Finding the right balance: Medicare Compliance Audits

Submission to the Senate Community Affairs Committee Inquiry into Compliance Audits on Medicare Benefits

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Peter Dodd, Solicitor – Health Policy and Advocacy

Level 9, 299 Elizabeth Street, Sydney NSW 2000 • DX 643 Sydney
Phone: 61 2 8898 6500 • Fax: 61 2 8898 6555 • www.piac.asn.au

1. Introduction

1.1 The Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights;
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from the NSW Government Department of Water and Energy for its work on utilities, and from Allens Arthur Robinson for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

1.2 PIAC's work on health and privacy

PIAC has undertaken a considerable amount of work on patient or health care rights over its 26 years of operation, in particular around patient safety, complaints and investigations processes and the development of an Australian Health Consumers' Charter.

PIAC welcomed the endorsement of the Australian Charter of Healthcare Rights by the Australian Health Ministers in July 2008. PIAC participated in the consultation process that led to the Commission's draft charter, including providing a written submission in response to the Consultation Paper on the draft charter.

PIAC also made a submission to the Senate Select Committee on Medicare in 2003.

PIAC has a long history of interest in, and concern about, the appropriate protection of privacy rights within both the public and private sectors. PIAC has been a strong advocate for the protection of the privacy rights of Australians, particularly the rights of individual Australians to control their personal information and to be free of excessive intrusions. PIAC's work as a consumer advocacy organisation, particularly in relation to health matters, has required PIAC to consider privacy issues because they are frequently a matter of concern to people who contact the Centre.

PIAC Chief Executive Officer, Robin Banks, is a member of the Privacy Advisory Committee (PAC), which provides strategic advice to the Federal Privacy Commissioner on privacy issues and the protection of personal information.

1.3 Overview

PIAC welcomes the opportunity to make a submission to this Inquiry. PIAC notes that the terms of reference of the Inquiry are for the Committee to inquire into and report on:

> Any Government proposal to implement the Government's announced 2008-09 Budget measure to increase compliance audits on Medicare benefits by increasing the audit powers to Medicare Australia to access the patient records supporting Medicare billing and to apply sanctions on providers.[1]

PIAC, in making this submission has accessed the exposure draft for the proposed Health Insurance (Compliance) Bill 2009 (Cth) (the Bill) as well as the Explanatory Material document circulated about the Bill.[2]

In the Explanatory Material, the possible impact of the Bill on health information privacy is acknowledged.[3] Further, it is acknowledged that a notice to produce served on a Medical Practitioner as envisaged in the Bill, may involve the disclosure of information from a patient medical record to Medicare Australia.[4]

PIAC notes that in consequence of this, the Increased Medicare Benefits Schedule (MBS) Compliance Audits Initiative (the IMCA initiative) has triggered a Privacy Impact Assessment (PIA) process.

PIAC notes the key issues identified in the PIA and will respond to each of these key issues individually.

The key issues identified in the Explanatory Material[5] are:

1. The collection of information: what kind of information is required, under what circumstances and whether it is possible to use de- identified information.

2. Use of information collected during a compliance audit.

3. Reporting requirements: whether Medicare Australia should be required to provide information in their Annual Report on how often information from patient medical records is provided during a compliance audit.

4. Review mechanisms to ensure that the benefits of requiring information to be provided to substantiate a Medicare benefit paid in respect of a service continue to outweigh the privacy impacts.

5. Patient notification: whether patients should be notified individually when information from their medical record is provided to Medicare Australia during a compliance audit.

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1 Inquiry into Compliance Audits on Medicare Benefits, *Terms of reference* (2009) <http://www.aph.gov.au/Senate/committee/clac_ctte/medicare_benefits_compliance_audits/tor.htm> at 24 April 2009.

2 *Exposure Draft of the Health Insurance Amendment (Compliance) Bill 2009 and Exposure Draft of the Health Insurance Amendment (Compliance) Bill 2009 Explanatory Material* (2009) <http://www.health.gov.au/internet/main/publishing.nsf/Content/exp-draft-HIA-bill2009> at 24 April 2009.

3 *Exposure Draft of the Health Insurance Amendment (Compliance) Bill 2009 Explanatory Material* (2009) [10] <http://www.health.gov.au/internet/main/publishing.nsf/Content/exp-draft-HIA-bill2009> at 24 April 2009.

4 Ibid 11.

5 Ibid.

2. Competing public interest principles involved

PIAC recognises that the draft Bill raises two potentially competing public interest principles.

The first is the public interest that Australian consumers have in the maintenance and integrity of Australia's universal health scheme, Medicare. Medicare is rightly praised for providing universal access to general health care (although sadly, not oral health care) to all Australian citizens and permanent residents. The integrity of the scheme is threatened by any fraud or dishonesty by health practitioners who participate in the scheme. Fraud and dishonesty add to the cost of Medicare, which is ultimately borne by consumers as taxpayers.

PIAC notes that compliance audits do not assess whether a service was clinically appropriate. Nevertheless, consumers do not benefit from under-servicing (where the service is not provided) or over-servicing if it derives from what has been described a 'sausage machine' medicine where standards are lowered in order that more patients are seen and therefore more income generated from Medicare. The latter is often, although not always, generated by a profit motive.

The private/public partnership of Medicare depends on the integrity of individual health practitioners and private health providers such a medical centres, hospitals and day treatment centres. Unfortunately not everyone has the same level of integrity, and it is in the clear interests of consumers for there to be a system of accountability, of which PIAC recognises that compliance audits are an important part.

On the other hand, there is a distinct public interest principle in the confidentiality of communications within the doctor/ patient relationship that are recorded in the medical records of patients. The principle of confidentiality of patient records long precedes the adoption of privacy laws in countries like Australia. Commonwealth, state and territory privacy laws protect medical information about health consumers by applying general privacy principles about the collection, storage, disclosure of health information as well as access to that information.

PIAC submits that the principle that patient medical records are totally confidential and that medical records should be provided with the same stringent protection as other sensitive information under privacy principles and privacy laws is a fundamental one.

There is an addition reason why there is a clear public interest principle in the maintenance of confidentiality of personal medical records. Quoting the Federal Privacy Commissioner:

> There is a risk that people will be discouraged from seeking medical assistance, particularly for conditions to which a stigma is attached, if they do not have confidence that they have control over who has access to their medical information. This could mean that some people will not seek assistance for some conditions. Or people may decide not to reveal sensitive but pertinent aspects of their symptoms or conditions to a health practitioner and this might have an adverse impact on the accuracy of the diagnosis or the appropriateness of treatment. This, in turn, impacts on both the individual and community - particularly if the condition is progressive or infectious.[6]

However it clearly is not an absolute principle. In Australian privacy legislation there are exceptions to the general principle that an individual's medical records cannot be disclosed to another person, organisation or corporate body, without that individual's consent. Few would object to patient records being accessed without the patient's permission when the patient is unconscious and needing urgent medical intervention to save their life. Australian privacy legislation also provides, reasonably uncontroversially, that there are certain

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6 Office of the Privacy Commissioner, *Issues Paper: Review of Medicare and PBS Privacy Guidelines* (2004) [15-16] <http://www.privacy.gov.au/consultation/ispaphealth.pdf> at 23 April 2009.

situations where an individual's medical information is seen or accessed by different persons, within a large health organisation, not always with the individual's express consent.

PIAC notes that medical records of individual patients have, as long as modern practices of litigation have existed, been subject to *subpoena* by Courts and Tribunals. PIAC also notes that in NSW, section 34A of the *Health Care Complaints Act 1993* (NSW) and section 69B of the *Medical Practice Act 1992* (NSW) gives the Health Care Complaints Commission and the Medical Board respectively, the power to access medical records of individuals in the course of assessment and/or investigation of health complaints. PIAC notes that the use of powers of *subpoena* has very recently come under criticism in sexual assault cases.[7]

The significant issue for PIAC is whether the draft Bill and the procedural practices that will flow if the Bill becomes law, appropriately balance the two potentionally conflicting principles of maintaining the integrity of Medicare and the importance of maintaining confidentiality of medical records. PIAC agrees that the issues raised by the PIA and referred to above, reflect the appropriate questions that arise from the conflict of these two important principles.

PIAC notes that there have been recent calls for the patient not only to be notified when their information is provided to Medicare Australia but also that the consent of the individual patient be required before the information can be accessed by Medicare Australia for the purpose of a compliance audit. PIAC comments on this proposition in this submission.

3. Collection of information and de-identified information

PIAC accepts that practitioners will, in some circumstances, be required to produce documentation that contains clinical information about a patient. PIAC notes the Explanatory Memorandum states:

> Clinical information will only need to be provided if that information is necessary to verify that a payment was properly made.[8]

PIAC submits that the audit process should be a multi-step process that ensures that a separate decision is made to determine whether the collection of clinical information is necessary for the audit process and in the public interest (see below).

3.1 De-identification

PIAC is of the strong view that if any personal information can be de-identified without undermining the integrity of the audit process or affecting the strength of evidence required, then it should be de-identified.

PIAC submits that, in the conduct of any subsequent prosecution or disciplinary proceeding flowing from an audit, any information that has the potential to identify and/or breach the confidentiality of patient records should be de-identified, unless the court or tribunal hearing the matters believes there are compelling reasons not to do so. This certainly occurs now in matters before medical disciplinary tribunals. An obvious exception would be in matters where it has been proven in a court or tribunal that the patient was a party to or an accessory to the alleged fraud or other misconduct.

Most, if not all, courts and tribunals have either express or inherent powers to make suppression orders in relation to the reporting of confidential information about third parties and witnesses, including the identity of individuals and in this case, the details of medical records.

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7 ABC News, *Calls mount for sex assault privacy reforms*, AM, 17 April 2009 <http://www.abc.net,au/news/stories/2009/04/17/2545213.htn?site=local> on 21 April 2009.

8 *Exposure Draft*, above n3, 19.

PIAC notes that in its recent media release on the area of the Inquiry, the Australian Medical Association (AMA) says that the Bill:

> … reverses current legal protections for patient privacy, ensuring that no part of the patient record is protected. The patient record will be completely exposed, extracts obtained, copied, retained and potentially submitted in court for all to see.[9]

PIAC sees nothing in the draft Bill or Explanatory Memorandum that suggests existing practices, as outlined above, will be overturned, and finds no evidence to suggest that the drastic outcomes predicted by the AMA would occur unless there are other significant changes in the future to existing Australian law and practice not found in the Bill in question.

PIAC does have concerns that, given the important public interest in maintaining confidentiality and privacy of medical records, there ought to be systems in place to prevent unlawful or non-essential disclosure of health privacy information in the audit process.

In this regard, PIAC notes the contents of section 130 of the *Health Insurance Act 1973* (Cth) ('officers to observe secrecy') that prohibits the unauthorised disclosure of personal information by Medicare employees and imposes sanctions by way of fines on breaches of the provisions in this section. Consideration should be given to ensuring that individuals affected by such a breach have a right of action for damages against Medicare and the individual employees.

PIAC also notes the *Privacy Guidelines for Medical Benefits and Pharmaceutical Benefits Programs*[10] issued by the Federal Privacy Commissioner on 6 March 2008. The *Explanatory Memorandum* indicates that the Privacy Commissioner is working with Medicare Australia on the PIA. PIAC submits that any concrete proposals to enhance confidentiality and privacy of medical records in the audit process should be implemented either through legislation and/or in revised Privacy Guidelines as above.

PIAC notes that the safeguards referred to above provide a higher level of protection to the privacy and confidentiality of personal health information held by Medicare Australia than the protection afforded similar information held by the private sector.

4. Use of information during a compliance audit

PIAC recognises that, in certain situations, the use of otherwise confidential patient records would be essential to prove, to the appropriate standard, that fraud or misconduct within the Medicare system has occurred. The converse could also be the case where the patient records indicate that a health professional's conduct that is under suspicion does not reveal fraud, overservicing or dishonesty.

An audit could reveal systemic problems within a medical practice, the resolution of which could be to the mutual advantage of the health practitioners concerned and Medicare, as well as patients and consumers.

5. Reporting requirements

PIAC supports a high level of transparency in the audit process, given the potential for unlawful or non-necessary disclosure of confidential health information.

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9 Australian Medical Association, 'Government set to strip privacy protection from patient records' Media Release, 15 April 2009 <http://www.ama.com.au/node/4568> at 24 April 2009.

10 Available at <http://www.privacy.gov.au/health/guidelines/#2.8> at 24 April 2009.

PIAC supports the inclusion of as much de-identified information about the audit process as is practicable in Medicare's Annual Report, as well as reporting on the frequency of the obtaining of patient records during the audit process.

Of course, all of this is subject to stringent review before any form of publication to ensure that the individual, whose medical records have been accessed, cannot be identified through there being too many characteristics of the individual or their situation included.

6. Review mechanisms

PIAC supports the introduction of review mechanisms within the audit process to ensure that no unnecessary personal health information is collected and used in the audit process. The process should have several steps.

One step would be to determine whether there was a 'reasonable concern' about the conduct of the health practitioner. If 'reasonable concern' is found, and it is proposed that obtaining patient records is the next necessary step in the process, the reasons that accessing the medical records is necessary should be drafted in a submission and the decision whether to obtain the records should be made on the basis that there is no alternative way to obtaining the information to continue the investigation and that continuing the investigation on this basis is in the public interest. This decision should be made by a senior officer or officers, delegated by the Medicare CEO, who has a thorough understanding of privacy principles and who does not have direct involvement in or oversight of the particular investigation.

Under no circumstances should access to patient records be allowed to become a routine part of every audit process and the necessary mechanisms should be set up to prevent this occurring.

PIAC also submits that an internal review of the decision to request records should take place if a consumer objects to their records being used in this way (see below).

7. Notification of patients when their health records are accessed

PIAC supports the principle that patients should be informed when their records are accessed for audit purposes. However, PIAC recognises the practical difficulty of achieving this in every case.

PIAC notes that there are certain areas where fraud and dishonesty in the Medicare system are more likely to take place to the detriment of health consumers. Examples of these are in the large medical centres and in the provision of GP visits to aged-care facilities. In the former, there is always the potential of overservicing, to the detriment of the quality (and quantity in terms of time) of care provided. In the latter, where the patients may suffer from dementia or physical frailty, and the level of scrutiny is low, the potential for over servicing, together with low levels of care provided to individual patients, is higher than in the setting of a GP's surgery.

In both these situations, advising the patients that their records have been accessed for audit purposes may be problematic. In the case of aged persons with dementia or related conditions, a guardian or 'person responsible' is likely to be recorded on the aged-care facility's files but less likely on the doctor's files. In the case of larger medical centres, these are often used by consumers for low-level weekend emergencies, and more often by consumers who are more regularly change their residential address and, as a result, have no long-standing relationship with a GP. Medicare may have access to a more recent address through the consumer's Medicare Card number but this raises further privacy concerns through data matching.

PIAC submits that, unless there is evidence of patient collusion with the doctor's suspected conduct, all patients should, in the normal course of events, be advised of the access of their medical records for audit purposes. However, for the practical reasons stated above, PIAC would not support the proposition that an audit should not go ahead if notification has not been successful or is not practicable.

8. Should an individual be required to consent for an audit to go ahead if their patient records are accessed?

PIAC does not support the proposition that an individual be required to consent for an audit to go ahead if their patient records are accessed.

As set out above there can be very real practical difficulties in contacting patients or their alternative decision makers in every situation where an audit is necessary.

Also, there is a real danger that if unscrupulous health professionals were aware that an audit could not go ahead if there was not consent to patient access, then they may well apply pressure on patients not to consent. Health professionals, in particular medical practitioners, still hold power and prestige in Australian society. If consumers were required to consent in such situations, patients may simply not provide consent so as not to upset their doctor, dentist, psychologist, etc.

This would particularly be the case and would have particularly detrimental effect in regional rural, remote areas and those suburban areas where there is a shortage of GPs. In a small town where there only one doctor, patients may be very reluctant to assist or be seen to assist in an audit of the doctor that could lead to a cessation of the practice or conditions on the doctor's practice.

People with disabilities are also often very dependent on their GP, particularly if their GP is prepared to treat by home visits. The temptation for health practitioners, who know that they are already under scrutiny, to apply pressure on patients not to consent would be an ever-present risk. Real consent in these situations would be very problematic.

The very request for consent in such situations could cause real distress to individuals, particularly those with disabilities and the elderly.

A requirement that individuals be advised of the access of their records where practicable means that the majority of patients will have the opportunity to express their concerns to Medicare if they object to the use of their records in an audit. These concerns should be taken into account when the various public interest factors are balanced in the decision-making process referred to above and an internal review should be mandatory if such concerns are expressed.

9. Conclusion

PIAC concludes that the Bill, together with the privacy safeguards already in place for Medicare Australia, appropriately balances the public interest in the integrity of Medicare and the public interest in the maintenance of patient confidentiality and privacy of health records.

PIAC believes that the balance between principles will be better achieved if the policy recommendations summarised below are implemented.

Recommendations

1. *That accessing patient records should not become a routine part of every compliance audit and mechanisms should be put in place to prevent this from happening.*
2. *That the compliance audit process should be a multi-step process that ensures that a separate decision is made to determine whether the collection of clinical information is necessary. This decision should be made by an officer or officers delegated by the CEO of Medicare Australia who are familiar with the privacy principles and are not directly involved in the conduct or oversight of the specific audit.*
3. *That if personal information can be de-identified without undermining the integrity of the audit process or affecting the strength of evidence required, then it should be de-identified.*
4. *That after completion of the Privacy Impact Assessment, with the necessary input of the Privacy Commissioner, any concrete proposals to enhance confidentiality and privacy of medical records in the audit process should be implemented either through legislation and/or in revised Privacy Guidelines for Medical Benefits and Pharmaceutical Benefits Programs.*
5. *Those patients, or their authorised substitute decision maker, should, where practicable, be advised if their person health record is accessed for the purpose of a compliance audit. They should be advised of this as early in the process as possible.*
6. *That if a patient or a substitute decision maker objects to the use of the personal medical record as part of a compliance audit, and gives reasons for the objection, the decision to access the information should be the subject of an internal review. Patients and substitute decision makers should be provided with a response to the internal review within a set timeframe and provided with written reasons for the decision.*

Finally, PIAC is concerned that much of the public debate surrounding the matters that are the subject of this inquiry has been misdirected and often verging on the hysterical.

Contrary to some of the commentary about the Bill, the proposal if enacted, should not be a significant threat to the confidentiality of health records, and does not represent a significant change from the long-existing practice that health records can be accessed, in the public interest, in certain controlled circumstances by bodies exercising investigative powers.

Since medicine became a profession, there have always been exceptions to the concept of doctor-patient confidentiality. In common law jurisdictions, courts and tribunals have historically had the power to *subpoena* documents relevant to matters being litigated, and personal health records have never been outside the scope of this power.

As referred to previously in this submission, this power is now coming under scrutiny in relation to the appropriateness of *subpoenas* on counselling notes in sexual assault matters. PIAC suspects that far more personal health information has been inadvertently made public through the *subpoena* process than would potentially be even accessed under the provisions of the current Bill. PIAC would certainly support the referral of the issue of the production of documents under *subpoena* and the consequent effect on health information privacy to an appropriate law reform body for review and report.

PIAC is far more concerned with the adequacy of current legislation to protect personal health information held by the private sector. Medicine in Australia is becoming increasingly corporatised.

A study by the Australia Institute in 2001[11] found that

[11] Dr Fran Collyer and Dr Kevin White, *Corporate Control of Healthcare in Australia* (2001) <https://www.tai.org.au/?q=node/8&offset=7> at 24 April 2009.

> …. corporatisation means that doctors are losing their capacity to make independent decisions about the best interests of patients. To maintain their incomes, GPs and specialists under contract to medical corporations are pressured to see more patients, to see patients for only one problem per visit, to prescribe minimum quantities of drugs to ensure return visits, to increase the number of diagnostic tests and to refer patients to other services owned by the corporation itself.[12]

The study highlights the public interest in the need for compliance audits in the Medicare system, as well as raising potential privacy problems. The corollary to doctors losing their autonomy is that the corporations that own the practices will have more control over patient care. Under the common law, the owner of the practice has the physical ownership of a patient's files. Nothing, bar the current privacy principles, prevents a corporate owner of a medical practice accessing health records of individual patients.

More sanctions similar to the provisions of section 130 of the *Health Insurance Act 1973* (Cth) are needed to deter unlawful use and disclosure of personal health records in the private sector. Unlawful breaches of the Privacy Act should lead to potential criminal sanctions, whether they occur in the public or private sector, and effective remedies to the individual affected.

PIAC has in this submission has emphasised that the maintenance of Medicare as a universal health care system is a significant public interest consideration. Compliance audits are necessary to maintain the integrity and efficiency of Medicare. The increased corporatisation of general practice in Australia raises broader questions regarding the future of Medicare.

PIAC notes that a study published in 2007[13] compared the financial performance of all companies listed on the Australian Stock Exchange pursuing vertical or virtual integration, horizontal integration or diversification in the pathology, diagnostic imaging and general practice sub-sectors over 2001-2005. The study found that medical centres yielded a modest to poor financial performance. The study concluded that the evidence provided tentative empirical support for the proposition that the value for a large corporation of acquiring a general practice is not for the financial return from the general practice per se, but its ability to generate referrals. It found corporations also find greater financial benefit from diagnostic services owned or provided by the corporation. Such diagnostic services are often now found in very close proximity to corporate GP services. PIAC has anecdotal evidence that patients are often now told that they must use a particular diagnostic service or their GP or Medical Centre will not treat them.

The author of the study concludes that the results of her study pose significant questions about the future of Medicare and accessible quality medicine in Australia. She points to the potential of increased Medicare expenditure from the co-location of general practices with diagnostic and other Medicare funded services, and she asks:

> Whether the provision of medical services by listed corporations, whose duty is first and foremost to shareholders represents the best use of limited public funds? An equally important and related question is whether large-scale multi-specialty medical centres owned by public corporations constitute a viable avenue for the delivery of cost-effective community-based healthcare?[14]

These are vital questions in this area that PIAC believes should be the subject of rational public debate and need further public scrutiny, including through the processes open to the Australian Parliament.

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12 Australia Institute, 'Corporate Medicine – Worst Fears Confirmed', Media Release, 23 October 2001 <https://www.tai.org.au/index.php?q=node/16> at 24 April 2009.

13 Jane Jones, 'Integration and diversification in healthcare: Financial performance and implications for Medicare' (2007) 1 *Health Sociology Review*.

14 Ibid 16-17.