review

RCPA Royal College of Pathologists of Australasia

SBA Source Based Audit

SCMC State Case Management Committee

Summary

The Health Insurance Commission

1. The Health Insurance Commission (HIC) is responsible for the administration of the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme. The Commission's responsibilities include addressing fraud and inappropriate practice against both Schemes. The Professional Review Division of the Commission is responsible for detecting, investigating and deterring inappropriate practice and external fraud.

The reasons for the audit

2. Benefits paid through the Schemes in 1995-96 were:

Medicare: $6038 million
Pharmaceutical Benefits: $2362 million

3. The ANAO decided to conduct the audit because:

- the very significant sums involved carry with them the possibility of some fraud and overservicing; and
- it was timely to follow up earlier ANAO reports on the HIC's operations, given new legislation and changes in the organisation.

Audit purpose

4. The ANAO's purpose was to report to Parliament on:

- HIC's management of approaches to minimise medifraud and inappropriate practice;
- HIC's reporting of its performance on these matters to stakeholders;
- the methodology used by the HIC to estimate the extent of fraud and inappropriate practice, including comment on the reliability of the estimates; and
- the HIC's implementation of the major recommendations from *Medifraud and Excessive Servicing* - Audit Report No.17 1992-93.

5. The audit was limited to the HIC's activities. Prosecutions for fraud are undertaken

by the Director of Public Prosecutions (DPP), while disciplinary action against practitioners for inappropriate practice is undertaken through the Professional Services Review Scheme. This audit does not cover the activities of the DPP or of the Professional Services Review Scheme.

Audit conclusion

6. The ANAO concludes that:

- the HIC has adopted a sound risk management approach to managing leakage through fraud and inappropriate practice from the Medicare and Pharmaceutical Benefits Schemes. Its approach, which emphasises the importance of preventative action, is being amended to bring it into accord with the Commonwealth Law Enforcement Board (CLEB) guidelines for the management of fraud against the Commonwealth;
- the measures the Commission uses to report to external stakeholders on management of fraud and inappropriate practice could be improved. These improvements include additional performance indicators, release of more useful information on results of Purpose Based Audits, and publication of estimates of fraud and inappropriate practice;
- while the Commission has followed advice from the Australian Bureau of Statistics in developing and using data from Source Based Audits, it is unable to produce a reliable estimate - at an acceptable cost - of leakage through fraud. The Commission intends to re-examine the possibility of producing an estimate once three years of data from Source Based Audits are available. The Commission has not produced national estimates of inappropriate practice from Medicare and the Pharmaceutical Benefits Schemes; and
- the Commission has implemented all major recommendations from Audit Report No.17 1992-93.

Other key findings

7. The concerns expressed in Report No.17 1992-93 of a lack of disciplinary action against practitioners suspected of overservicing no longer apply.

8. Privacy provisions in the relevant health legislation may need clarification to staff.

9. The ANAO has prepared indicative estimates that suggest that leakage through fraud, combined with the extent of inappropriate practice, is around 1.3 to 2.3 per cent of payments from the Medicare and Pharmaceutical Benefits Schemes. In financial terms, this translates to about $110 million to $190 million. The figures are preliminary pending the preparation of firmer estimates by the HIC.

10. It appears that the Commission's objective of reducing inappropriate practice by 10 per cent by the year 2000 may not be met, as the HIC inappropriate practice key

performance objective has been growing at approximately 8.6 per cent per year in recent years. The Commission, in responding to a draft of this report, commented that it was confident that it could deal with the challenge of inappropriate practice and move to meeting its target by June 2000 (see para 3.55).

11. In 1995-96 the Commission reported that $1.1 million in Medicare and Pharmaceutical Benefits paid incorrectly was recovered.

12. Expenditure by the Commission on Professional Review Division's activities for 1995-96 was $13 million. The magnitude of the problems the Commission confronts with respect to medifraud and inappropriate practice will continue to require strong, well directed and concerted efforts for some time to come.

13. The Commission responded to these findings by indicating that the audit had been a particularly useful exercise and it accepted all of the ANAO recommendations.

Recommendations

Set out below are the ANAO's recommendations with Report paragraph references and the HIC's abbreviated responses. More detailed responses and any ANAO comments are shown in the body of the report. The ANAO considers that the HIC should give priority to Recommendations Nos. 4, 7 ,8, 14 and 15.

Recommendations on strengthening various aspects of effectiveness, efficiency and accountability are grouped under the heading of fraud control, inappropriate practice and other. Recommendations are numbered according to how they appear in the text.

All of the recommendations below have been accepted by the Health Insurance Commission.

Fraud control

Recommendation No. 1 Para. 2.25	The ANAO *recommends* that, to ensure that responsibility for fraud control is clear, the manager responsible for a program be responsible for the management of the relevant fraud control plan and that this be specified in the fraud control plan.
Recommendation No. 2 Para. 2.51	The ANAO *recommends* that Professional Review Division update the Professional Review Guidelines and complete the Professional Review Policy Manual.
Recommendation No. 3 Para. 2.66	The ANAO *recommends* that the prepayment controls for claims lodged by EDI with the HIC be upgraded by making cost-effective use of currently available technology.
Recommendation	The ANAO *recommends* that the Commission prepare and publish

No. 4
Para. 2.79

estimates of the value or order of magnitude of leakage through fraud from the Medicare and Pharmaceutical Benefits Schemes to:

draw the attention of all stakeholders to the problem of medifraud;

promote greater understanding; and

permit antifraud strategies to be better targeted.

Recommendation
No. 14
Para. 6.32

The ANAO *recommends* that Professional Review Division publish reports on the results of Purpose-Based Audits to better inform stakeholders of Commission activities to combat fraud as part of its accountability for better performance.

Recommendation
No. 16
Para. 6.46

The ANAO *recommends* that, to make its antifraud strategy more effective, the Commission collect accurate data on:

the number of fraud investigations undertaken;

the number of cases referred to the DPP for prosecution;

the number of successful prosecutions; and

reasons for non-successful prosecutions.

Inappropriate practice

Recommendation
No. 5
Para. 3.31

The ANAO *recommends* that the HIC develop a well documented and widely available plan, including key performance objectives and indicators, for minimising inappropriate practice.

Recommendation
No. 6
Para. 3.37

The ANAO *recommends* that the HIC develop an effective mechanism to permit resources to be reallocated to meet workload demands efficiently. With respect to Professional Review Division, this would allow the timely reallocation of resources between States as the risk of inappropriate practice or fraud varies.

Recommendation
No. 7
Para. 3.68

The ANAO *recommends* that Professional Review Division complete its long-running work on better measures of savings as a result of actions to minimise inappropriate practice. In addition, to assist the HIC in its education campaign, the ANAO *recommends* that *HIC* publish estimates of the savings.

Recommendation
No. 8
Para. 3.78

The ANAO *recommends* that the HIC prepare and publish estimates of the value or order of magnitude of inappropriate practice from the Medicare and Pharmaceutical Benefits Schemes to:

draw the attention of all stakeholders to the problem of inappropriate practice;

promote greater understanding; and

permit strategies to combat inappropriate practice to be better targeted.

Recommendation No. 12 Para. 6.6

The ANAO *recommends* that the Professional Review Division's key performance objective for inappropriate practice be extended to include specialities recently added to the Neural Net.

Recommendation No. 13 Para. 6.22

The ANAO *recommends* that Professional Review Division's State Branches prepare annual work plans and targets to ensure staff focus their efforts on the most critical areas of performance and associated accountability.

Recommendation No. 15 Para. 6.40

The ANAO *recommends* that the Commission report progress against the inappropriate practice key performance objective in the Commission's Annual Report as part of its performance assessment.

Other

Recommendation No. 9 Para. 4.9

The ANAO *recommends* that the Commission review the procedures used by its relevant Divisions to manage recoveries of benefits improperly obtained by beneficiaries, in order to identify best management practices for implementation on a uniform basis in all States.

Recommendation No. 10 Para. 4.13

The ANAO *recommends* that Professional Review Division put further emphasis on cost-effective recovery action, not only to improve performance but also as a means of deterrence against fraud.

Recommendation No. 11 Para. 5.39

The ANAO *recommends* that the HIC clarify and communicate the responsibilities of staff under the relevant legislation for the release and use of information on individuals to ensure equitable treatment and observe privacy requirements.

1. Introduction

This chapter provides the background to the audit, and details the audit objectives and criteria.

Background

1.1 The Medicare and Pharmaceutical Benefits Schemes are funded under Program 2 of the Health and Family Services Portfolio. The objective of this program is 'to achieve quality health outcomes for people by enabling access to timely and appropriate health care services at a reasonable cost'. The Health Insurance Commission (HIC) administers the Schemes.

1.2 Benefits paid through the Schemes in 1995-96 were:

Medicare: $6038 million

Pharmaceutical Benefits: $2362 million

1.3 The mission statement for the Health Insurance Commission reads:

We exist to support the delivery of quality health and child care to Australian residents by providing the highest quality benefit payment services and private health insurance services and ensuring that all benefit payments are correctly made for services properly rendered.

1.4 The Commission is responsible - in the programs it administers - for preventing, detecting and investigating fraud and inappropriate practice by service providers and the public. Within the Commission, the task of combating fraud and inappropriate practice against the Medicare and Pharmaceutical Benefits Schemes has been allotted to Professional Review Division (PRD) . The work of PRD is overseen by the Board of Commissioners through the Fraud and Audit Services Committee (FASAC).

1.5 Over the years, there have been a number of reports issued by the Parliamentary Joint Committee of Public Accounts (JCPA) dealing with medical fraud and excessive servicing. The JCPA reports have discussed a number of factors which have affected the Commonwealth health budget. These have included:

- legislative weaknesses;
- prosecution difficulties - e.g. problems associated with collecting admissible evidence;
- problems with the Medical Benefits Schedule - e.g. lack of clarity;
- the cost of technological advances, especially in regard to pathology;
- oversupply of doctors; and
- entrepreneurial fraud.

1.6 The ANAO has also produced a number of reports addressing medifraud and inappropriate practice. Recent reports include:

- *Medifraud and Excessive Servicing* - Audit Report No.17 1992-93; and
- *Impact of Sunset Clause on Investigatory Powers* - Audit Report No.24 1995-96.

1.7 The objectives and key findings for these reports are at Appendix 2.

1.8 One of the recommendations of Audit Report No.17 was that the HIC's investigatory powers be strengthened. Legislation to this effect was passed in 1994. The legislation had a sunset clause of 30 June 1996. Audit Report No.24 was produced to assist Parliament in deciding whether to repeal the sunset clause or allow it to apply.

1.9 Since Audit Report No.17 was published, there have been a number of changes to the legislation governing the HIC. There have also been significant organisational changes within the Commission. This led the ANAO to decide that a further audit revisiting Report No.17 would be of value.

Audit objectives

1.10 The ANAO's objective was to report to Parliament on:

- HIC's management of approaches to minimising medifraud and inappropriate practice;
- HIC's reporting of its performance on these matters to stakeholders;
- the methodology used by the HIC to estimate the extent of fraud and inappropriate practice, including comment on the reliability of the estimates; and
- the HIC's implementation of the major recommendations from Audit Report No.17 1992-93.

Audit scope

1.11 Medifraud is defined as fraud against Medicare or the PBS (see para. 2.6). A medical practitioner has engaged in inappropriate practice if a committee of the practitioner's peers concludes that the conduct of the practitioner would be unacceptable to the general body of the profession/speciality in which the practitioner is practising (see para. 3.1).

1.12 Management of steps to reduce fraud and inappropriate practice is essentially management of risk. The audit examined the HIC's approach to risk management with respect to fraud and inappropriate practice against the Medicare and Pharmaceutical Benefits Schemes. It compared the HIC's approach with guidelines laid down in the report 'Fraud Control Policy of the Commonwealth' issued by the Commonwealth Law Enforcement Board (CLEB).

1.13 The audit was limited to the HIC. Prosecutions for fraud are undertaken by the Director of Public Prosecutions (DPP) (para. 2.18), while disciplinary action against practitioners for inappropriate practice is undertaken by Professional Services Review Committees (para. 3.4). This audit does not cover the activities of the DPP or Professional Services Review Committees.

1.14 The cost of this audit totalled $210 000. The audit was conducted in accordance with ANAO Auditing Standards.

Audit criteria

1.15 Audit criteria encapsulate auditors' expectations of sound management and administration. The audit then tests entity practice to determine whether these expectations or criteria are met.

1.16 This audit used two levels of criteria. The first level was designed to allow the ANAO to comment on the management of the Commission's exposure to fraud and inappropriate practice. The second-level criteria were designed to allow the ANAO to comment on Professional Review Division's management of approaches to reduce fraud and inappropriate practice. The audit criteria are at Appendix 3.

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2. Fraud

This chapter describes the Commission's management of approaches to minimising fraud against the Medicare and Pharmaceutical Benefits Schemes and makes recommendations for improvement. It also describes the methodology used by the HIC to estimate the extent of fraud.

Background

Medicare

2.1 The Medicare Scheme provides for Australian residents to have ready access to medical services provided by medical doctors and other health care providers. At no or minimal cost to the patient Medicare also provides hospital treatment in public hospitals for all Australian residents, irrespective of age, income or health status. Medicare works by subsidising patients. In concept, patients pay providers for the services received and are reimbursed through the Scheme.

2.2 Under Medicare there are no restrictions on the amounts a provider may charge but the amount payable for the treatment is defined in the Medicare Benefits Schedule. However, not all services provided by doctors and other health care providers are covered by Medicare.

2.3 All claims for payment under the Medicare Scheme are processed by the Health Insurance Commission. The volume of claims processed is very high, with 196 million Medicare services processed in the year to June 1996.

2.4 An important component of the Medicare Scheme is direct (or bulk) billing. Under direct billing the patient assigns the right to receive the subsidy to the service provider. In return for prompt payment, the provider limits the charge for the treatment to the amount specified in the Medicare Benefits Schedule. In the year to June 1996, 139 million services (71 per cent of all Medicare services) were direct billed.

2.5 A more detailed description of the Medicare Scheme can be found in the Health Insurance Commission's 1995-96 Annual Report, (page 31).

Medifraud

2.6 There are two elements which must be present for fraud to have occurred. Firstly, a person must have obtained a payment to which he or she is not entitled. Secondly, the payment must have been obtained by the person supplying misleading or false information. Medifraud here is defined as fraud against Medicare or the PBS.

GP Fraud

The offender in this matter came under notice as a result of an anonymous complaint alleging he was claiming for services rendered at his New South Wales surgery at the same time that he was claiming for services rendered at his surgery in Tasmania.

Patient interviews were conducted with nine statements being obtained providing prima facie evidence of 28 offences of *knowingly making false statements relating to Medicare benefits*. These statements related to patients' attendances at the New South Wales surgery for weight loss treatment where it was alleged that the treatment was provided by a nurse and not a doctor.

An application to obtain a search warrant was granted and a search warrant was executed on the doctor's New South Wales surgery.

Evidence obtained under warrant enabled the compilation of a brief of evidence and the subsequent prosecution of the offending doctor who was convicted on seven counts under Section 128(A) (*False statements relating to Medicare benefits*).

Provided by the HIC

2.7 Medicare operates on a fee-for-service basis. The more services provided, the higher a provider's gross income. If practitioners' margins increase with volumes there is an incentive to increase volumes. With direct billing the patient pays no money. Thus there is little incentive for the patient to verify the bill. Providers can add extra services to the claim on Medicare, or bill for a more expensive service than was provided. Both of these are common types of fraud.

2.8 Some secondary service providers, such as pathologists and radiologists, have attempted to form links with primary service providers to capture referrals from them. A concern with these arrangements is that unnecessary services will be ordered by the primary service providers in return for benefits from the secondary service provider. This leads to leakage from the Medicare Scheme. Certain types of linkage between primary and secondary service providers are now specifically prohibited by legislation. The Commission is responsible for enforcing this legislation.

2.9 Finally, possession of a Medicare card, which entitles an individual to the benefits of the Medicare Scheme at no cost to the individual, can be a valuable asset, particularly for temporary residents of Australia. This is also an area where fraud is known to occur and one which the HIC is addressing.

2.10 The importance of Medicare to the health of Australian nationals and residents highlights the need for these matters to continue to be addressed strongly by the HIC.

Pharmaceutical Benefits Scheme

2.11 The Pharmaceutical Benefits Scheme allows Australian residents subsidised access to a wide range of drugs. There are two basic levels of subsidy. The general subsidy limits the cost of a prescription drug to $20. The concession level, which applies to Australians in receipt of a pension or social security benefit, limits the cost to $3.20 per prescription. In addition, the 'safety net' further subsidises those who spend more than a set threshold on approved drugs in a given year.

2.12 A similar scheme, the Repatriation Pharmaceutical Benefits Scheme, applies to pharmaceuticals supplied to war veterans.

2.13 Pharmacists purchase drugs at full wholesale cost. Where the retail price of the pharmaceutical exceeds the $20/$3.20 PBS limit, the subsidy is paid to the pharmacist. To obtain the subsidy from the Commission the pharmacist has to produce the prescription and evidence that the pharmaceutical has been supplied.

FALSE PBS CLAIMS

Whilst operating a Melbourne pharmacy in partnership with other pharmacists, the alleged offender submitted PBS claims for items not dispensed. During an eight week period, entitlement holders, medical and dental practitioners were interviewed and evidence was adduced to prove 250 repeat subscriptions to have been the subject of forged signatures. Shortly after this, the alleged offender's partners contacted the Professional Review Branch to arrange a meeting where a letter allegedly written by the person in question was tendered to investigators. The letter admitted full responsibility for anomalies regarding incorrect pension numbers on scripts. The partners alleged that the person in question has admitted to them that he had been manufacturing false repeat authorisations with forged patient signatures.

The alleged offender subsequently entered into a record of interview with investigators. He made full admissions to having manufactured 95 false identities in respect of which 315 repeat authorisations had been submitted. The false PBS claims were submitted over a 22 month period and were for a value of $7854.72. A brief of evidence alleging an offence contrary to section 29D of the Crimes Act (Fraud) has been referred to the DPP.

Provided by the HIC

2.14 Claims from pharmacists are processed by the HIC. In the year to June 1996, 131 million services were processed under the Pharmaceutical Benefits and Repatriation Pharmaceutical Benefits Schemes.

2.15 The intention is that the subsidy be paid to Australian residents. Until the 1996-97 Budget, a person who handed a pharmacist a valid prescription and did not claim under the safety net was not required to provide evidence that he or she qualified for the subsidy. Pharmacists are now being encouraged to sight the patient's Medicare

card. A fuller description of the PBS is included on page 37 of the HIC's 1995-96 Annual Report.

OVERSEAS DIVERSION OF PBS ITEMS

In March 1996 as a result of information received from the Australian Customs Service, investigators attended at the Melbourne International Mail Exchange where they inspected a parcel bound for Vietnam that contained numerous pharmaceutical items to the value of $466.75. All of the items had been removed from their original packaging and some had all identifying marks removed.

Examination of the contents of the parcel combined with information held by the HIC, indicated that similar pharmaceutical items had been prescribed under the provisions of the PBS to the offender by four different doctors in the Sydney suburb of Cabramatta. The scripts were subsequently dispensed by an approved pharmacist in Footscray, Victoria.

A search warrant was executed upon the Customs Service to obtain the parcel for further investigation action, which was commenced. However, the suspect in the matter left the country for Vietnam. The HIC has advised that the suspect has recently returned from Vietnam and will be interviewed in due course.

Provided by the HIC

2.16 There are a number of ways in which persons may acquire pharmaceutical products through the PBS fraudulently. These have been referred to in Budget papers and in Ministerial press releases. Some examples include:

- doctor shopping, which is the term used to describe people who see a very large number of doctors (over 30 a year) for the purpose of obtaining drugs of dependence, such as narcotics and benzodiazepines. In 1994 about 1000 people were identified under the PBS Safety Net as having prescriptions from more than 30 practitioners in one year. Those seeing more than 50 doctors average 235 consultations per year. The objective of these persons is to obtain large quantities of drugs;
- overseas diversion, where a person visits a doctor and obtains a prescription, and then sends the subsidised drug overseas; and
- resale, where a person obtains a prescription, and then sells the prescribed drug and pockets the difference between the prescription price and price obtained.

Investigation and prosecution

2.17 A common problem with all subsidy schemes is the temptation to the less ethical service provider to cheat the system. To counter this, there is a need for a body to investigate and prevent possible abuse. The Professional Review Division of the HIC performs this role for both Medicare and the Pharmaceutical Benefits Schemes. The Division is charged with preventing, detecting and investigating fraud and other offences against the Schemes.

2.18 The Commission does not prosecute fraud cases. When the Commission decides that sufficient evidence has been collected to establish a prima facie case of fraud, the

evidence is forwarded to the DPP. It is the DPP who decides whether to prosecute and who conducts the prosecution. In practice PRD involves the DPP in cases as soon as it becomes apparent that fraud has occurred and seeks advice from the DPP on the evidence required.

2.19 It should be noted that the DPP may decide that there is insufficient evidence to prosecute or that, while there is sufficient evidence to prosecute, a prosecution may not be appropriate in the circumstances. Of course the final decision as to whether a person is guilty of fraud is made by the courts.

Responsibility for fraud control plans

2.20 Within the Commission, Government Programs Division (GPD) is responsible for the systems used to process the programs administered by the Commission, including the development and maintenance of internal or system controls against fraud. PRD has the responsibility for external fraud control measures, the investigation of both internal and external fraud, and fraud awareness programs. Internal Audit plays a coordinating role in the development of fraud risk assessments and fraud control plans and in the investigation of internal fraud. Overall executive responsibility for the management of fraud control lies with the Chief Executive Officer of the Commission.

2.21 The Board of Commissioners oversees PRD's activities through the Fraud and Audit Services Committee (FASAC). This Committee monitors the practices adopted by PRD in combating external threats to the programs administered by the Commission. The Committee meets bimonthly and is generally attended by all Commissioners.

2.22 Fraud risk assessments and fraud control plans in the Commission are program-based; that is, there is a separate risk assessment and control plan for each program administered by the Commission.

THE DOCTOR SHOPPER

This matter relates to a 26 year old female offender who was prosecuted in February 1996 for offences related to doctor shopping contrary to section 29D of the *Crimes Act 1914 (Fraud)*. In that matter she was convicted and sentenced to 100 hours community service, ordered to pay restitution to the HIC of $6066.75, and placed on a three year good behaviour bond.

Information received by the HIC suggests that the person may have continued to offend. She is currently under investigation for having attended numerous medical practitioners for the purpose of obtaining (by deceit) prescribed items to sustain her drug dependency. Each prescription normally provided would have been dispensed as a pharmaceutical benefit under Part 17 of the *National Health Act 1953*. However in these instances, the person attended numerous medical practitioners and specifically requested pethidine in order to alleviate alleged migraine attacks which she has subsequently admitted were fictitious. It is believed that the pethidine was provided

from 'doctors bag' or private prescriptions.

It is alleged that the person received 282 services from different medical providers during the period 1 January 1996 to 31 December 1996. These services were obtained in the names of other people using their Medicare numbers. The person's attendance at many of the surgeries was not for the purpose of obtaining a "professional service", but to deceive medical practitioners into providing her with the means to support her drug dependency.

At interview, the person admitted seeing multiple medical practitioners per day in order to obtain drugs. On a number of occasions she received pethidine injections from each medical practitioner. When presenting herself to medical practitioners to obtain pethidine, she admitted assuming the identities of friends and relatives.

The person was formally interviewed by HIC investigators. Although unable to positively identify specific dates of attendance or surgeries visited, she conceded that she could have received the services purportedly provided to relevant friends or relatives. Prior to that interview, each of six friends and relatives was interviewed in relation to numerous services listed on their personal histories. After examination of their records, each witness was able to identify their individual services from those allegedly provided to the offender and provided statements to that effect.

A common factor concerning the witnesses is that all but one were aware of the person's drug problem but were unaware that she was using their personal details in order to obtain prescriptions.

At this juncture a brief of evidence has been referred to the DPP and is awaiting prosecution action.

Provided by the HIC

2.23 The ANAO has no argument with the division of responsibilities outlined above. However, there is a risk that necessary actions can be overlooked because each area believes that the action is a responsibility of another area. The ANAO observed an occurrence (since corrected) of this within the HIC.

2.24 Experience in other organisations administering multiple programs has shown that there is a benefit in having a manager responsible to the CEO for the management of fraud against each program. The ANAO also believes this to be the case within the HIC. Typically the responsibility is given to the program manager.

Recommendation No. 1

2.25 The ANAO *recommends* that, to ensure that responsibility for fraud control is clear, the manager responsible for a program be responsible for the management of the relevant fraud control plan and that this be specified in the fraud control plan.

HIC response

2.26 Agreed. The HIC, with the assistance of external consultants, has recently revised its Fraud Control Plans. The plans now assign responsibility for fraud management to the relevant program manager.

Professional Review Division's management of fraud control

2.27 This section of the chapter reports against criteria designed to allow the ANAO to reach a conclusion on the efficiency, economy and administrative effectiveness of PRD's management of approaches to minimising fraud.

Criterion 1: *There is a risk assessment of the probability of fraud which:*

- *identifies risk; and*
- *analyses, assesses and ranks risk.*

2.28 The audit team examined fraud risk assessments for Medicare and the Pharmaceutical Benefits Scheme. These documents identified threats and risk levels against the Schemes and against the major systems required to operate them. Responsibility for coordinating the risk assessments lies with Internal Audit. PRD is a major contributor to the risk assessments.

2.29 Statements were produced analysing fraud risk for each group of participants in the Schemes (e.g. pharmacists, GPs, patients). These statements rank risks associated with each individual participant group.

2.30 The ANAO found that the HIC ranked fraud risks against criteria using rating scales. The criteria used ensured that priority was given to areas of risk that are financially material and/or concern the use of confidential information which needs to be protected.

2.31 The team found that the Commission had been preparing fraud risk assessments since 1989. The team also found that the Commission had engaged expert advice to assist in the development of methodologies for preparing fraud risk assessments. In preparing previous risk assessments the HIC did not promulgate standards or guidelines. However, guidelines and standards have been promulgated for the current development of risk assessments and fraud control plans in accordance with Commonwealth Law Enforcement Board guidelines.

2.32 These findings have led the ANAO to conclude that the fraud risk assessment processes used by the Commission analyse, assess and rank risk.

Criterion 2: *There is a fraud control plan, which reflects the fraud risk assessment.*

2.33 The development of fraud control plans is coordinated by Internal Audit. PRD is a major contributor to these plans. All fraud control plans developed by the Commission have been developed from fraud risk assessments and reflect the risks identified.

2.34 In the past there has been no single fraud control plan for the Commission. Rather, there has been a fraud control plan for each benefit payment system administered by the Commission. The Commission is currently developing new fraud control plans and fraud control strategies which are consistent with CLEB

guidelines. Fraud risk assessments and control plans will be developed for each program and then a consolidated control plan will be prepared.

2.35 Within PRD, staff charged with combating fraud did not work to the fraud control plans. Rather, they worked to the PRD divisional plan. This was not a problem because corporate fraud control plans were a major influence in the development of PRD plans. Other influences are:

- outcomes from previous years' activities;
- political/lobby group interests;
- materiality of activity against which the plan is directed;
- research and analysis conducted on HIC databases; and
- reports from external (e.g. Department, individual complaints) and internal sources (e.g. Customer Service staff, Medical Advisers).

2.36 Overall, the fraud control plans reflected fraud risk assessments. These approaches will be enhanced once the consolidated control plan is prepared.

Criterion 3: *The fraud control plan is consistent with CLEB guidelines and with the principles contained in the 1987 report, 'Review of Systems for Dealing with Fraud on the Commonwealth', by the Special Minister of State.*

2.37 Current fraud control plans do not comply with CLEB guidelines in that they are not based on a 'greenfields' or inherent risk assessment and they do not specify the area or position responsible for implementing fraud control strategies. New fraud control plans which comply with CLEB guidelines are nearing completion.

2.38 Major issues raised in the 1987 report, 'Review of Systems for Dealing with Fraud on the Commonwealth', are:

- detection of fraud;
- methods of dealing with fraud;
- deterrence;
- prevention; and
- accountability statistics.

These are dealt with in detail below.

Detection

2.39 Most fraud detected by the Commission comes from complaints by the public or by members of the medical and pharmaceutical professions. Another major source is processing staff in the branch and State offices of the Commission. The results of Purpose Based Audits and to a lesser extent Source Based Audits can also lead to

fraud investigations.

Methods of dealing with fraud

2.40 PRD investigates allegations of fraud and, where it decides that sufficient evidence has been gathered to establish a prima facie case that an offence has been committed, refers the case to the Director of Public Prosecutions. The DPP decides whether or not to prosecute and conducts the prosecution. Where the amount involved is small and the HIC considers that there is no ongoing threat, the HIC may recommend to the DPP that treatment be limited to recovery action.

2.41 All other investigations are referred to National or State Case Management Committees (CMCs) for a decision on the final disposition of the investigation. If money has been improperly obtained and there is no or insufficient evidence of fraud, the CMC will decide whether recovery action should be taken.

Deterrence

2.42 Examples of fraud deterrence activities undertaken by PRD include:

- issuing press statements on successful prosecutions;
- items in Medicare Forum (published by the Commission);
- articles in the medical press;
- Commission officers speaking at forums; and
- education seminars for new providers.

Prevention

2.43 The Commission runs comprehensive fraud awareness programs for staff. Awareness of the procedures in place to detect, investigate and prosecute fraud will have a deterrent effect amongst Commission staff.

2.44 An example of prevention action is feedback by the HIC to the Department of Health and Family Services, which is responsible for the Medicare Benefits Schedule. This can lead to changes to the Schedule which prevent or deter fraudulent charging practices.

Accountability statistics

2.45 Accountability statistics are discussed in para. 6.14.

2.46 These findings have led the ANAO to conclude that the HIC's fraud control procedures are consistent with the principles contained in the 1987 report, 'Review of Systems for Dealing with Fraud on the Commonwealth. The ANAO notes that some deterrence measures are recent initiatives and encourages continued activity in this area.

Criterion 4: *The fraud control plan gives directions/yardsticks for the conduct of cases.*

2.47 The ANAO found that the Professional Review Division Guidelines give comprehensive guidance to HIC staff on the conduct of investigations and inquiries but they had not been revised to reflect the introduction in July 1994 of the enhanced investigatory powers contained in Part IID of the *Health Insurance Act 1973*. The Guidelines include a section on recoveries.

2.48 The updated information on enhanced investigatory powers is contained in the Professional Review Division Policy Manual. However, the Manual contains some incomplete sections, including the recoveries section. When read together, these documents between them provide a comprehensive set of instructions.

2.49 The ANAO was informed that the reason for the Guidelines and Manual not being revised was resource considerations: operational matters had to be given priority.

2.50 These findings led the audit team to conclude that guidelines and yardsticks exist. While comprehensive, their useability could be improved by updating the Professional Review Guidelines and completing the Professional Review Policy Manual, or by combining these documents.

Recommendation No. 2

2.51 The ANAO *recommends* that Professional Review Division update the Professional Review Guidelines and complete the Professional Review Policy Manual.

HIC response

2.52 Agreed. The HIC is updating the Professional Review Guidelines and the Professional Review Manual to take into account recent administrative and policy changes and to incorporate revised CLEB procedures.

Criterion 5: *There are appropriate internal and external accountability measures in place.*

2.53 The results of the audit test program have led the ANAO to conclude that, although internal accountability measures are in place, further improvements are both possible and desirable. In particular, the development of a key performance objective (KPO) that covered fraud investigation and audit activity would be an advantage. The ANAO also concludes that external accountability mechanisms need to be strengthened.

2.54 Chapter 6 contains a more detailed discussion and recommendations for improvement.

Criterion 6: *The fraud control plan is implemented efficiently and effectively.*

2.55 The efficiency and effectiveness of fraud control is discussed under the three headings of CLEB guidelines, prepayment and post-payment controls, and recoveries.

CLEB guidelines

2.56 In 1994 the Commonwealth Law Enforcement Board published 'Fraud Control Policy of the Commonwealth'. This established new guidelines for the fraud risk assessments and fraud control plans of Commonwealth bodies.

2.57 HIC fraud control plans were reviewed by CLEB in early 1996. As mentioned earlier, they did not meet CLEB guidelines, either in presentation or content. Particular omissions identified by the ANAO were:

- the fraud control plans were not based on a 'greenfields' or inherent risk assessment; and
- the fraud control plans did not specify the area or officer responsible for each strategy to rectify shortcomings identified in the risk assessment.

2.58 At the time of writing, risk assessments consistent with CLEB guidelines had been completed, and fraud control plans and fraud control strategies were nearing completion.

2.59 The above findings led the audit team to conclude that the HIC has taken steps to control the risks identified in its risk assessments. In particular, the ANAO supports the HIC's priority to completing the development of fraud control plans and fraud control strategies consistent with CLEB guidelines.

Prepayment and post-payment controls

2.60 Current fraud controls are a mix of prepayment controls and post-payment controls. An example of a prepayment control is eligibility. Before a person can obtain a Medicare card the HIC must be satisfied that the person is entitled to it. Further checks are made over time to verify continuing entitlement. In order to claim a Medicare benefit as cash, a valid Medicare card or suitable proof of identity must be produced. Where the claim is for a payment by cheque, the claimant's Medicare number must be produced and must reconcile with the claimant's name.

2.61 An example of a post-payment control is Purpose Based Audits. These are audits targeted at known areas of high fraud or inappropriate practice risk. Cases of fraud identified by these audits are investigated and prosecuted.

2.62 An area where further prepayment checks are possible is contingent or conditional payments. An example where these payments would be made is a pathology test which qualifies for a Medicare benefit only if the patient has a precursor condition. A prepayment control would check for that condition before payment was authorised. Of note is that there are some prepayment controls in operation now for pathology claims.

2.63 The Neural Net (para. 3.16) - which is a computing technique where a computer program recognises patterns in data - can be used to identify transactions which have a high probability of being fraudulent and allow them to be subject to further checking before payment. An example is the identification by the Neural Net of a grouping of pathology tests for which there is no logical clinical justification. If the explanation is that a more expensive test than the test actually performed has been

claimed, then a prepayment test can be instituted. Similar systems are already successfully used by credit card companies.

2.64 During field work, the audit team became aware of a potential problem arising from the introduction of Electronic Data Interchange (EDI) for bulk-billing doctors with computerised accounting systems. Potential problems are that there will not be an adequate audit trail (para. 5.34) and that proving fraudulent practice will be extremely difficult. The ANAO notes that EDI has been implemented for these doctors before legislation similar to that covering EDI for pathology practices has been introduced into Parliament. The ANAO has been informed that the Commission's view is that legislative support for EDI would assist it to obtain relevant documentation from practitioners to support claims.

2.65 A prepayment control system has been trialed by the HIC and promises worthwhile savings. The ANAO considers the introduction of a Neural Net-based prepayment control system to be a necessary adjunct to the introduction of a paperless claim system to assist in identification of transactions which have a high probability of being fraudulent. In other words, the move to EDI for computerised bulk-billing doctors should be accompanied by an upgrading of the HIC's prepayment controls.

Recommendation No. 3

2.66 The ANAO *recommends* that the prepayment controls for claims lodged by EDI with the HIC be upgraded by making cost-effective use of currently available technology.

HIC response

2.67 Agreed. The HIC has developed a pilot project for prepayment risk assessment. HIC has sought funding to implement the project in the operational environment. Progress towards wider use of electronic claiming may require review of legislative arrangements.

Recoveries

2.68 Another area relevant to the efficiency and effectiveness of fraud control is recovery of funds otherwise lost through fraud or inappropriate practice. As Chapter 4 suggests, the recovery of moneys are incorrectly paid and the systems supporting recovery are an area in need of management attention. It also suggests that greater HIC attention to receivables could be a useful deterrent tool against fraud.

2.69 To summarise, viewed against the criterion of whether the fraud control plan was implemented efficiently and effectively, the HIC has made considerable strides regarding conformity with CLEB guidelines and in introducing prepayment controls. Problems with PRD's performance indicators are discussed further in Chapter 6. Overall the ANAO found that there was no summary performance indicator for the management of leakage through fraud as there was with inappropriate practice. Notwithstanding this, the PRD plan includes targets for the Compliance area of PRD. However, there was insufficient information to allow the ANAO to form an opinion

as to whether PRD's management of approaches to minimising fraud is completed efficiently and effectively.

Fraud value estimates

2.70 In order to decide whether its response is proportionate to the problem, an organisation should have an estimate of the order of magnitude of the leakage or wastage of funds it manages. The Commission has attempted to estimate the value of leakage expenditure from the Medicare and Pharmaceutical Benefits Schemes through fraud.

2.71 The estimate is derived from data from the Source-Based Audits (SBAs). SBAs are based on a random selection of claims and involve the examination of benefits paid to form an opinion on the correctness and appropriateness of the payment. The principal objective of SBAs is 'to enable the Commission to risk assess aspects of the benefit Schemes administered by the Commission and to document those risks'.

2.72 This is achieved by verifying all aspects of a claim. The services or prescription items selected are verified with all parties to the transaction: for example, a consultation with a GP will be verified against the GP's records. The patient will also be contacted to confirm that the GP was visited and that the patient's recollection of the topic and duration of the consultation is consistent with the claim lodged.

2.73 An outcome of the SBA program is the identification of the incidence of 'critical errors'. A critical error is 'any practice or action by a party to the transaction which causes a dollar value error to occur'. The incidence of critical errors is used by the Commission to risk-assess aspects of benefit schemes. The Australian Bureau of Statistics (ABS), which was consulted by the Commission during the development of the SBA program, has advised the Commission that this is an acceptable use of SBA data.

2.74 Another outcome of the SBA program is the quantification of expenditure leakage (incorrect benefits paid) in relation to total claims paid. Since this leakage is mainly through fraud, this would allow an estimate of leakage through fraud. However, the ABS has advised that the sample size used for SBAs is too small to provide reliable estimates of the value of leakage.

2.75 The Commission has examined the possibility of increasing the sample size to the level required for a reliable estimate. It has concluded that the cost would far outweigh the expected benefits.

2.76 Notwithstanding this, data from the SBAs can be used to give an indication of the order of magnitude of leakage through fraud from the Medicare and Pharmaceutical Benefits Schemes. Using these data, the ANAO has derived estimates of $135 million for 1994-95 and $52 million for 1995-96. The variation illustrates that the estimates are order-of-magnitude estimates only.

2.77 Expressed as a percentage of total expenditure on claims, these estimates are 1.6

per cent for 1994-95 and 0.7 per cent for 1995-96. However, the small sample used to derive these estimates means that it is possible that the leakage could be up to three times higher than estimated. It should be noted that there is a 95 per cent chance that the actual value lies below this upper limit.

2.78 The Commission advised the ANAO that it had received verbal advice from ABS that after several years of data had been collected it would be possible to produce a more reliable estimate. The Commission will re-examine the possibility of publishing an estimate of the value of leakage through fraud in 1997, once three years of data are available. The ANAO considers that knowledge of the magnitude or value of leakage is important both for management purposes and for accountability. Publication of the estimates will assist the Commission in its education role, and encourage greater attention amongst all stakeholders to the importance of antifraud action. The annual report may be a suitable place for this information.

Recommendation No. 4

2.79 The ANAO *recommends* that the Commission prepare and publish estimates of the value or order of magnitude of leakage through fraud from the Medicare and Pharmaceutical Benefits Schemes to:

- draw the attention of all stakeholders to the problem of medifraud;
- promote greater understanding; and
- permit antifraud strategies to be better targeted.

HIC response

2.80 Agreed. The HIC agrees that its role includes promoting greater understanding of issues to do with fraud and the development of strategies to combat fraud.

2.81 The HIC advised further that the value of leakage resulting from fraud is difficult to estimate in any situation, but the HIC's Source Based Audit program does provide the capacity to place a value on the extent of leakage. The Source Based Audit program is resource-intensive and the HIC has not yet been able to conduct sufficient Source Based Audits to arrive at a value that has statistical validity. Estimates derived from the Source Based Audit program are the best estimates available in the current environment and will achieve greater accuracy as the program evolves.

2.82 Further recent strategies involving letters to providers and patients will provide additional information on the extent of leakage through fraud. The HIC will publish as part of its Annual Report the outcome from both the Source Based Audits and the provider and patient letter program.

Conclusion

2.83 In summary, the ANAO concluded that:

- the Commission has adopted a risk management approach to managing leakage through fraud from the Medicare and Pharmaceutical Benefits Schemes. Its approach is being amended to bring it into accord with the CLEB guidelines for the management of fraud against the Commonwealth;
- the Commission has followed advice from the Australian Bureau of Statistics in developing and using data from Source Based Audits. However, the Commission is unable to produce a reliable estimate of leakage through fraud at an acceptable cost due to the expense of the surveys used to collect the data. The Commission intends to re-examine the possibility of producing an estimate once three years of data are available;
- the loss to the Commonwealth through medifraud could be between 0.7 and 1.6 per cent of payments. However, these should be considered preliminary estimates only; and
- internal accountability could be improved through emphasising that program managers have the primary responsibility for fraud control.

3. Inappropriate Practice

This chapter describes the Commission's management of approaches to minimising inappropriate practice in the Medicare and Pharmaceutical Benefits Schemes and makes recommendations for improvement. The chapter includes an ANAO estimate of the extent of inappropriate practice.

Background

Inappropriate practice

3.1 Inappropriate practice is defined in section 82 of the *Health Insurance Act 1973*. In essence, a practitioner has engaged in inappropriate practice if a committee of the practitioner's peers concludes that the conduct of the practitioner would be unacceptable to the general body of the profession/speciality in which the practitioner is practising.

3.2 Before passage of the *Health Legislation (Professional Services Review) Amendment Act 1994,* disciplinary action against practitioners who were overservicing patients was undertaken through Medical Services Committees of Inquiry (MSCI). MSCIs were able to consider only overservicing; other forms of inappropriate practice were not within their scope.

3.3 In Audit Report No.17 1992-93, *Medifraud and Excessive Servicing,* the ANAO was critical of the lack of disciplinary action against overservicing doctors. The ANAO was also critical of the operations of MSCIs and recommended that the process be reviewed (see Appendix 1, Recommendation 2). Subsequently, after Parliamentary hearings, the *Health Legislation (Professional Services Review) Amendment Act 1994* was passed. This Act replaced MSCIs with the Professional Services Review Scheme.

3.4 The role of the Health Insurance Commission under the Scheme is to investigate suspected cases of inappropriate practice. If the Commission considers that sufficient

evidence of inappropriate practice is available, it refers the case to the Director of Professional Services Review, which is an independent statutory office. If the Director concurs, he must convene a committee to consider whether the person under review has engaged in inappropriate practice. Note that the Commission does not decide whether or not a practitioner has engaged in inappropriate practice.

3.5 Before the Commission can refer a practitioner to the Director of Professional Services Review, the Commission counsels the practitioner and provides an opportunity for the practitioner to change his or her practice.

3.6 Within the Commission, Professional Review Division is responsible for investigating and counselling suspected cases of inappropriate practice. PRD's activities are overseen by the Fraud and Audit Services Committee (see para. 2.21).

3.7 As discussed earlier, Medicare operates on a fee-for-service basis. The more services provided, the higher a provider's gross income. If practitioners' margins increase with volumes there is every incentive to increase volumes. This has led to some providers seeing very large numbers of patients. If one assumes that all the patient visits were necessary, more appropriate behaviour by the practitioner may not reduce expenditure from the schemes, as the patients can visit other doctors. A related form of inappropriate practice is for a practitioner to schedule further appointments, which from a medical point of view are not strictly necessary.

3.8 Another form of inappropriate practice can occur when a doctor is practising defensive medicine. In this case the doctor may order more tests than would be considered appropriate by the doctor's peer group. The concern is that this leads to unnecessary payments from the Medicare Benefits Scheme.

3.9 Some practitioners hold strong, unconventional beliefs on medical practice which do not have the support of the practitioner's peer group. The referral and prescribing habits of these practitioners can also lead to unnecessary payments from the Medicare and Pharmaceutical Benefits Schemes.

3.10 Inappropriate practice can also lead to leakage from the Pharmaceutical Benefits Scheme. A doctor who prescribes unnecessary pharmaceuticals is causing unnecessary payments from the PBS.

3.11 The Commission also investigates medical practices which, while they may not lead to unnecessary expenditure from the Medicare and Pharmaceutical Benefits Schemes, are examples of treatment which would not be acceptable to the practitioner's peers. An example is surgical removal of a tumour with no subsequent pathology tests to determine whether or not cancerous cells were present.

Education

3.12 As well as investigating and counselling suspected cases of inappropriate practice, the Commission has an important role in promoting better practice. The Commission uses its database to provide feedback to practitioners on their referral and prescribing patterns. This data compares the practitioner's practice and prescribing and referral patterns with a group of practitioners with similar practices.

The practitioner is given information on where his or her practice fits within the group.

3.13 The Commission also runs projects to improve the use of a particular drug by educating practitioners on appropriate prescription of the drug. Again, practitioners are given a comparison between their prescribing habits and the prescribing habits of their peers. This is accompanied by information on the preferred use of the drug and the problems that could be caused by overuse.

3.14 The Commission informed the audit team that education is important, as a 1 or 2 per cent reduction in prescribing over a large number of practitioners could produce significant savings. As mentioned in para. 3.66 the Commission is trialing methods to allow these savings to be quantified. A more detailed description of the Commission's educational activities can be found on page 52 of the Health Insurance Commission Annual Report, 1995-96.

3.15 In summary, the passage of the *Health Legislation (Professional Services Review) Amendment Act 1994* has allowed the Commission to take a holistic approach to inappropriate practice. The evidence collected by the audit team is consistent with a holistic approach. In other words, the Commission is working to maximise appropriate practice in order to achieve best possible health outcomes. The reduction of waste may be one of the consequences that flow from PRD activities.

Neural Net

3.16 The information collected in processing Medicare and Pharmaceutical Benefits claims has enabled the Commission to build practice profiles for each Medicare provider. By using Neural Net techniques, the Commission has been able to identify practitioners whose practice profile suggests that there is a high probability that the practitioner is practising inappropriately.

3.17 A Neural Net [1] is a computing technique where a computer program recognises patterns in data. The HIC used experts in a medical speciality to identify indicators of inappropriate practice. These indicators were used to 'program' the Neural Net to recognise practice profiles for that speciality which are consistent with a high (or low) risk of inappropriate practice.

3.18 The Commission uses the Neural Net to classify the practice profiles of practitioners in a speciality into the following categories:

1. there is a high degree of certainty that the provider is practising abnormally;

2. there is a lesser degree of certainty that the provider is practising abnormally;

3. there is a lesser degree of certainty that the provider is practising normally; and

4. there is a high degree of certainty that the provider is practising normally.

3.19 Table 1 shows the number of GPs in each category at June 1996.

Table 1

GPs by Category

Category	Number of GPs	Percentage
1	1846	12
2	4539	30
3	6479	43
4	2355	15
Total	15219	100

3.20 The Neural Net covers a majority of practitioners, including:-

- general practitioners;
- optometrists;
- psychiatrists;
- dermatologists;
- pathologists;
- radiologists;
- obstetricians; and
- ophthalmologists.

3.21 The only major speciality not covered by the Neural Net is anaesthetists. The work of an anaesthetist is governed by the work of the surgeon the anaesthetist is assisting. As a result, the Commission has not yet been able to identify sufficient patterns in the practice profiles of anaesthetists to enable them to be analysed by the Neural Net.

3.22 The Neural Net covers only practitioners practising full-time. To be included a practitioner must practise in all four quarters of the year.

3.23 The Neural Net covers 68 per cent of all medical practitioners registered under Medicare. These practitioners are responsible for 69 per cent of Medicare benefits. Practitioners practising part-time are not included. The Neural Net allows Commission resources to be concentrated on those practitioners whose practice profile suggests a high risk of inappropriate practice.

3.24 The next section of this chapter reports against the audit criteria developed to examine the Commission's management of inappropriate practice.

The Commission's management of inappropriate practice

Criterion 1: *There is a risk assessment of the probability of inappropriate practice which:*

- *identifies risk; and*
- *analyses, assesses and ranks risk.*

3.25 The Commission does not prepare a formal risk assessment for inappropriate practice. However, the Neural Net application and the risk assessment process used for Purpose Based Audits (PBAs) serve to identify and analyse significant risks associated with inappropriate practice.

3.26 The Commission has not prepared a formal estimate of the value of inappropriate practice. Discussions with PRD staff indicate that they have a view as to what this value may be.

3.27 These findings have led the ANAO to conclude that the HIC has identified significant risks of invalid payments through inappropriate practice against the Medicare and Pharmaceutical Benefits Schemes and has analysed, assessed and ranked these risks.

Criterion 2: *There is an inappropriate practice control plan, which reflects the inappropriate practice risk assessment.*

3.28 Significant risks are being identified, analysed, assessed and ranked through the Neural Network and the PBA audit program. However, PRD has not produced a formal national plan for the management of inappropriate practice.

3.29 A formal plan would discuss actual and desired performance against PRD's Key Performance Objective. It would also discuss factors affecting the achievement of KPOs, such as the number of practitioners in each State falling into Neural Net Category 1, and the proportion that could be counselled with existing resources. A formal plan would state how obstacles to the achievement of PRD's KPO and other targets are to be surmounted.

3.30 The ANAO considers that without a formal plan it is not possible for the Commission to be assured that it is allocating resources in the most efficient way possible.

Recommendation No. 5

3.31 The ANAO *recommends* that the HIC develop a well documented and widely available plan, including key performance objectives and indicators, for minimising inappropriate practice.

HIC response

3.32 Agreed. The HIC agrees that documentation of current planning processes for dealing with inappropriate practice can be improved.

3.33 The development of the HIC's approach for the identification of inappropriate practice has required complex and iterative processes involving external consultants and the HIC's medical advisers over a period of years. The implementation of the HIC's approach has required a highly sophisticated technological solution that has

recently earned the Prime Minister's award for Innovation in Public Sector Administration (Process Improvement).

3.34 The HIC indicated that in addition, the approach to management of inappropriate practice has also required development of significant management processes and controls. These processes can now be documented and made available as the ANAO recommends.

3.35 The audit team observed that the level of inappropriate practice varied between States. The team also observed the level of resources available to address inappropriate practice varied between States but not in a way which matched the level of inappropriate practice. As a result, some States were able to counsel all Category 1 practitioners and some Category 2 practitioners. Other States had to rank and counsel only some Category 1 practitioners, because they did not have the resources to counsel them all.

3.36 The allocation of resources within an HIC State office is controlled by the State manager, including the resources allocated to Professional Review Branches. PRD cannot reallocate PRB resources from one State to another to even out inappropriate practice workloads without the agreement of the State manager who is giving up resources.

Recommendation No. 6

3.37 The ANAO *recommends* that the HIC develop an effective mechanism to permit resources to be reallocated to meet workload demands efficiently. With respect to Professional Review Division, this would allow the timely reallocation of resources between States as the risk of inappropriate practice or fraud varies.

HIC response

3.38 Agreed. HIC's Executive Management Committee has agreed the principles for allocating resources for Professional Review activities in the context of the annual planning and budget processes to meet workload demands efficiently.

Criterion 3: *The inappropriate practice control plan is consistent with CLEB guidelines and the principles contained in the 1987 report, 'Review of Systems for Dealing with Fraud on the Commonwealth' by the Special Minister of State.*

3.39 Major issues raised in the 1987 report were:

- detection of inappropriate practice;
- methods of dealing with inappropriate practice;
- deterrence;
- prevention; and
- accountability statistics.

3.40 The CLEB guidelines applicable to inappropriate practice cover similar issues. These issues are covered in detail below.

Detection

3.41 The HIC makes use of its Neural Network to identify practitioners who may be practising inappropriately. Those not covered by the Neural Net fall under the PBA program.

Methods

3.42 Methods available to PRD for dealing with inappropriate practice include counselling, further counselling if there is no response, and/or reference to the Director, Professional Services Review.

3.43 The Professional Services Review process, if a case is proved, may result in a reprimand, recovery of inappropriate payments, and partial or full disqualification from the Medicare Scheme.

Deterrence

3.44 Deterrence initiatives include counselling interviews by medical advisers, a pamphlet explaining the Professional Services Review process, and publicity through a regular newsletter.

Prevention

3.45 Prevention activities designed to encourage improvements in practice, prescribing and ordering habits include educational activities for new and existing practitioners and feedback to practitioners practising appropriately (see para. 3.12). Another example of prevention is the 'coning' policy introduced for pathologists. This policy states that irrespective of the number of tests ordered by a GP, pathologists will be paid for only a maximum of any three tests at a time.

3.46 A further example of prevention is feedback to the Department of Health and Family Services leading to changes in the Medicare Benefits Schedule which may discourage inappropriate practices.

Accountability statistics

3.47 Accountability statistics are discussed in Chapter 6.

3.48 These findings have led the ANAO to conclude that the HIC's inappropriate practice control procedures are consistent with the principles contained in the 1987 report, 'Review of Systems for Dealing with Fraud on the Commonwealth'.

Criterion 4: *The inappropriate practice control plan gives directions/yardsticks for the conduct of cases.*

3.49 The audit team found that there were measures in place to address inappropriate practice. We observed these in some detail in both Central Office and State Offices.

3.50 The Professional Services Review Scheme Procedures Manual gives directions/yardsticks for the conduct of cases. The ANAO noted that the chapter on the selection of practitioners had not been completed. Educational material advising Medical Advisers of their role and responsibilities has also been produced.

Criterion 5: *There are appropriate internal and external accountability measures in place.*

3.51 The results of the test program for this criterion are discussed in detail from para. 6.10. The ANAO concluded that, although internal accountability measures are in place, further improvement is both possible and desirable particularly through PRD having the authority to reallocate resources between States. The ANAO also concludes that external accountability mechanisms need to be strengthened, for instance through publishing the results of Purpose Based Audits.

3.52 Chapter 6 contains recommendations for improvement.

Criterion 6: *The inappropriate practice control plan is implemented efficiently and effectively.*

3.53 The PRD has a KPO (see para. 6.1 for a detailed description) of reducing the relative incidence of inappropriate practice by ten per cent by the end of the century. Table 2 shows that there has been a growth of 25 per cent (as measured by the KPO index) from the base quarter of March 1993 to the March quarter of 1996. Note that the current KPO measures only the incidence of inappropriate practice amongst GPs.

Table 2

HIC's Achievement of Inappropriate Practice Key Performance Objective (KPO Index)

Quarter	1993	1994	1995	1996
March	100	110	111	125
June	78	113	114	131
September	106	112	118	123[1]
December	110	111	125	n.a.

[1] In September 1996 niche practitioners were excluded for the first time. See para. 6.5.

3.54 In addition to recording its achievement against the KPO, the PRD compiles performance information on other topics - see para. 6.10. Information of this nature is desirable, as KPO data is not in itself a complete indication of PRD performance.

3.55 The growth of approximately 8.6 per cent a year to date shown in Table 2 is not consistent with PRD's inappropriate practice target, which calls for a reduction in the inappropriate practice KPO. In replying to the draft report, the HIC commented that:

we are very much aware that until the very recent past, the KPO for inappropriate practice has been increasing rather than decreasing. However, along with the development of the inappropriate practice measurement technologies and management approaches, we have been developing a clear

understanding of the factors that drive inappropriate practice. In recent times, there has a better defined focus to our targeting of practitioners for counselling and a substantial increase in the number of counselling activities undertaken by our Medical Advisers. The most recent measurement of inappropriate practice shows a decrease in the KPO on the national level and some very significant decreases in some States. We remain confident that we can deal with the challenge in inappropriate practice and believe that we are now in a position to apply effective effort so that we can move to meeting our target by June 2000.

Summary

3.56 These findings led the audit team to conclude that the HIC is using a risk management approach to address inappropriate practice. The use of the Neural Net is innovative and is effective in concentrating PRD resources on cases where the likelihood of inappropriate practice is high. The ANAO considers that PRD would benefit by developing a formal plan for the management of inappropriate practice.

Referrals for inappropriate practice or overservicing

3.57 Audit Report No.17 1992-93 was critical of the low number of referrals to MSCIs of practitioners suspected of overservicing. Table 3 shows that PRD has been able to nearly triple the number of counselling interviews by Medical Advisers from 155 to 464. Further increases in the number of interviews are planned.

Table 3

HIC Inappropriate Practice Counselling and Review Activities

Year	1991-92	1992-93	1993-94	1994-95	1995-96
PSR counsellings	n.a.	n.a.	n.a.	155	464
PSR referrals	n.a.	n.a.	n.a.	10	19*
MSCI referrals	13	12	6	n.a.	n.a.

* As of 30 June 1996, there were 38 PSR referrals on hand. This reflects the large increase in counselling activity and the time lag from counselling to referral.

3.58 The number of referrals for disciplinary action has also increased. In the three years to 1993-94 there were 31 referrals to MSCIs for possible disciplinary action (para. 3.2). In the two years that the Professional Review Scheme has been in place, there have been 29 referrals and a further 38 cases have been recommended for referral.

3.59 All practitioners referred to a Professional Review Committee have been counselled by the Commission and given a chance to amend their practice habits. Table 3 shows that in 1995-96 the number of practitioners referred or recommended for referral to the Director, Professional Services Review was only 12 per cent of practitioners counselled. This suggests that most practitioners are responding to counselling in a positive manner.

3.60 A review of the effectiveness of the new scheme is beyond the scope of this audit. Notwithstanding this, the evidence collected by the ANAO on the Commission's approach to minimising inappropriate practice have led to the conclusion that the criticism in Audit Report No.17 1992-93 of the low number of referrals of practitioners for disciplinary action no longer holds.

Savings - inappropriate practice

3.61 As indicated earlier, inappropriate practice is defined as conduct which is unacceptable to the majority of the profession practising in the speciality. This definition focuses upon qualitative rather than upon quantitative issues. The primary beneficiaries of appropriate practice are health consumers who then receive the most suitable medical treatment. Another beneficiary can be government, if savings can be identified from inappropriately high levels of service.

3.62 The difficulty is how to identify savings from an unnecessarily high level of service. An example of a difficulty is how, even in cases where HIC interventions resulted in changes in the servicing behaviour of the targeted practitioner, no one can be sure that the patient does not compensate by receiving similar services from other practitioners, or in the displacement of costs to other areas of Commonwealth expenditure. These can include hospitalisation, nursing home or other social welfare provision. Further, it is possible to identify aspects of practice behaviour where change in the direction of appropriate practice can result in greater cost to the Commonwealth. An example is a practitioner who is seeing a large number of patients with very short consultations. More thorough consultations may lead to better diagnosis and more appropriate but more costly treatment.

3.63 Notwithstanding this, the Commission can demonstrate savings as a result of actions to minimise inappropriate practice. The Commission uses two types of intervention in minimising inappropriate practice. These are:

- counselling of selected high-risk doctors; and
- education measures aimed at the general body of doctors.

3.64 The Commission has argued that its compliance audit activities have provided estimates of the cost of some aspects of inappropriate practice, for example in Diagnostic Imaging, Pathology and prescribing. The Commission was able to demonstrate to the audit team that the prescribing and referral patterns of a doctor practising inappropriately could change substantially after a counselling session. The impact of the change on cost to the Medicare and Pharmaceutical Benefits Schemes could be measured. The Commission claimed average savings of $40000 of Medicare expenditure per intervention in the first year after counselling.

3.65 If accurate, this suggests that PRD may currently be achieving savings of up to $19 million per year through counselling, through reducing expenditure which would have otherwise occurred. PRD is working to better document the savings from counselling sessions.

3.66 PRD also runs education programs aimed at the general body of doctors (para. 3.12). HIC data suggests that these programs can lead to significant savings. PRD is trialing the use of control groups to better measure the impact of education programs.

3.67 The evidence examined by the audit team suggests that both PRD's counselling activities and its education programs are encouraging better practice and achieving significant savings. Publication of better measures of savings could assist the Commission in its negotiations with medical practitioners over improvements to practice. In other words, as with fraud estimates, publication of estimates will strengthen the Commission's education role.

Recommendation No. 7

3.68 The ANAO *recommends* that Professional Review Division complete its long-running work on better measures of savings as a result of actions to minimise inappropriate practice. In addition, to assist the HIC in its education campaign, the ANAO *recommends* that HIC publish estimates of the savings.

HIC response

3.69 Agreed. Evaluation of savings resulting from current approaches to minimising inappropriate practice following the amendments to the legislation have been possible only since July 1996, and involve the accumulation of data on the result of individual interventions. HIC will progressively accumulate such data over time as interventions occur.

3.70 Recently completed evaluation of interventions confirm that HIC actions are producing significant savings. These evaluations will be published as soon as possible.

Inappropriate practice value estimates

3.71 As mentioned in para. 2.70, an organisation should have an estimate of at least the order of magnitude of the leakage of funds it manages, in order to decide whether its response is proportionate to the problem. The audit team found that the HIC has not attempted to formally estimate the value or order of magnitude of unnecessary expenditure from the Medicare and Pharmaceutical Benefits Schemes through those forms of inappropriate practice which lead to unnecessary expenditure.

3.72 This led the ANAO to attempt to estimate the value of inappropriate practice. The estimate is based on the Commission's claimed savings of $40 000 of Medicare expenditure per intervention (see para. 3.64) with those Category 1 practitioners suspected of the greatest incidence of inappropriate practice. When discounted for a lower likely incidence amongst other Category 1 practitioners and multiplied by the number of GPs in Neural Net Category 1, this gives an estimate of $35 million per year.

3.73 One additional factor that must be kept in mind is that a doctor who, after counselling for inappropriate practice, saw fewer patients, may find that some of those patients may go to other doctors. Therefore, estimates of the effects of reduced expenditure through counselling may partially be offset by increased services from other practitioners in the area. A further consideration is that only some forms of inappropriate practice are likely to be overservicing. That is because some inappropriate practice can involve under expenditure on a medical treatment.

3.74 The estimate does not cover other specialities included in the Neural Net, nor does it allow for practitioners not included in the Neural Net. It also does not allow for inappropriate practice by practitioners in Category 2. When these factors are considered, the ANAO considers that the probabilities are that the value of inappropriate practice exceeds $35 million.

3.75 The ANAO also estimated the value of inappropriate practice involving other medical specialities covered by the Neural Net and practitioners not covered by the Neural Net. This estimate included the $35 million in inappropriate practice amongst GPs. This higher estimate assumed that practitioners not on the Neural Net were as likely to be practising inappropriately as those covered. The combined estimate for GPs, other medical specialities and practitioners not on the Neural Net was $62 million per year.

3.76 It is known that there is also a problem with inappropriate use of pharmaceutical products listed on the PBS. However, there was no information available on which an estimate could be based. For this reason the ANAO considers that these estimates here are conservative. The Commission has altered its database so that information on PBS inappropriate practice will be available in the future.

3.77 In summary, an indicative estimate of the order of magnitude of inappropriate practice is probably around $60 million per year, or about 1.0 per cent of Medicare payments. This gives an indication of the possible value, but there is insufficient information to allow a more precise estimate. The ANAO considers that information of this kind is important both for management purposes and for accountability. The estimate should be considered as interim until the HIC prepares firmer estimates.

Recommendation No. 8

3.78 The ANAO *recommends* that the HIC prepare and publish estimates of the value or order of magnitude of inappropriate practice from the Medicare and Pharmaceutical Benefits Schemes to:

- draw the attention of all stakeholders to the problem of inappropriate practice;
- promote greater understanding; and
- permit strategies to combat inappropriate practice to be better targeted.

HIC response

3.79 Agreed. The HIC proposes to publish in its Annual Report the Index of

Inappropriate Practice as one of the Key Performance Objective measures for the organisation. In addition, supplementary to the Annual Report, the HIC proposes to publish a report which focuses upon issues dealt with by Professional Review Division. This report will provide for stakeholders further information on Professional Review activities both in the area of professional education and in the area of compliance. It is expected to include the outcome of research and evaluation conducted on the budgetary implications of Professional Review interventions.

Conclusion

3.80 In summary, the ANAO concludes that:

- the Commission has adopted a risk management approach to managing leakage through inappropriate practice from the Medicare and Pharmaceutical Benefits Schemes;
- it appears that PRD's objective of reducing inappropriate practice by 10 per cent by the year 2000 may not be met, as the inappropriate practice KPO has been growing at approximately 8.6 per cent per year;
- the criticisms contained in Audit Report No.17 1992-93 of a lack of disciplinary action against practitioners suspected of overservicing by the Commission no longer apply;
- the Commission is achieving significant savings through counselling providers practising inappropriately. However, the extent of these savings could be better quantified;
- the Commission has taken steps to prevent and control inappropriate practice;
- currently there is no information on which an estimate of inappropriate practice from the PBS can be based. The Commission has taken steps to obtain such information; and
- an estimate of the order of magnitude of the value of inappropriate practice against Medicare is around $60 million, or 1.0 per cent of Medicare payments;

3.81 The ANAO has made recommendations for further improvements to the Commission's management of inappropriate practice.

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4. Recoveries

This chapter describes the Commission's management of recoveries of moneys improperly obtained through fraud and makes recommendations for improvement.

Background

4.1 When HIC investigations provide evidence that a person has improperly obtained moneys from the Medicare or Pharmaceutical Benefits Schemes, the Commission seeks to recover these moneys. In 1995-96, $ 1.1 million (1994-95, $0.9 million) of Medicare and Pharmaceutical benefits paid incorrectly was recovered from providers and the public.

Recoveries

4.2 All investigations are managed through State Case Management Committees (SCMCs). If an investigation concludes that a member of the public or a practitioner has improperly obtained moneys, one of the decisions to be made is whether recovery action will be taken. The investigator responsible for the case will make a recommendation to the SCMC, which will decide whether recovery action will be taken. This happens in all States.

4.3 Moneys outstanding can be repaid or, in the case of a provider, recovered from future payments. The legislation governing the Pharmaceutical Benefits Scheme allows the HIC to recover moneys from future provider claims.

4.4 There is no such provision in the Medicare legislation and moneys can be recovered from future claims only with the consent of the provider. Outstanding moneys cannot be recovered in this fashion from doctors who do not bulk bill, as they do not claim on the Schemes. If legislation allowed for the recovery of moneys, in theory practitioners could avoid it by not bulk billing.

4.5 If the money is to be repaid, an invoice is raised and sent. In some States the Finance Branch takes follow-up action if the money is not received. In other States the follow-up action is taken by Professional Review Branch.

4.6 The ANAO observed good procedures in some States. For example, one State reported outstanding balances at SCMC meetings using a locally-developed spreadsheet.

4.7 As a result of field work, the ANAO identified a number of control weaknesses in the HIC's receivable system, such as a lack of regular reconciliation between minuted SCMC decisions and Finance Branch records. The ANAO also identified inconsistencies in recoveries data held in Central Office and recoveries data held in the States.

4.8 The ANAO considers that the following areas need to be addressed:

- the development of a national deterrence strategy in which the HIC is seen to be pursuing recoveries vigorously;
- recoveries generally should be the responsibility of an area independent from the investigators;
- sound practice suggests that reconciliations need to be undertaken on a regular basis to ensure that all recoveries due are recorded on the finance system;
- reporting of not only recoveries received but also recoveries to be received. This would provide stakeholders with information relating to HIC activity, act as a deterrent factor and send a message that the HIC was active in recovering outstanding moneys; and

- improved guidelines, support and guidance from Central Office.

Recommendation No. 9

4.9 The ANAO *recommends* that the Commission review the procedures used by its relevant Divisions to manage recoveries of benefits improperly obtained by beneficiaries, in order to identify best management practices for implementation on a uniform basis in all States.

HIC response

4.10 The Commission agrees with this recommendation.

4.11 An important principle in the management of fraud is deterrence. Vigorous and highly visible recovery action is an important component of a deterrence strategy. Observations through field work and feedback from stakeholders indicate that HIC's recovery actions are insufficiently vigorous and visible to medical practitioners.

4.12 PRD management has to decide on the appropriate balance between prosecution and recovery action as methods of deterrence. The ANAO believes that there may be advantages in more vigorous recovery action.

Recommendation No. 10

4.13 The ANAO *recommends* that Professional Review Division put further emphasis on cost-effective recovery action, not only to improve performance but also as a means of deterrence against fraud.

HIC response

4.14 Agreed. The HIC believes that recovery itself does not produce a deterrent effect and that greater effect is gained through publicising disciplinary action and prosecutions. Prosecution action necessarily takes a considerable time as it involves the DPP and courts. Furthermore, the outcomes of prosecutions do not necessarily identify the full extent of the cost to the Budget of the fraud committed. Additionally, notwithstanding successful action by the HIC, external factors can preclude successful recoveries.

4.15 It is the policy of the HIC to issue press releases in relation to prosecutions and related recovery actions. This has been done in the case of overseas diversion of pharmaceutical and provider frauds. Recovery will continue to be pursued in all cases where such action is judged to be the appropriate course of action.

Recovery ratios - fraud

4.16 A feature of PRD fraud recoveries is the seemingly low ratio of recoveries to estimated leakage through fraud. Recoveries for 1995-96 were $1.1 million, while leakage through fraud was estimated at about $135 million (para. 2.76). In other words, the recovery ratio is around 1 per cent.

4.17 Medifraud typically consists of many fraudulent small transactions, often of the order of $10 to $20, rather than a small number of large transactions. Investigators can be faced with several thousand apparently fraudulent transactions. The technique used is to select 50 or so transactions and collect the evidence necessary to prove that they are fraudulent. The case being prosecuted is systematic fraud.

4.18 A court can order restitution only on charges proved, that is, on the 50 or so transactions selected for prosecution. If the Commission wishes to recover the moneys improperly obtained through the other apparently fraudulent transactions it would have to bring a civil action against the offender. This would require the collection of further evidence and the expense of a further court case. The Commission often decides that a conviction and the consequences that flow from it are satisfactory outcomes.

4.19 Another problem is that many people who have improperly obtained moneys have no income or assets or have transferred their assets into another person's name. In these cases, the Commission has to judge whether likelihood of a successful recovery action justifies the expense.

4.20 This leads to the conclusion that a low ratio of recoveries to estimated fraud leakage by PRD is not necessarily an indication of a lack of success or effectiveness. It underlines, however, the centrality of preventative mechanisms to avoid leakage in the first place.

Recoveries - inappropriate practice

4.21 The recovery of moneys improperly obtained through inappropriate practice can be ordered only by a Determining Officer under the Professional Review Scheme. Administrative support for Professional Review Committees is provided by the Department of Health and Family Services, which is responsible for any recoveries ordered.

Conclusion

4.22 The ANAO concludes that the HIC is seeking to recover moneys improperly obtained from the Medicare and Pharmaceutical Benefits Schemes. However, the systems supporting the recovery process vary widely between States and suffer from some control weaknesses. The ANAO has recommended that the Commission review its recovery procedures.

4.23 Audit Report No.23 1996-97, *Recovery of the Proceeds of Crime*, made recommendations for improving the management of the recovery of moneys obtained through crime. The ANAO believes that the Commission would find this report useful in improving the management of the recovery of moneys obtained through fraud.

The HIC has won a Prime Minister's Innovation Award for its use of Neural Net techniques.

5. Legislation

This chapter discusses privacy provisions in current legislation.

Secrecy clauses

5.1 The secrecy clauses governing the Medicare and Pharmaceutical Benefits Scheme operations of the Commission can be found in the *Health Insurance Act 1973* (Medicare) and the *National Health Act 1953* (Pharmaceutical Benefits Scheme).

5.2 Section 130 (1) of the *Health Insurance Act 1973* reads:

A person shall not, directly or indirectly, except in the performance of his duties, or in the exercise of his powers or functions, under this Act or for the purpose of enabling a person to perform functions under the *Health Insurance Commission Act 1973,* and while he is, or after he ceases to be, an officer, make a record of, or divulge or communicate to any person, any information with respect to the affairs of another person acquired by him in the performance of his duties, or in the exercise of his powers or functions, under this Act.

5.3 Sub-clause (1) is qualified by a further 24 sub-clauses. One of the functions of these sub-clauses is to specify exemptions to 130 (1). These exemptions are summarised below:

- where the Minister certifies that it is in the public interest that information should be released to a person nominated by the Minister, the Secretary or the Managing Director of the Commission may release that information to the nominated person;
- where regulations under the Act authorise the release of particular information to authorities or people named in the regulations, the Secretary or the Managing Director of the Commission may release that information to the named authorities or people; and
- where a person has been convicted of an offence against the Medicare Scheme regulations, the Secretary or the Managing Director of the Commission may release information about that person to:

- the Secretary to the Department of Social Security;
- the Secretary to the Department of Veterans' Affairs;
- State Registration Boards; and/or
- the director, secretary or employee of a registered organisation who is authorised by the Secretary or the Managing Director of the Commission.

5.4 Section 135A (1) of the *National Health Act 1953* is very similar. It is qualified by a further 23 sub-clauses.

5.5 One of the effects of these clauses is that they cover all information held by the Commission on individuals, not just medical information. This is not consistent with the Commission's powers to obtain information, which distinguish between medical information and other information.

5.6 The ANAO found that employees in State offices of the Commission interpret the secrecy provisions as preventing the disclosure outside the HIC of any information on an individual, whether medical or non-medical. They are aware that Central Office has the discretion to authorise release of information. However, the audit team was informed that it can sometimes take considerable time to obtain a decision from Central Office.

5.7 What follows is a brief description of how the Commission interprets the secrecy provisions in the legislation in regard to:

- doctor shoppers;
- pharmaceutical cocktails; and
- impaired practitioners.

Doctor shoppers

5.8 As previously indicated, doctor shopping is the term used to describe people who see a very large number of doctors (over 30 per year) for the purpose of obtaining prescriptions for drugs of dependence. The prescriptions are then filled by a number of pharmacists. In some cases the drugs obtained are sent overseas or sold. In other cases the drugs are for the patient's own use. Where the drugs are sent overseas, ineligible persons are benefiting from the Pharmaceutical Benefits Scheme and inappropriate use of the Medicare Scheme. Where drugs are sold, individuals are profiting from the Pharmaceutical Benefits Scheme.

5.9 Where the drugs obtained are for the patient's own use there are two problems. The first is that Medicare and the Pharmaceutical Benefits Schemes are being used to finance an individual's drug of dependence. The second is that very high drug consumption is likely to lead to further medical problems, requiring further preventable expenditure from the Schemes.

5.10 A pharmacist who suspects that a person is a doctor shopper may contact prescribing doctors and check whether each doctor is aware that the person is obtaining prescriptions for the prescribed drug from other doctors. As well, doctors in consultation with one another may become aware that they are seeing the same patient. Although there is little reliable statistical evidence on these checks, their incidence is probably relatively low.

5.11 Doctor shoppers may qualify for the PBS safety net. Qualification may be through either their receipt of Social Security benefits or the volume of prescriptions incurred. As a result, the Commission knows the identity of high-volume doctor shoppers and which doctors they are seeing. The legislation allows the Commission to tell a doctor that a patient is a doctor shopper and is seeing other doctors.

5.12 As a result of an initiative in the 1996-97 Budget, the Commission is undertaking a project against high-volume doctor shoppers. Finding them can be a problem, as many are very mobile and hard to locate. Another problem is that investigations are costly.

5.13 The Commission reported to the audit team that during 1996 13000 people saw more than fifteen doctors. About 2000 people saw more than one doctor per day.

5.14 An example observed during field work was a doctor from a drug rehabilitation clinic who had a patient who was taking life-threatening quantities of a drug. The doctor asked for the Commission's assistance in identifying the doctors from whom the patient was obtaining prescriptions. Commission staff had the information the doctor was seeking. They believed that because of the secrecy provisions they were unable to help the doctor.

5.15 Central Office staff later informed the audit team that information can be released if it is in the public interest and that this provision is being interpreted broadly. They felt the case quoted should have been referred to Central Office.

Pharmaceutical cocktails

5.16 Another instance where the Commission can be aware of a problem but where it can be difficult to act is in cases relating to what could be called 'pharmaceutical cocktails'. If a pharmacist is presented with a prescription which clashes with another drug the pharmacist knows the patient is taking, the pharmacist is under an ethical obligation to bring the clash to the attention of the prescribing doctor before supplying the drug. This can occur only if the patient uses the same pharmacist.

5.17 The Commission is aware of patients seeing several doctors for different conditions. In some cases, these people are taking incompatible mixes of drugs that will almost certainly lead to a need for further, preventable, medical treatment.

Impaired practitioners

5.18 During our visits to State offices, members of the audit team talked to Commission Medical Advisers and State Medical Registration Boards. One concern raised by both was the ability of a Medical Adviser to act if the adviser had concerns about a practitioner's fitness to practice.

5.19 In discussions with Central Office the audit team was informed that the Commission had notified State Registration Boards of suspected impaired doctors, particularly cases of doctors prescribing addictive drugs for themselves.

HREOC view

5.20 These matters were raised with the Human Rights and Equal Opportunity Commission, HREOC. The latter was of the view that Medicare and pharmaceutical claims information can reveal sensitive and potentially stigmatising details about a person's health and, from a privacy perspective, it would be difficult to argue that

this information should not be highly protected. Although privacy considerations extend beyond secrecy issues, section 130(1) of the Health Insurance Act appeared to incorporate well-established privacy principles. Such principles protected personal information from being used or disclosed for purposes other than those for which the information was originally collected. *The Privacy Act 1988* has similar principles (Information Privacy Principles 10 and 11) limiting the use and disclosure of personal information.

5.21 Both the Health Insurance Act and Privacy Act also set out exemptions to the general rule. These exemptions recognise that there are likely to be some circumstances where the cost to privacy of using and disclosing personal information for secondary purposes would be considered by the Parliament to be outweighed by other public or individual benefits. Safeguards are necessary to ensure that such exemptions are appropriately and responsibly applied, especially if they are 'being interpreted broadly'. This may mean ensuring that the delegation to authorise an exemption is at an appropriately senior level within an organisation, that procedures exist for approving the use or disclosure of information under an exemption, and that decisions to allow an exemption are made on a case-by-case basis. The greater the sensitivity of the information involved, the more important it is to have adequate safeguards and checks built into procedures for authorising exemptions.

5.22 There may be other purposes related to the functions of the HIC where it is desirable to use or disclose only part of the medical information record held about an individual. However, even though this information is only part of the whole record, its sensitivity does not necessarily diminish and nor should the corresponding privacy protections. Information extracted from an individual's health record inappropriately used or disclosed can still be embarrassing, potentially stigmatising, and put the individual at risk of unlawful or unfair discrimination (for example, illnesses that an individual may be suffering can be inferred from a list of medications that have been prescribed).

5.23 It should be noted that, even if non-medical personal information was no longer covered by the secrecy provisions in the Health Insurance Act, this information would continue to be protected under the Privacy Act, and limits on its use and disclosure would remain.

5.24 The HIC's Medicare enrolment data-base with up-to-date name and address information of almost all Australian residents is very valuable and there have been increasing pressures to make use of this non-medical information for purposes not directly related to the administration of the Medicare program. The wider use of Medicare enrolment data including the Medicare number, in the absence of legally binding limitations and safeguards, is a matter of discussion within the community and one about which the Privacy Commissioner has expressed concern.

5.25 In particular, the Privacy Commissioner has suggested that if such pressures continue, consideration should be given to developing a legislative basis with safeguards for the use of Medicare enrolment data including the Medicare number and opening the issue to broader public debate. It is likely that the Commonwealth

Department of Health and Family Services (as the Department responsible for health policy issues) will be giving this issue further consideration in 1997, in consultation with HREOC.

On-line pharmacy systems

5.26 PBS claims from pharmacists are currently processed in batches. As part of the system, each pharmacy has a computer. As each prescription is filled the details of the prescription are entered into the computer.

5.27 Periodically the chemist will download the prescriptions filled onto a floppy disk and send it and a copy of each prescription to the HIC. This will be accompanied by a summary claim. The Commission will then process the claim and pay the pharmacist.

5.28 Pharmacists have several problems with this system. First is the amount of paper the pharmacist needs to handle and store. A second is that the pharmacist must make a decision as to whether the patient is eligible for a subsidy such as the safety net, for example, where a patient claims to hold a Health Care Card from the Department of Social Security. This decision can be countered by the Commission, with the result that the pharmacist does not receive the subsidy that has been allowed to the patient.

5.29 A third problem is that the pharmacist may have reason to believe that the patient is a doctor shopper and/or that the drugs the person is taking are not compatible. Unless the pharmacist's own records supply the needed information there is little the pharmacist can do.

5.30 As a result, the Pharmacy Guild of Australia is keen to see an on-line system installed, similar to a system in operation in British Columbia. With this system each prescription would be entered by the pharmacist into an on-line database maintained by the Commission before the prescription is filled.

5.31 The pharmacist would then be able to determine whether the subsidy claimed by the patient would be paid. The system would also warn the pharmacist if the patient had recently received excessive amounts of the same drug, or if the prescription clashed with other drugs already obtained from other pharmacies. Another advantage of this system is that little or no paper would need to be exchanged between the pharmacist and the Commission in order for a pharmacist's claim to be paid.

5.32 HREOC has advised that, despite numerous safeguards being developed as part of the scheme, the British Columbia Privacy Commissioner remains opposed to it because of its mandatory nature, the risk of unauthorised use or disclosure from the database, the absence of provisions forbidding an employer or third party from requiring people to produce a print-out of their drug profile, and the stigmatising conclusions that can be drawn from the data about pharmaceutical usage.

5.33 HREOC has also pointed out that questions about the scale of deliberate abuse,

whether the proposed solution is proportionate to the problem and alternate ways of targeting people deliberately abusing the Pharmaceutical Benefits Scheme should be considered before a population-wide approach like PharmaNet in British Columbia is taken. Any new proposal should be realistically and independently assessed for its likely cost and benefit implications.

Legislative provision for record retention - EDI

5.34 Pathology laboratories have been able to lodge claims using Electronic Data Interchange for several years. Sections 23DK and 23DKA of the *Health Insurance Act 1973* oblige approved pathology practitioners to keep records in a form specified in regulations and to produce those records on request, with penalties for non-compliance.

5.35 There is no similar legislative requirement for a bulk-billing practitioner submitting claims by EDI to keep copies of the forms which assign the right to receive payment from the patient to the practitioner. The current EDI contract requires practitioners to keep records, but the only enforceable penalty is removal of the right to submit claims by EDI.

5.36 The ANAO has concerns about the lack of an audit trail for bulk-billing doctors who submit claims by EDI (see para. 2.64). The HIC has informed the ANAO that it has sought amendment to the legislation to strengthen the need to obtain documentation to support claims. The ANAO's concern is that, until the legislation is passed, the introduction of EDI for computerised bulk-billing doctors (which the ANAO supports) will increase the risk of fraud.

Clarification of responsibilities

5.37 As the earlier discussion indicated (paras 5.14, 5.15), there is some uncertainty among HIC staff about how they can best implement the privacy provisions in the HIC legislation. Accordingly, the ANAO suggests that the HIC clarify and communicate the responsibilities of staff under the relevant legislation for the release and use of information.

5.38 Of relevance to any clarification are:

- the House of Representatives Standing Committee on Family and Community Affairs inquiries into health information management and telemedicine, and into concession card availability and eligibility for concession; and
- the Australian Pharmaceutical Advisory Council's discussion paper on privacy issues relating to use of medication data to promote quality use of medicine.

Recommendation No. 11

5.39 The ANAO *recommends* that the HIC clarify and communicate the responsibilities of staff under the relevant legislation for the release and use of

information on individuals to ensure equitable treatment and observe privacy requirements.

HIC response

5.40 Agreed. The HIC has a clearly stated policy for education of staff to observe privacy requirements. Delegation of responsibility for release of information is strictly controlled. There are individual instances where the inability to release information in a timely manner may conflict with external requirements, but this must be balanced against the HIC's excellent record in protecting the privacy of the information it holds.

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6. Accountability Mechanisms

This chapter describes the HIC's use of performance indicators in its management of approaches to minimising medifraud and inappropriate practice. As well, the Commission's reporting to stakeholders is examined. Several recommendations for improvement are made.

Key performance objectives

6.1 As mentioned earlier, PRD has a KPO of reducing the relative incidence of inappropriate practice by ten per cent by the year 2000. The KPO is expressed as an index number with the March quarter of 1993 as the base. It is calculated as the ratio of the number of General Practitioners in Neural Net Category 1 (the highest risk classification in a four-class scale - see para. 3.18) to the number of General Practitioners in all categories. If the incidence of inappropriate practice decreases, the index number decreases.

6.2 Achievement against this objective is measured quarterly. The KPO is used solely for internal purposes; progress against it is not reported in the annual report or other public documents. As Table 4 shows (see also para. 3.53), the incidence of inappropriate practice has been increasing. A fuller analysis of the data in Table 4 can be found in Chapter 3.

Table 4

HIC's Achievement of Inappropriate Practice Key Performance Objective (KPO Index)

Quarter	1993	1994	1995	1996
March	100	110	111	125
June	78	113	114	131
September	106	112	118	123[1]
December	110	111	125	n.a.

[1] In September 1996 niche practitioners were excluded for the first time.
See para. 6.5.

6.3 When the KPO was developed the only practitioners on the Neural Net were GPs. Since then Neural Nets have been developed for other specialities. These are not yet used in calculations to estimate the KPO. Therefore, at present, the KPO reflects data for GPs only. GPs accounted for $3.4 billion of the Government's expenditure of $6 billion on Medicare in 1995-96.

6.4 Another issue is that counselling of practitioners by PRD has revealed that approximately one third of practitioners in Category 1 are niche practitioners. These are practitioners who have prescribing or referral patterns that place them in Category 1 but which are appropriate for the type of medicine being practiced. An example is doctors practicing sports medicine, who will have high radiology referrals. This is expected, given the type of injuries being treated.

6.5 At the time of field work, niche practitioners were not excluded from the Category 1 practitioners used to calculate the KPO. If the proportion of niche practitioners in Category 1 is growing this would tend to distort the KPO upwards. The Commission has advised that niche practitioners have been excluded from the KPO from the September quarter 1996.

Recommendation No. 12

6.6 The ANAO *recommends* that the Professional Review Division's key performance objective for inappropriate practice be extended to include specialities recently added to the Neural Net.

HIC response

6.7 Agreed. This has always been the intention of the HIC. Focus has initially been on General Practitioners as the largest "speciality" and the area where inappropriate practice is most likely to be identified. Inclusion of other specialities in the KPO index requires careful management to ensure equity of treatment of the issue across specialities.

6.8 The KPO does not cover PRD activities in investigating and combating fraud and other offences against the Medicare and Pharmaceutical Benefits Schemes. A consequence has been that the development of formal plans and performance indicators for these tasks has been neglected, particularly at a State level. Only one State visited had developed formal plans and performance indicators for counselling, investigations and audits.

6.9 Key performance objectives can be a very useful tool in concentrating management attention on particular business activities. However, unless they are carefully designed they can divert attention away from other important areas. In theory, this problem is easily solved by development of a KPO which reflects PRD's fraud control and investigation activities. Further thought indicates that the development of such a KPO is far from simple. Later in this chapter (para. 6.15) we discuss the further development of performance indicators for PRD's fraud investigation activities.

Performance information

Inappropriate practice

6.10 In addition to recording its achievement against the Divisional KPO, PRD compiles a number of inappropriate practice performance indicators.

6.11 PRD reported to Parliament through the Commission's 1995-96 Annual Report on the following indicators:

- Medical Adviser visits;
- number of Medical Adviser interviews by State;
- number of PSR referrals; and
- repayments from practitioners practising inappropriately.

6.12 These are all input or process measures; the exception is the repayments indicator, which refers to outputs.

6.13 PRD is introducing systems that will provide information on the cost of counselling. It is also examining the possibility of collecting better information on the effect of inappropriate practice counselling and inappropriate practice education programs on leakage.

Fraud

6.14 PRD reported to Parliament through the Commission's 1995-96 Annual Report on the following fraud indicators:

- number of practitioners referred to the Medicare Participation Review Committee (including further action);
- recovery of Medicare benefits (recovered or in the process of being recovered); and
- use of the investigatory powers contained in Part IID of the *Health Insurance Act 1973*.

6.15 The ANAO suggests that any of the following indicators may provide useful additional performance information:

- the number of investigations successfully concluded (guilty verdict, deregistration, punishment, recoveries, etc) compared with the number commenced;
- number of practitioners and members of the public referred for prosecution;
- number of alleged frauds reported over time;
- number of alleged frauds investigated over time;
- number and value of recoveries over time; and
- average estimated value of fraud prosecuted over time.

6.16 PRD is introducing a case management and recording system that will provide information on the cost of fraud investigations.

6.17 Current fraud performance information tends to concentrate on investigations - there is little reporting of PRD fraud education, deterrence or monitoring activities. As well, the audit team observed that there was a lack of performance targets at section level for fraud investigation work in most States visited.

Performance targets

6.18 Each year PRD prepares a Divisional plan which outlines strategies and sets targets for the coming year. The plan links the Division's strategies to the Commission's Mission Statement and objectives. Included in the plan are strategies to address priority areas and the Division's objectives for these priority areas.

6.19 PRD was able to provide the ANAO with information on achievements against targets during the year. However, the processes used to provide this information appeared to be rather informal. An objective in the 1996-97 plan is 'to further develop and implement management information systems to ensure that resources are directed to areas of highest risk'. The ANAO commends and supports this initiative.

6.20 ANAO field work led to the conclusion that Professional Review Branch Managers in the States are given considerable freedom in planning and managing to meet Divisional targets. Field work indicated that only one State visited had developed formal plans and performance targets for all areas of activity for 1996-97.

6.21 Professional Review Branches vary greatly in size from State to State. The detailed plans required in larger States would be unnecessarily detailed in the smallest States. Notwithstanding this, even the smaller States would benefit from the preparation of formal plans and targets for all significant areas of activity.

Recommendation No. 13

6.22 The ANAO *recommends* that Professional Review Division's State Branches prepare annual work plans and targets to ensure staff focus their efforts on the most critical areas of performance and associated accountability.

HIC response

6.23 Agreed. Plans and targets already exist in various formats: more work needs to be done to develop the planning and targeting processes, particularly in relating them to national objectives.

Audit reports

6.24 Professional Review Division conducts Source-Based Audits (see para. 2.71 for a description) and Purpose-Based Audits.

6.25 PBAs are specific in-depth reviews of perceived high-risk areas, designed to

validate a hypothesis. They are targeted audits of problem situations involving a comprehensive assessment of the area of concern. PBAs are integrated with other PRD activities and are one of a number of strategies used to address threats or abuse against the various programs administered by the Commission.

6.26 A PBA can involve the examination of provider profiles, claim documentation and other relevant material. It can also require interviews with patients and providers.

6.27 An example of a PBA is a recent audit of the highest claiming Approved Pathology Authorities (APAs) for four Medicare benefit items. All of the items audited had preconditions that needed to be met before the item qualified for a Medicare Benefit. The results of the audit led to an estimate that, of the $16.8 million of benefits paid for the items audited in 1995, $4.8 million was paid improperly. The audit led to further investigation, counselling and recovery action.

6.28 An audit report is prepared for each PBA. Audit reports are used by PRD as a starting point for investigations and/or recovery action. They are also used by other areas of the Commission to address any weaknesses in processing systems that are identified by the audit.

6.29 Material from the reports may also be passed to the Department of Health and Family Services if the audit finds weaknesses in the Medicare or Pharmaceutical Benefits schedules. Pertinent details may also be passed to the Department of Finance. The results of PBAs can also be discussed with other interested bodies. For instance, the results of a recent pathology audit were discussed with the Royal College of Pathologists of Australasia. Some results are also reported in Medicare Forum, as is the intent to conduct audits.

6.30 Currently PBA reports are not distributed more widely. Responses from stakeholders (see para. 7.5) are critical of the Commission for not providing feedback on action taken in response to complaints laid by stakeholders. PBAs are one of the methods used by the Commission to respond to information from stakeholders. The ANAO suggests that a wider distribution of PBA reports or their summaries during the year would be one way of better informing stakeholders.

6.31 PBA reports contain confidential information. In many cases the Commission may be able to publish only a summary of the report. The ANAO believes that even this would be useful.

Recommendation No. 14

6.32 The ANAO *recommends* that Professional Review Division publish reports on the results of Purpose-Based Audits to better inform stakeholders of Commission activities to combat fraud as part of its accountability for better performance.

HIC response

6.33 Agreed. The HIC intends to produce de-identified reports of Purpose Based Audits for distribution to stakeholders. Additionally, where appropriate, the HIC

will publicise the outcomes from PBA's in the Annual Report and in the professional media.

Reports to stakeholders and Parliament

6.34 The HIC uses a number of methods to report to Parliament and other external stakeholders. These include:

- an annual report to Parliament;
- briefings to Parliamentarians and other stakeholders as required; and
- reports at regular intervals to the Department of Health and Family Services on programs funded by the Department.

6.35 Information provided on PRD's activities in the Commission's Annual Report is detailed in paras 6.11 and 6.14. This does not include information on progress against PRD's inappropriate practice KPO. The Annual Report does not contain any indication of the magnitude of leakage through fraud or the magnitude of inappropriate practice and the savings achieved through counselling.

6.36 The 1995-96 Portfolio Budget Statement for Human Services and Health contained little information on PRD inappropriate practice or PRD fraud control activities.

6.37 Briefings are provided to Parliamentarians and stakeholders as requested or when appropriate. Further comment on communications between the Commission and stakeholders can be found in Chapter 7.

6.38 As well as the reports at regular intervals mentioned above, PRD also briefs the Department as required.

6.39 The information contained in PRD's inappropriate practice KPO is of interest to external stakeholders. The ANAO believes that the Commission should report progress against the KPO in its Annual Report.

Recommendation No. 15

6.40 The ANAO *recommends* that the Commission report progress against the inappropriate practice key performance objective in the Commission's Annual Report as part of its performance assessment.

HIC response

6.41 Agreed. The development and testing of the Inappropriate Practice KPO has required considerable research and management development. The HIC believes that the KPO is now at a stage where it can be published and explained along with the more easily understood and measured indices of performance.

Prosecutions

6.42 Stakeholders consulted were critical of the seeming lack of action by the Commission after apparent breaches of the legislation were reported to it (para. 7.5). The ANAO noted that the Commission's 1995-96 Annual Report had no information on the number of investigations for fraud and the number of referrals to the DPP for prosecution. The ANAO sought information from the Commission on:

- the number of referrals to the DPP for prosecution for both the public and providers; and
- the number of successful prosecutions, again for the public and for providers.

6.43 This information, when received, was compared with information in the Commission's 1994-95 Annual Report. The two sets of information did not match.

Table 5

Prosecutions for fraud

Outcome	**1993-94**	**1994-95**	***1994-95 Annual Report***	**1995-96**
Public				
Referred to the DPP for prosecution	24	24	*167*	35
Successful prosecutions	45	25		30
Providers				
Referred to the DPP for prosecution	14	6	*41*	13
Successful prosecutions	12	4		4

6.44 The Commission stated that the data in the 1994-95 Annual Report had been obtained by a poll of State Offices. The other data had been obtained from PRD management systems. Given the interest by stakeholders and the complaints about lack of prosecution activity, the ANAO considers that it is essential for the Commission to have accurate data on at least:

- the number of fraud investigations undertaken;
- the number of cases referred to the DPP for prosecution;
- the number of successful prosecutions; and
- reasons for non-successful prosecutions.

6.45 Both Central Office and State Offices have a responsibility to ensure that data in management systems is both accurate and readily available. The ANAO acknowledges that once a case is referred to the DPP decisions on that case are a

matter for the DPP, not the Commission. Nevertheless, the ANAO considers that knowledge of the number of successful prosecutions is important management information.

Recommendation No. 16

6.46 The ANAO *recommends* that, to make its antifraud strategy more effective, the Commission collect accurate data on:

- the number of fraud investigations undertaken;
- the number of cases referred to the DPP for prosecution;
- the number of successful prosecutions; and
- reasons for non-successful prosecutions.

HIC response

6.47 Agreed. The HIC operates systems which collect all this information on a monthly basis. The HIC recognises that the timeliness and accuracy of this data collection can be improved.

Benchmarking

6.48 The ANAO considers benchmarking an important management tool. We saw no indication that PRD was making use of this technique. We suggest that PRD examine the possibility of the benchmarking of key processes. This can be done either internally (over time and/or between States) or against another organisation performing similar tasks. An example already commented on would be recoveries - see Chapter 4.

Summary

6.49 Professional Review Division has developed a key performance objective and a range of performance indicators. The Division is still refining these indicators. The problems PRD is facing are not unique - they are being tackled across the Australian Public Service (see Audit Report No.25 1995-96 *Performance Information, Department of Employment, Education, Training and Youth Affairs).*

6.50 The ANAO observed that the PRD had a number of effectiveness indicators but that there needed to be a greater emphasis on efficiency indicators to maintain balance.

6.51 The ANAO suggests that Audit Report No.25 1995-96 and the Better Practice Guide, *Performance Information Principles*, developed from that report may be of use to PRD.

Conclusion

6.52 The results of the audit test program have led the ANAO to conclude that Professional Review Division has internal and external accountability measures in place. The results of the test program have also led the ANAO to conclude that improvement in internal and external accountability measures is both possible and desirable. In reaching this conclusion, the ANAO acknowledges the measures under way within PRD to improve performance information and accountability.

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7. Stakeholders

This chapter provides a summary of the views expressed by stakeholders interviewed during the audit.

Background

7.1 As part of the audit testing, the ANAO consulted a number of stakeholders. These were organisations whose members may be subject to investigation or counselling by the HIC for fraud or inappropriate practice.

Those consulted

7.2 Stakeholders consulted included:

- Australian Medical Association;
- Australian Association of Pathology Practices;
- Doctors' Reform Society;
- Health Issues Centre;
- Pharmacy Guild of Australia; and
- Royal College of Pathologists of Australasia.

Comments

Support for Professional Review Division

7.3 All stakeholders consulted supported the efforts of PRD to combat leakage from the Medicare and Pharmaceutical Benefits Schemes through fraud and inappropriate practice. This is consistent with stakeholder comments in the ANAO's audit of the Commission's use of enhanced investigatory powers (Audit Report No.24 1995-96, *Impact of Sunset Clause on Investigatory Powers*).

7.4 While stakeholders supported the Commission and PRD, there were aspects of PRD's activities where stakeholders sought improvement.

Feedback to stakeholders

7.5 A common theme propounded by stakeholders was a seeming lack of action by PRD after apparent breaches of legislation were reported to it and after the HIC provided case material to the Director of Public Prosecutions. Chapter 6 discusses information provided to stakeholders and makes recommendations for improvement.

7.6 A limit on the Commission's ability to provide feedback to all complainants, including stakeholders, is the Commission's obligation to observe due process. Even if the Commission believes that a person or a company has committed an offence, until the evidence has been tested in court the Commission can do no more than allege that an offence has been committed. If a professional reputation is at stake the Commission is quite properly reluctant to release information which has not been tested in court and which may damage that reputation.

7.7 The audit team sought comment from State Offices of the DPP on liaison between the HIC and the DPP and the quality of the briefs presented by the HIC. As mentioned in para. 2.18, the HIC involves the DPP as soon as it becomes apparent that fraud has occurred. DPP State Offices visited during field work had no complaints about HIC liaison or the quality of HIC briefs.

7.8 The audit did not examine how the DPP used briefs from the HIC. In view of the criticisms by stakeholders of what they believed was a small number of prosecutions, there would be value in a review of the links between the DPP and the HIC.

HIC contact with doctors

7.9 The AMA and the Doctors' Reform Society both reported that members had complained that counselling interviews could be very intimidating. A necessary component of any strategy to combat fraud or inappropriate practice is deterrence. The Commission has to strike a fine balance between deterrent action which has sufficient vigour to be effective and action which is so vigorous that it ceases to be deterrence and becomes intimidation. It should be noted that in Chapters 2 and 4 the ANAO is encouraging the Commission to increase fraud deterrence efforts.

7.10 The AMA submission also stated that many doctors were not aware that the Commission has the ability to monitor Medicare and Pharmaceutical Benefits expenditure by individual doctors. This highlighted the importance of the HIC continuing to provide information to the AMA and to other professional bodies about its work, and to intensify that communication and liaison. It is encouraging that stakeholder submissions also indicate a desire for better communications.

Education programs

7.11 Stakeholders expressed support for the education activities of the Commission (para. 3.12). However, views were expressed that the Commission should put more effort into educating practitioners on the roles and activities of the Commission, particularly PRD.

Other matters

7.12 Other matters raised in discussions with stakeholders included:

- estimates of the value of leakage through fraud and the magnitude of inappropriate practice; and
- impact of secrecy provisions.

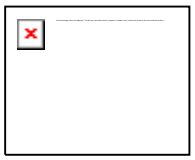
7.13 Secrecy provisions are discussed in Chapter 6, while estimates of the value of leakage are discussed in Chapters 2 and 3.

PRD liaison with stakeholders

7.14 PRD commented that it seeks quarterly meetings with all major stakeholders. PRD also offers briefings to stakeholders as required.

Conclusion

7.15 The HIC has considerable support amongst stakeholders for its efforts to combat leakage from the Medicare and Pharmaceutical Benefits Schemes through fraud and inappropriate practice. However, stakeholders wish to be better informed on PRD activities. They have also indicated their willingness to cooperate with the HIC and other government authorities to achieve improvements to the means used to combat fraud and inappropriate practice.



P. J. Barrett
Auditor-General

Canberra ACT
13 May 1997

Appendix 1.
Implementation of Recommendations from *Medifraud and Overservicing,*
(ANAO Report No.17, 1992-93)

One of the objectives of this audit was "to report to Parliament on the HIC's implementation of the major recommendations from Audit Report No.17, 1992-93". The table below gives the ANAO's comments on the HIC's implementation of each of the major recommendations.

Report No. 17 Rec.	Recommendation	ANAO comment

No.		
2	The ANAO recommends a review of the current MSCI process. Consideration could be given to implementation of an independent Medical Benefits Tribunal to deal with gross levels of overservicing. The Tribunal should be chaired by a judge and include one lay person and two medical practitioners of the same speciality as the practitioner referred to the Tribunal. A Tribunal would be specially constituted for each case referred to it.	The MCSI process has been replaced with Professional Services Review Committees. While the ANAO suggested a tribunal, the new system addresses our concerns, including removing the right for the practitioner to be legally represented, access to information, and reporting deadlines.
3	The ANAO recommends that the Commission's legislative powers be enhanced and apply equally to all Medicare providers and to fraud committed by the public so as to allow the effective prosecution of all Medicare offenders. The Commission should also consider pursuing the following approaches: the possibility of dealing directly with the DPP, particularly if the Commission's investigation and prosecution powers are increased; the formation of multi-disciplinary teams to investigate major fraud; and the General Manager to have the authority to prosecute cases.	The testing conducted as part of the 'Impact on Sunset Clause on Investigatory Powers' (Report No.24 1995-96) has allowed the ANAO to conclude that this recommendation has been implemented. In place - the HIC liaises closely with the DPP where required. This is occurring where required. Prosecutions are conducted by the DPP.
5	The ANAO recommends that Medicare Benefits Schedule items numbers and a description of the services should appear on all accounts and assignment forms and should be a legal requirement for the payment of benefits. The addition of the description as well would assist greatly in any investigation into fraud and/or overservicing and guard against mis-itemisation.	Item numbers or descriptions are now required.
6	The ANAO recommends that the Commission: compile a comprehensive privacy policy that clearly delineates the boundaries of the *Privacy Act 1988*; seek ways to liaise with private health funds, and medical bodies without compromising the privacy legislation and guidelines; obtain advice as to the application of the privacy legislation and guidelines to the operations of Medibank Private; and review the role Medibank Private can play within industry associations and fraud detection units.	In place. In place. In place. In place.
7	The ANAO recommends that computer matching of data be implemented where there is a definite indication of fraud. One solution to overcome privacy concerns may well be to establish or have one Government agency (the Institute of Health and Welfare) collect all medical data (Medicare, Medibank Private, private health funds, State health expenditure, etc). This would enable analysis of all government and private health expenditure in Australia for both	Computer matching of data has been the subject of correspondence between the HIC and the Privacy Commissioner. The HIC informs clients that information provided could be passed to DHFS, DSS and DVA. Current legislation limits access to clinical records in hospitals in relation to

	research and investigation purposes, and expose more easily those who are defrauding the system.	the collection of evidence for investigations. As well, there are restrictions in the exchange of information with State Medical Registration Boards, again due to legislative constraints.
9	The ANAO recommends that the Commission consider the following: the benefits of having a mechanism for formal liaison between Medibank Private and other private health funds in relation to the detection of fraudulent claims; the exchange of information with the funds and other government agencies of past prosecuted cases and current investigations; and the possibility of establishing a joint approach to the investigation and prosecution of fraudulent cases that may affect more than one health fund.	In place. In place. In place.
10	The ANAO considers that where a person receives a benefit from the Commonwealth, the Commonwealth should be able to use all information at its disposal to ensure the benefit paid is valid. As a privacy safeguard, the ANAO recommends that before matching of data takes place, the terms of agreement between the two data matching agencies be made public. The agreement would specify the purpose, authority and circumstances under which data matching would occur. The Privacy Commissioner should approve all agreements, audit the agreements to ensure they are complied with and take action against any transgressions of the agreement.	There has been extensive liaison between the HIC and the Privacy Commission in these matters. The public is informed that information provided to other government agencies may be used by the HIC for specific data-matching purposes.
17	The ANAO recommends that the Commission implement the recommendations of the consultant as soon as possible. The cooperation of the medical profession and the Department of Health, Housing and Community Services should be sought in implementing recommendations that need their assistance.	The evidence gathered for Report No. 24 1995-96 and this audit has led the ANAO to conclude that the recommendations of the consultant have been implemented.

Appendix 2.
Audit Objectives and Findings - Prior Audits

Audit Report No. 24 1995-96, *Impact of Sunset Clause on Investigatory Powers*

Audit objective

1. The objective of the 1996 audit was to prepare an assessment for Parliament on the HIC's implementation of the *Health Legislation (Powers of Investigation) Amendment Act 1994,* including the impact on the Commission's ability to investigate and prosecute offences.

Key findings

2. The ANAO concluded that:

- the enhanced powers to investigate fraud and excessive servicing had improved the Commission's ability to conduct investigations and prepare prosecutions. The ANAO considered that without powers of this kind the ability of the Commission to conduct investigations and prepare prosecutions would be impaired. This view was been supported by stakeholders consulted during the audit; and
- the Commission was using the enhanced powers in accordance with the legislation and in a professional manner.

3. Audit Report No. 24 contained one recommendation.

Audit Report No. 17 1992-93, *Medifraud and Overservicing*

Audit objectives

1. The objectives of the 1992-93 audit were to assess the Commission's management of :

- the investigation of suspected cases of abuse;
- prosecution of fraudulent activities conducted against the Medicare, Pharmaceutical Benefits Scheme and Medibank Private programs; and
- the resources available to the investigation function and whether they were sufficient to provide an efficient and effective mechanism for the monitoring of abuses of medical and health services. Those services were provided under the Health Insurance Commission legislation.

Findings

2. The key findings from the original audit were as follows:

- there was a lack of prosecutions and disciplinary action taken against unethical practitioners. The performance of the Commission, with the exception of that over the previous twelve months, showed little improvement compared with that of the Department of Health in the early 1980s;
- the Commission's legislative powers to combat fraud and excessive servicing were deficient in regard to the investigation and prosecution of unethical medical providers;
- Medical Services Committees of Inquiry, the main disciplinary bodies, were not operating effectively. They needed to be made more effective or replaced with a Tribunal;
- the growth in Pathology Benefits had slowed to the extent that there was a marginal decrease in expenditure in 1991-92 compared with that in 1990-91. However, Diagnostic Imaging expenditure was still escalating, increasing from $470 million in

1989-90 to $550 million in 1990-91 and to $595 million in 1991-92; and

- the ability to release information for investigation was important in preventing medifraud. The Commission was reluctant to fully utilise its powers under the Health Insurance Act because of uncertainty about the effect of privacy legislation. A comprehensive policy was needed.

3. Audit Report No.17 1992-93 included 17 recommendations addressing these findings.

Appendix 3.
Audit Criteria

Introduction

1. Audit criteria encapsulate auditors' expectations of sound management and administration. The audit then tests to determine whether these expectations or criteria are met.

2. The audit used two levels of criteria. The first level was designed to allow the ANAO to comment on the management of the Commission's exposure to fraud and inappropriate practice. The second-level criteria were designed to allow the ANAO to comment on PRD's management of approaches to fraud and inappropriate practice. The second-level criteria were the basis for arriving at an opinion on the first-level criteria.

First-level criteria

3. The first-level criteria were:

- the HIC has identified and analysed all risks to invalid payments against the Medicare and Pharmaceutical Benefits Schemes;
- the HIC has assessed and ranked the risks; and
- the HIC has taken steps to control those risks.

Second-level criteria

4. There were two sets of second-level criteria, one set addressing fraud and the other inappropriate practice.

5. The criteria were:

Fraud

- There is a fraud risk assessment which:
  - identifies risk;

- analyses risk; and
- assesses and ranks risks.
- There is a fraud control plan, which reflects the fraud risk assessment;
- The plan is consistent with CLEB guidelines and with the principles contained in the 1987 report, 'Review of Systems for dealing with Fraud on the Commonwealth', by the Special Minister of State;
- The plan gives directions/yardsticks for the conduct of cases;
- There are appropriate accountability measures in place;
- The fraud control plan is implemented efficiently and effectively; and
- Professional Review Branches in State Offices are running efficiently and effectively and have appropriate accountability measures in place.

Inappropriate practice

- There is a risk assessment of the probability of inappropriate practice which:
- identifies risk;
- analyses risk; and
- assesses and ranks risk.
- There is an inappropriate practice control plan, which reflects the risk assessment;
- The plan is consistent with CLEB guidelines and the principles contained in the 1987 report, 'Review of Systems for dealing with Fraud on the Commonwealth', by the Special Minister of State;
- The plan gives directions/yardsticks for the conduct of cases;
- There are appropriate accountability measures in place;
- The inappropriate practice control plan is implemented efficiently and effectively; and
- Professional Review Branches in State Offices are running efficiently and effectively and have appropriate accountability measures in place.

6. The criteria are based on the *Fraud Control Policy of the Commonwealth* issued by CLEB and the principles contained in the 1987 report, 'Review of Systems for dealing with Fraud on the Commonwealth', by the Special Minister of State.

Appendix 4.

Performance Audits in the Health and Family Services Portfolio

Set out below are the titles of the reports of the main performance audits by the ANAO in the Health and Family Services Portfolio tabled in the Parliament in the past three years.

Performance audits relevant to the Human Services and Health Portfolio

Audit Report No.42 1993-94
Mind the Children
The Management of the Children's
Services

Audit Report No.5 1995-96
Provision of Hearing Services
Australian Hearing Services

Audit Report No.14 1995-96
The Sale of CSL
Commonwealth Blood Product
Funding and Regulation

Audit Report No.18 1995-96
Impact of Sunset Clause on Investigatory
Powers
Health Insurance Commission

Audit Report No.19 1994-95
Validation of Nursing Home Funding
Department of Human Services and Health

Audit Report No.12 1995-96
Risk Management by Commonwealth
Consumer Product Safety Regulators

Audit Report No.18 1995-96
Competitive Employment, Training and Placement Services
Department of Health and Family Services

Audit Report No.8 1996-97
Drug Evaluation by the Therapeutic Goods Administration
Department of Health and Family Services

Other relevant audit reports

Audit Report No.6 1993-94
An Audit Commentary on Aspects of
Commonwealth-State Agreements

Audit Report No.16 1994-95
Specific Purpose Payments to and
through the States and Territories

Audit Report No.28 1993-94
Department of Veterans' Affairs
Use of Private Hospitals

Audit Report No.6 1996-97
Commonwealth Guarantees, Indemnities and Letters of Comfort