CONTROLLING PATHOLOGY EXPENDITURE UNDER MEDICARE — A FAILURE OF REGULATION?

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INTRODUCTION

Health is one of the major areas of public expenditure in Australia. In 1991–1992, Australian governments spent $22.5 billion of the total health expenditure of $33.2 billion.[1] A substantial part of Commonwealth expenditure subsidises patient access to private medical services through Medicare, which operates within the fee-for-service system with no cap on the number of services or on the total budget outlays for them.[2] Expenditure control in this context is inherently problematic. The use of private medical services, particularly diagnostic services, has been increasing steadily over the last decade and the Commonwealth must reconcile this growth in service use with the national capacity to pay.[3] In the absence of effective market or other mechanisms, any expenditure controls must be implemented through government regulation and the legal and administrative enforcement of government-imposed controls.[4]

This paper critically examines the legal difficulties of implementing cost-control policies in private pathology, which has accounted for a large and, until very recently, rapidly increasing proportion of the Medicare budget. After outlining the factors which have made expenditure control in pathology especially problematic, the paper considers the Commonwealth's constitutional power with respect to the provision of benefits for medical services and its limitations. It then identifies the main features of the legal framework which regulates pathology for Medicare purposes, focusing on the

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1 Australian Institute of Health and Welfare, *Health Expenditure Bulletin* (Number 8 April 1993) at 1. The Commonwealth is the source of 42.4% (about $14 billion) of the government funds spent in 1991-1992 (at 9).

2 Just under $5.02 billion was paid in Medicare benefits in 1992-1993, an increase of 9.5% on the $4.58 billion paid in 1991-1992: Department of Health, Housing, Local Government and Community Services, *Annual Report 1992-93* at 19 of Statistical Supplement.

3 Between 1984-1985 and 1989-1990, medical service use per person increased by 23.2% overall and by 42.6% in pathology: J Deeble, *Medical Services Through Medicare*, National Health Strategy Background Paper No 2 (February 1991) at 6-7.

4 S Sax, *Health Care Choices and the Public Purse* (1990) at ch 1.

legal and administrative difficulties of certain key aspects, particularly the controls on overservicing and fraud. The analysis includes a critical discussion of an important case which exemplifies how judicial review can act as a constraint on the implementation of decisions aimed at reducing public expenditure.[5]

The paper concludes that the shortcomings of the regulatory structure, combined with inadequate enforcement of the provisions in respect of overservicing and fraud, have constituted a failure by the Commonwealth to realise the potential of existing legal mechanisms to control pathology expenditure within the fee-for-service system. Initiatives introduced in the 1993/94 Budget seek to overcome only some of the shortcomings of the existing scheme. The paper notes the constraints imposed by judicial review of important policy decisions in the health area and raises the possibility of basing regulation on other constitutional heads of power.

OVERVIEW OF PATHOLOGY UNDER MEDICARE

Growth in service volumes and costs

Australia, like many other fee-for-service health systems, faces expansionary pressures, particularly in diagnostic services. Pathology use increased by 770 per cent between 1965–1966 and 1989–1990, compared to the growth in the average use of all other medical services of 115 per cent, although the benefits to patients of greatly expanded pathology testing over the past 20 years are undocumented and unknown.[6] In spite of restraints on schedule fee increases, increased use has meant that Medicare payments for pathology services grew by 81.8 per cent in only eight years, rising to $628.8 million in 1991–1992. There was a small reduction (0.33 per cent) in benefits paid in 1991–1992 over the previous year.[7]

Characteristics of the private pathology industry

The practice of pathology has unique characteristics which pose challenges for legal regulation aimed at cost containment. It has been one of the most rapidly-changing branches of medicine in recent years, with the introduction of automated testing increasing the speed and efficiency and reducing the cost of testing. At the same time, the rapid acquisition of high-technology equipment has fostered large-scale, commercial and profit-dominated service delivery, because the capital costs of the equipment used in modern pathology make the full use of its capacity a commercial imperative.[8]

Pathology provision has increasingly become a private sector function, dominated by a few large private organisations. The largest 20 organisations (out of the 500 public and private authorities approved to provide pathology services under Medicare)

5 *Queensland Medical Laboratory v Blewett* (1989) 84 ALR 615.

6 J Deeble and P Lewis-Hughes, *Directions for Pathology*, National Health Strategy Background Paper No 6 (July 1991) at 53.

7 Auditor-General, Audit Report No 17, 1992-93, *Medifraud and Excessive Servicing Health Insurance Commission* (1992) at 12 (cited as *Audit Report No 17*). The value of pathology services processed in 1992-1993 was more than $633 million: Health Insurance Commission, *Annual Report 1992-93* (statistical tables at 14).

8 J Deeble and P Lewis-Hughes, above n 6 at 13.

delivered almost half of the total services in 1988-1989, and received a similar proportion of revenue.[9] The three largest Approved Pathology Authorities (APAs), all private, provide a total of 5,436,000 services annually and have annual turnovers of more than $35 million each. Just over half of the total services, episodes and fees came from company providers.[10]

In this context, the Commonwealth since 1977 has sought to regulate certain aspects of pathology referrals and provision and to control "sharp practices", such as inducements to order unnecessary tests. The statutory mechanisms are the Health Insurance Act 1973 (Cth) and regulations, with administrative support from the Department of Health[11] and the Health Insurance Commission (HIC).

REGULATION OF PRIVATE PATHOLOGY UNDER MEDICARE: COMMONWEALTH CONSTITUTIONAL POWERS

The Commonwealth Government has played an increasingly dominant role in the development and implementation of health policy and programmes since the 1940s, despite the fact that it has no general constitutional power with respect to health matters. This central role derives mainly from the Commonwealth's financial dominance and its power to appropriate funds for its own purposes under s 81 and to make conditional grants to the States under s 96 of the Constitution.[12] The Commonwealth's own health and welfare programmes — Medicare, the Pharmaceutical Benefits Scheme and aged accommodation programmes — are based on the legislative power in s 51(23A), the "health and social welfare power". The executive powers under ss 61 and 64 support the bureaucratic structures for administering health programmes. This section examines the scope of s 51(23A), which gives the Commonwealth substantial regulatory capacity in spite of its perceived limitations.

The scope of the health and social welfare power

Section 51(23A) grants to the Commonwealth power to make laws with respect to:

> The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.

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9 Ibid at 43. They charged $293.8 million of the $641.3 million in total fees charged under Medicare in that year.

10 Of the 500 APAs which existed in 1988-1989, 159 were companies, 60 were partnerships and 164 were individuals. The remaining 117 were State APAs: J Deeble and P Lewis-Hughes, above n 6 at 7 and 42-44. A recent amendment to the Health Insurance Act by s 9 of the Health and Community Services Legislation Amendment Act (No 2) 1993 (Cth) provides that a pathology authority that is a wholly or partly owned State, Territory or public authority is no longer an approved APA.

11 The Commonwealth Department responsible for health policy has changed its name several times over the period relevant to this paper and for simplicity will be called the Department of Health. Its current title is the Department of Human Services and Health.

12 J McMillan, *Commonwealth Constitutional Power Over Health* (1992) at 1.

These words were added to the Constitution in 1946 (one of the very few Commonwealth legislative powers approved by referendum) to enable the Commonwealth in the postwar period to provide a wider range of benefits than the invalid and old-age pensions authorised under s 51(23).[13] The High Court had held that other powers, specifically the appropriations power (s 81) and the incidental power in s 51(39), were insufficient to support a more comprehensive health and welfare programme.[14]

Even on a liberal reading, s 51(23A) does not confer on the Commonwealth a comprehensive power to regulate health and social welfare services. The power authorises legislation to provide "assistance" to the public in the form of "a motley group" of specific services and benefits.[15] The mechanism adopted by the Commonwealth is to provide "benefits" by subsidising the cost to individuals of the services of private doctors, optometrists, pharmacists and nursing homes. Only some of the terms in s 51(23A) have received judicial interpretation.[16] "Benefits" broadly covers the supply of things or services as well as monetary payments,[17] clearly authorising the universal Medicare programme in the Health Insurance Act 1973 (Cth). "Sickness" is defined to include any form of ill-health or incapacity,[18] although the term probably does not authorise benefits payments for health screening tests. The Act reflects this, making ineligible for benefits any service which is "not reasonably required for the management of the patient's medical condition".[19] The way the Commonwealth's power over health is expressed limits its ability to act directly on health promotion and screening and probably reinforces the focus of the medical system on treating illness rather than promoting health.[20]

Section 51(23A) has been held to authorise the Parliament to legislate for the Commonwealth *itself* to provide services or benefits.[21] It does not authorise the general regulation of the medical profession or the way medical or dental services are performed, for example where Government-subsidised health services are delivered by the private sector.[22] In spite of this apparent limitation, significant regulation of the provision of private medical services, as well as pharmaceutical and aged care services

13 T Carney and P Hanks, *Australian Social Security Law, Policy and Administration* (1986) at 176-177.

14 *Attorney-General for Victoria ex rel Dale v Commonwealth* (1945) 71 CLR 237. The Court held invalid the Pharmaceutical Benefits Act 1944 (Cth), which established a scheme providing free medicines, because it sought to regulate certain activities of pharmacists and medical practitioners when there was no Commonwealth power to do so.

15 Constitutional Commission, *Final Report of the Constitutional Commission* Volume 2 (1988) at para 10.258.

16 J McMillan, above n 12 at 32-35.

17 *Federal Council of the British Medical Association in Australia v Commonwealth* (the *BMA* case) (1949) 79 CLR 201 at 260 per Dixon J.

18 Ibid at 230 per Latham CJ.

19 Health Insurance Act 1973 (Cth), s 19(5). The exclusion probably also reflects the need to limit expenditure.

20 Community-wide prevention programmes get support instead via Commonwealth grants authorised by the constitutional powers with respect to finance: J McMillan, above n 12 at 11-16.

21 *BMA* case (1949) 79 CLR 201 at 242-243 per Latham CJ.

22 *Alexandra Private Geriatric Hospital v Commonwealth* (1987) 162 CLR 271 at 279 (Full Court of the High Court).

has occurred, supported by the principle of constitutional interpretation that every legislative power carries with it the authority to regulate matters incidental or ancillary to the subject matter of the power, the control of which is necessary to achieve its main purpose.[23] The concept of what is "necessary" has been read liberally and extends to regulation "which may reasonably and properly be done" to fulfil the main purpose of the power.[24] The application of the principle to the health and welfare power was explained by Gibbs J in the context of a challenge to the validity of detailed requirements placed on pathology providers:

> Of course no express power is conferred on the Parliament to make laws to regulate the manner of performance of medical or dental services, but it appears clearly necessary to the effective exercise of the power conferred by s. 51(xxiiiA) that the Parliament should be able to make laws as to the way in which medical and dental services provided by the Commonwealth under the authority of that paragraph are performed, and laws annexing conditions to the entitlement to any of the benefits provided under that authority even if those conditions may have the result that a medical or dental service must be rendered in a particular way if the benefit is to be obtained.[25]

The exercise of the power is subject to the prohibition on "civil conscription", discussed below under "Limitations on Commonwealth power".

Relying principally on the inherent incidental power in s 51(23A), the High Court has held to be constitutionally valid legislation requiring special conditions to be satisfied before Medicare benefits for pathology services are payable: *The General Practitioners Society in Australia and Ors v Commonwealth* (the *GPS* case).[26] This incidental regulation has been extended to require specimen collection centres to be licensed and tests to be performed only in accredited laboratories.[27] Requirements on doctors and pharmacists incidental to the provision of "pharmaceutical benefits" and a comprehensive range of controls over nursing homes are also valid.[28] The inherent incidental power has been important therefore in facilitating quite comprehensive regulation (and concomitant policy control) of specific health programmes by the Commonwealth to match its financial support of them.

Limitations on Commonwealth power

There are a number of limitations on the constitutional power of the Commonwealth which are of potential importance to legal regulation in the health area, including freedom of interstate trade, commerce and intercourse (s 92), state insurance (s 51(14))

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23 *Grannall v Marrickville Margarine Pty Ltd* (1955) 93 CLR 55 at 77 per Dixon J.

24 *BMA* case (1949) 79 CLR 201 at 274 per Dixon J; see generally J McMillan, above n 12 at 22-23.

25 *The General Practitioners Society in Australia and Ors v Commonwealth* (the *GPS* case) (1980) 145 CLR 532 at 557-558 per Gibbs J.

26 (1980) 145 CLR 532. For example, pathology providers were required to obtain annual ministerial approval and sign undertakings as to the ethics of their practice. These requirements still apply.

27 Health Insurance Act 1973 (Cth), ss 16A(2) and 16A(5AA) and Division 4A of Part IIA.

28 *BMA* case (1949) 79 CLR 201; *Alexandra Private Geriatric Hospital v Commonwealth* (1987) 162 CLR 271. The High Court also relied in the latter case on the principle of constitutional interpretation that a single law can possess more than one character (at 279).

and acquisition of property on just terms (s 51(31)).[29] The most important limitation on regulating medical services pursuant to s 51(23A) is that the regulation must not "authorize any form of civil conscription". This qualifying provision has been considered twice by the High Court. Its expansive reading in *Federal Council of the British Medical Association in Australia v Commonwealth* (the *BMA* case)[30] was substantially rejected in the *GPS* case,[31] implying that there is considerable scope to regulate the incidents of medical practice under s 51(23A) without infringing the civil conscription prohibition.

The words were intended to prevent any sort of compulsion on persons, equivalent to military conscription, to practise as doctors or dentists or to perform particular medical or dental services, in particular to prevent an imposition on medical personnel of a duty of attending patients for fees paid by the Government.[32] The degree to which the words provide protection from less direct regulation is unclear. In the *BMA* case, the British Medical Association challenged the constitutional validity of provisions in the Pharmaceutical Benefits Act 1947 (Cth), requiring doctors to use government-supplied forms when writing prescriptions for free medicines under the pharmaceutical benefits scheme. A majority of the Court upheld the challenge, on the grounds that the prohibition prevented not only any legal compulsion upon people to engage in a particular occupation, but also a compulsion to perform work in a particular way.[33] The dissenting judges (Dixon and McTiernan JJ) held that "civil conscription" was confined to a compulsion to serve medically or to render medical services.[34] The obligation to use a government form was simply "a procedure in performing an incident of medical service ... done in order to effect a non-medical purpose" and they doubted whether this incidental interference in the complete freedom of medical practice involved a form of civil conscription.[35]

In the *GPS* case, the Court preferred the minority view. The General Practitioners Society had argued that the detailed obligations placed on certain medical practitioners as a prerequisite to the payment of benefits for their services offended against the

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29 J McMillan, above n 12 discusses them comprehensively at 42-50. Section 51(31) has received recent judicial consideration in the context of a litigated claim for assigned benefits for pathology services: *Peverill v Health Insurance Commission* (1992) 104 ALR 449. The applicant argued sucessfully that an Act which provided for the retrospective reduction in the amount of Medicare benefits payable to him was a law with respect to the acquisition of property within s 51(31). The Court held that the acquisition was effected otherwise than on just terms. An appeal before the Full Federal Court against this decision was removed, pursuant to s 40 of the Judiciary Act 1903 (Cth), to the High Court, whose decision allowing the appeal was handed down on 10 March 1994: *Health Insurance Commission v Richard Edwin Peverill* (unreported decision FC 94/006). For a detailed discussion of the competing public and private interests raised by the case, see P Hanks, "Adjusting Medicare Benefits: Acquisition of Property?" (1992) *14 Syd L R* 495.

30 (1949) 79 CLR 201.

31 (1980) 145 CLR 532.

32 *BMA* case (1949) 79 CLR 201 at 249-50 per Latham CJ; at 261-262 per Dixon J; at 287 per Williams J; *GPS* case (1980) 145 CLR 532 at 555 per Gibbs J.

33 *BMA* case (1949) 79 CLR 201 at 249 per Latham CJ; at 287 and 291 per Williams J; at 293-294 per Webb J. Rich J, the other member of the majority, perhaps did not support the broadest reading of "civil conscription" (at 255-256).

34 Ibid at 278 per Dixon J; at 283-284 per McTiernan J.

35 Ibid at 262 per Dixon J.

prohibition because they were required to perform medical services, or compelled to carry on their current practice in a different way.[36] The High Court unanimously rejected the widest reading of the prohibition, adopted by three of the Justices in the *BMA* case, that civil conscription is imposed by a law which compels people to perform services in a particular manner. The Court in the *GPS* case held that the expression did not refer to compulsion to do, in a particular way, some act in the course of carrying on a practice or performing a service, when there is no compulsion to carry on that practice or perform the service.[37] Nothing in the new legislative provisions regulating pathology compelled the performance of any medical service, but only regulated the financial and administrative incidents of the practice of a medical practitioner who opted to deliver a service which was to be financed by the Commonwealth.[38] The new provisions were therefore valid.

The decision in the *GPS* case suggests that the "civil conscription" prohibition is no longer a substantial constraint on the Commonwealth's power to regulate the incidents of medical practice. Nevertheless, two additional matters must be mentioned. First, whilst the "civil conscription" qualification is expressed grammatically in s 51(23A) to apply only to the provision of medical and dental services, it has nevertheless been held that the prohibition is also relevant to other provisions of the power. This means that whenever medical or dental services are provided pursuant to a law about the provision of some other benefit, such as sickness and hospital benefits, "the law must not authorise any form of civil conscription of such services".[39] The capacity of the Commonwealth to regulate also remains constrained, at least theoretically, by a proposition expressed in *obiter* comments in the *BMA* case and supported by some judicial opinion in the *GPS* case. The proposition is that civil conscription might be found in a law in which there is no legal compulsion on a medical practitioner to perform a service, but where there is "practical compulsion", such as economic pressure which cannot reasonably be resisted.[40] The circumstances in which a law might be held to impose "practical compulsion" sufficient to infringe the "civil conscription" prohibition are unclear and naturally would turn on the particular circumstances of the case.[41]

Allowing for these possible constraints, the *GPS* case and *Alexandra Private Geriatric Hospital v Commonwealth* suggest clearly that, relying on the inherent incidental power in s 51(23A), substantial requirements can be placed on subsidised private sector providers without infringing the civil conscription prohibition. The pressure on medical practitioners to participate in Medicare (because patients expect to claim benefits for medical services), with the result that they must therefore submit to

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36 (1980) 145 CLR 532 at 549 per Gibbs J.

37 Ibid.

38 Ibid at 558 per Gibbs J.

39 *Alexandra Private Geriatric Hospital v Commonwealth* (1987) 162 CLR 271 at 279. The quotation is from the *BMA* case (1949) 79 CLR 201 at 286-287 per Williams J.

40 *GPS* case (1980) 145 CLR 532 at 537-538 per Barwick CJ; at 550 per Gibbs J; at 565 per Murphy J; at 566 per Aickin J.

41 J McMillan, above n 12 at 46 raises the possibility that moves away from a purely fee-for-service system might test the prohibition again. The former Minister for Health refused to rule out a system "where general practitioners are given more autonomy with lump-sum government funding alongside fee-for-service payments": *Age* 15 September 1993 at 4.

regulation of the incidents of their practice, does not constitute either legal or practical compulsion.

REGULATION OF PRIVATE PATHOLOGY PRACTICE BY THE HEALTH INSURANCE ACT 1973 (CTH)

The Government's regulatory response through the Health Insurance Act 1973 (Cth) to the increasing outlays on benefits payments for pathology has been threefold. First, it has specified detailed conditions which must be satisfied before a benefit will be paid; second, it has developed specific legal and administrative mechanisms to address excessive servicing (or overservicing, as it is sometimes called)[42] and fraud, and third, it has amended the pathology schedule to reduce benefits for some tests and to change the way in which many services are reimbursed. The changes have been mostly piecemeal responses to reports on dishonest practices in the pathology industry and accompanying criticisms of the inadequate controls over abuses of the Medicare system.[43] This has resulted in a complex and detailed legislative scheme which has been vulnerable to legal challenge and exploitation of loopholes, and which has been characterised generally by poor administration, particularly of the overservicing and fraud provisions.[44] A new professional review system to operate from 1 July 1994, combined with proposed new measures to combat fraud, may improve the regulatory scheme. Only the third approach has had some success, although adversely affected by a successful legal challenge by private pathology providers.[45] The following sections outline these three regulatory approaches and the main difficulties with each; the analysis is followed by a brief discussion of the influence of administrative culture on the choice of enforcement strategies under Medicare.

Eligibility criteria and accreditation schemes

Given that the constitutional basis for Medicare is the payment of cash benefits for individual services, it is not surprising that increasingly detailed legislative requirements about eligibility have been attached to services in attempts to protect revenue. There are requirements about establishing the necessity for a test,[46] how a test is ordered,[47] where samples are collected,[48] where tests are performed and by whom.[49]

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42 An "excessive pathology service" is defined in s 3 of the Health Insurance Act to mean a service "that is not reasonably necessary for the adequate medical or dental care of the patient concerned".

43 Parliament of the Commonwealth of Australia Joint Committee of Public Accounts, *Report No 236 — Medical Fraud and Overservicing Inquiry — Report on Pathology* (1985), cited as *PAC Report No 236*; Pathology Services Working Party, *Report of the Pathology Services Working Party* (1977).

44 *Audit Report No 17*, above n 7, esp chs 1 and 5; Harvey Bates and Co, *Health Insurance Commission Review of the Operations and Procedures for the Conduct of Investigations* (1992), esp at 2-6 (hereafter cited as the *Bates Report*).

45 *Queensland Medical Laboratory v Blewett* (1989) 84 ALR 615.

46 A pathology service must be a "professional service" (s 3) which is a "clinically relevant service" (s 3). It must be determined to be necessary, ie "reasonably necessary for the adequate medical care of the patient concerned": s 16A(1) and16A(12).

47 Most pathology tests must be requested or confirmed in writing: s 16A(4) and 23DK. A pathology service may be an excessive service whether or not it was requested under

A pathology service will be ineligible for a benefit where there are inducements for the ordering of tests.[50] There are also a range of services specifically excluded from benefits, for example, tests for the purposes of life insurance or health screening, reflecting the constitutional basis of the legislation.[51]

Detailed eligibility requirements in the form of Ministerial approval or accreditation apply to service providers, laboratory proprietors and laboratory premises. The accreditation schemes aim to ensure high quality testing, to achieve greater administrative control over who participates in the benefits scheme and to discourage sharp practices and overservicing. Providers require annual approval before their tests are eligible for benefits. Approval depends on them satisfying a "fit and proper person" test, acceptance by the Minister of prescribed written undertakings and the payment of a fee.[52] Undertakings by Approved Pathology Practitioners (APPs) and Approved Pathology Authorities (APAs) (usually the individual or corporate proprietors of laboratories) require them, *inter alia*, to meet legislative obligations in respect of test supervision, not to offer inducements for referrals and not to perform excessive services.[53] The Minister may refuse or revoke undertakings, subject to appeal.[54] Laboratories are accredited for Medicare purposes according to their size and facilities, staff qualifications and the level of test supervision.[55]

There are a number of difficulties with a regulatory approach based heavily on eligibility criteria in a system as large and pressured as Medicare.[56] Whilst modern computer systems can trace non-compliance with some legal requirements, a failure to meet others may be difficult or impossible to detect at the time of claim (or at all).[57] For example, it has been estimated that screening tests represented a substantial proportion

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s 16A, but the cases in which a pathologist acting on a request may be found to have rendered excessive services will be confined to those involving "personal fault": *Minister for Health v Peverill* (1991) 100 ALR 73.

48 The Act prescribes a limited range of approved collection places: s 16A(5AA). Where samples are collected in commercial collection centres, these must be licensed under Part IIA.

49 A test must be performed by or "on behalf of" an Approved Pathology Practitioner in a laboratory accredited by the Department of Health to perform that type of test: s 16A(2)(a) and 16A(2)(b). The proprietor of the laboratory must be an Approved Pathology Authority: s 16A(2)(c). A recent amendment to s 16A ensures that not more than one APA controls a laboratory, to prevent double claims for the same services: see s 7 Health and Community Services Amendment Act (No 2) 1993 (Cth).

50 Section 16A(5A).

51 Section 19. Specific screening programmes like the one for cervical cancer may be funded under Part IV of the Act.

52 Sections 23DA-23DK. The Minister considers, amongst other things, the provider's previous conduct under Medicare and the conduct of those business associates of the provider who may derive a financial benefit from the practice: s 23DC(6).

53 Section 23DB.

54 Section 23DC.

55 Section 23DN. For an example of the Minister's refusal to accredit a laboratory because of failure to meet quality assurance standards, see *Preci Services Pty Ltd v Minister for Health, Housing and Community Services* (1992) 15 AAR 505.

56 The Health Insurance Commission processed claims for more than 172 million services on a "fee-for-service" basis in 1992-1993: HIC, *Annual Report 1992-93* (statistical tables at 12).

57 *PAC Report No 236*, above n 43 at 81-82.

of the increase in Medicare expenditure on pathology services in the early 1980s.[58] There is some evidence that screening tests are still contributing to this growth, in contravention of the Act.[59] Other eligibility criteria, such as requirements that a test be "necessary" or not ordered as a result of an inducement, are only effective in protecting revenue if there are administrative mechanisms in place to detect breaches once the claim has been paid and legal mechanisms to ensure restitution.

The same observation can be made about accreditation schemes. Prospective regulation based on ministerial approval can have an educative and deterrent effect, given the dependence of practitioners and laboratory owners on participation in Medicare.[60] In practice, however, prospective regulation requires significant administrative support — in particular, its success in an industry where sharp practices have already been identified as a problem depends on visible and regular audits to ensure that participants abide by their undertakings, and a preparedness to use sanctions if they do not.[61] Provider approval has been judged ineffective in the past due to poor administration, particularly the failure to link the approval system with the audits of pathology provider claims used to detect overservicing.[62] Although it is difficult to establish the level of resources currently devoted to scrutinising applications for APP and APA approvals, it is noteworthy that the approvals scheme has co-existed with the burgeoning of pathology expenditure, some of which has been attributed to overservicing and inducements to ordering about which every APA and APP gives undertakings as a condition of approval. The provision in the Act for referral of APPs and APAs who are suspected of breaching their undertakings to a Medicare Participation Review Committee has hardly been used.[63] The approvals scheme is under review in the Department.

Excessive servicing and fraud

The factors which have prompted the increasing demand for diagnostic tests, and the contribution each factor makes, are complex and difficult to define precisely. They include factors which are clearly beyond the influence of government regulation, such as the availability of better medical technology, patient and doctor demand prompted by changes in societal expectations of an appropriate level of care and, possibly, the practice of defensive medicine due to the fear of litigation.[64]

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58 Ibid.

59 The biggest rises in Medicare claims for pathology tests between 1984-85 and 1988-89 were in HDL cholesterol (511%) and triglyceride and total cholesterol measurement (303%), which are likely to be at least partly attributable to preventive health management rather than the diagnosis of disease: J Deeble and P Lewis-Hughes, above n 6 at 36-39.

60 The Public Accounts Committee concluded that legal action and attempts at restitution from pathology providers had been shown to be clumsy, inefficient and costly. Preventive action was preferable: *PAC Report No 236*, above n 43 at 82.

61 Ibid at 41.

62 Ibid.

63 Sections 23DL, 124FB and 124FC. One practitioner was referred to a Medicare Participation Review Committee in 1992-93 for a possible breach of an APP undertaking: HIC, *Annual Report 1992-93* at 32.

64 Commonwealth Department of Health, Housing and Community Services, *Compensation and Professional Indemnity in Health Care A Discussion Paper* (1992) at 69-70. There is little evidence to support anecdotal reports that changes in clinical practice are related to trends

The issue of government regulation is most relevant where there is abuse of the payments system by deliberate overservicing and fraudulent practices. The public health insurance system offers built-in financial incentives to excessive servicing and fraud, with the unlimited allocation of public funds to pay for private fee-for-service medical services,[65] although the incentives for illegality built into fee-for-service do not, in themselves, explain these abuses.[66] There is little doubt that dishonest practices have contributed to the growth in the volume and cost of services, although the extent of this contribution is unknown. Estimates about the cost to Medicare of overservicing and fraud generally range from $100 million to $320 million per annum.[67] The contribution made by pathology abuses is apparently substantial and the concern for regulators is that abuses have become entrenched, taking the form mainly of inducements to general practitioners to maintain a high level of test ordering.[68]

Given that the "eligibility criteria" in the Health Insurance Act constitute fairly weak controls on inappropriate claims for pathology benefits, the administrative and legal mechanisms in place to deal with medical practitioners who misuse or abuse the benefits system are very important in the regulatory strategy. The culture of the Medicare administration is also important because it has a significant effect on the way administrative and legal controls are implemented and how the balance between them is struck.

Administrative and legal approaches to excessive servicing

Conciliatory intervention by the HIC has been preferred over more formal legal intervention in addressing the problem of overservicing (and to a lesser extent fraud) by doctors, although the efficacy of compliance models of regulation has been criticised.[69] The HIC seeks to obtain compliance from practitioners by providing them with statistical information about their level of servicing to enable them "to critically assess their own practices"[70] and advising and counselling those whose service patterns may indicate overservicing or other inappropriate practices. This approach recognises that some excessive servicing may be inadvertent and that aggressive use of formal disciplinary measures might have a chilling effect on the provision of adequate medical care.[71] In pathology specifically, education strategies have been emphasised in tackling high levels of test ordering by general practitioners, who are notified about how their pathology (and more recently diagnostic imaging) ordering patterns compare with State and area averages. The HIC has attributed the sharp drop in

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in litigation, although overseas studies have found that doctors' perceptions of liability have had a profound influence on their practice and on service delivery.

65 A A Tarr and A P Moore, "Regulatory Mechanisms in Respect of Entrepreneurial Medicine" *(1988) 16 Australian Business Law Review* 4 at 6.

66 P Grabosky and A Sutton, *Stains on a White Collar Fourteen Studies in Corporate Crime and Corporate Harm* (1989) at 81.

67 *Audit Report No 17*, above n 7 at xi; D Challinger, "Fraud on Government A Criminological Overview" in (1988) *56 Canberra Bulletin of Public Administration* 18 at 21.

68 P Grabosky and A Sutton, above n 66 at 78; *Audit Report No 17*, above n 7 at 15.

69 P Grabosky and J Braithwaite, *Of Manners Gentle: Enforcement Strategies of Australian Business Regulatory Agencies* (1986).

70 HIC, *Annual Report 1992-93* at 29.

71 P Grabosky and J Braithwaite, above n 69 at 155.

pathology benefits growth in 1991-1992 in part to the success of these initiatives, although it is arguably too early to know if this will be a continuing trend.[72]

The alternative to education and conciliatory intervention is the formal investigation of practitioners who are reasonably suspected of initiating or performing excessive services by a committee of medical practitioners established under Part V of the Act.[73] The provisions rely on the inherent incidental power in s 51(23A) of the Constitution, because "it is clearly incidental to any law which provides for the payment of benefits for the rendering of medical services that provision be made to deal in an appropriate way with the rendering of excessive services".[74] Formal inquiries are reserved for more persistent and serious cases of overservicing.[75] For many years this statutory peer review system consisted of Medical Services Committees of Inquiry (MSCIs) which had the power to inquire into cases referred by the Minister and, where appropriate, to recommend a limited range of sanctions. The number of cases referred for investigation has been small in the light of the estimated level of overservicing. Between 1 July 1985 and 30 June 1992, only 88 medical practitioners were referred to MSCIs, 51 being required to repay a total of $556,826.[76] The trenchant criticisms levelled at the MSCI system over many years have been directed to the inadequacy of the powers available to MSCIs under the Health Insurance Act and the costs, delays and overly legalistic procedures which have adversely affected outcomes.[77]

These criticisms have prompted the introduction, from 1 July 1994, of a new Professional Services Review Scheme which retains the "peer review" model of its predecessor, whilst addressing some of its shortcomings. Professional Services Review Committees comprising at least three medical practitioners will consider whether a practitioner's conduct in rendering or initiating services under Medicare is inappropriate.[78] The concept of "excessive service" has been abandoned in favour of a

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72 HIC, *Annual Report 1991-92* at 35.

73 The new Health Legislation (Professional Services Review) Amendment Act 1994 (Cth), assented to on 16 February, 1994, repeals Divisions 3 and 3A of Part V of the Health Insurance Act (the peer review system comprising Medical Services Committees of Inquiry) and replaces it with a new system, effective from 1 July 1994.

74 *Hill v Minister for Community Services and Health and Ors* (1991) 30 FCR 272 at 282 per Olney J.

75 This will not change with the new Professional Services Review system. Practitioners will only be referred for review after advice and counselling from the HIC have failed to influence those practices which have caused concern: see H Reps Deb 1993, Weekly Hansard No 7 at 1550-1.

76 *Audit Report No 17*, above n 7 at 44. The HIC used the MSCI system more aggressively in 1992 when it initiated formal investigations into 11 general practitioners with suspected excessive levels of pathology ordering, but this reflected the lack of success in prosecuting cases of pathology inducements: HIC, *Annual Report 1991-92* at 38.

77 For example, there was no power to demand a doctor's records. Also, determinations for repayment of benefits could be based only on the number of patients actually reviewed, which averaged 20 to 30 in each case. In many cases, this was believed to represent only a small proportion of the excessive servicing that had occurred: *Audit Report No 17*, above n 7 at 5 and 13.

78 Section 95 of the Health Insurance Act, as amended by the Health Legislation (Professional Services Review) Act 1994 (Cth) (all subsequent references are to the principal Act, as amended). Practitioners are referred to the Director of Professional Services Review by the

broader concept of "inappropriate practice". This is defined as conduct which a Committee could reasonably conclude would be unacceptable to the general body of the members of the specialty or profession in which the doctor under investigation practises.[79] Where a Committee makes such a finding, it has a new power to recommend disqualification of the practitioner. Recommendations for counselling, reprimand and repayment of benefits with penalties are still available.[80] Overall co-ordination of the review process and administrative efficiency are promoted by the appointment of a Director of Professional Services Review and a Professional Services Review Panel. The Director has the power to partially disqualify a medical practitioner without review by a Professional Services Review Committee.[81]

The provisions seek a better balance between the need for procedural fairness in inquiries and the need for an efficient and effective system of review.[82] The new scheme retains both the detailed notice requirements for persons under review at all stages of the process and appeals to the Medical Services Review Tribunal and the Federal Court from determinations of a Professional Services Review Committee.[83] Changes have occurred in Committee procedures and evidentiary requirements. These include the removal of the right of a doctor to legal representation[84] and the granting to the Committee of greater powers to require attendance by persons under review and the power to require them to give evidence and present documents. Penalties may be imposed for failure to comply with these requirements and for knowingly providing false or misleading information.[85] Importantly, a Committee may now base its findings, wholly or partly, on a sample of services of the person under review, although that person may request the sample to be increased or not used at all.[86] These new provisions seek to overcome the requirement under the repealed provisions for an MSCI to identify each and every service which it believed to be excessive.[87] Unlike

HIC (s 86). Committees must include some doctors who are members of the profession or specialty in which the person under review was practising when he or she performed or initiated the services which are the subject of the review: s 95(2).

79 Section 82(1) and (2). The section applies also to an employer or officer of a body corporate who "knowingly, recklessly or negligently causes or permits" an employee practitioner to engage in conduct that would constitute inappropriate practice.

80 Section 106U.

81 Section 92. The power can be exercised only with the consent of the practitioner and secrecy provisions apply.

82 The MSCI system was described by one judge as "a complicated procedure protective of the position of medical practitioners": *Edelsten v Health Insurance Commission* (1990) 96 ALR 673 at 688 per Davies J.

83 Sections 114-119 (appeal to a Medical Services Review Tribunal against a determination of a Committee) and 124-124A (appeals to the Federal Court from a Tribunal Decision on a question of law only).

84 Although not the right to an adviser at a Committee hearing: s 103.

85 Sections 104-105. A person under review who fails to attend a hearing after notice has been given under s 102 must be disqualified fully from practice under Medicare until he or she complies: s 105(3). There is an exception for ill-health.

86 Sections 106G-106K. The samples must be produced in accordance with ministerial directions. The person under review may request the Committee to allow the person to present his or her case, addressing all of the referred services, in which case the Committee may not use the sample: s 106J(2) and (3).

87 *Edelsten v Health Insurance Commission* (1990) 96 ALR 673 at 686. However, there was some judicial approval for MSCIs considering an unusual pattern of services rendered to a large

MSCI investigations, reviews under the new scheme may include only those services performed or initiated in the two years prior to the referral.[88]

Assessing "overservicing" under Medicare

The establishment of a peer review system in the Act to inquire into overservicing recognises that whether or not a service is necessary or appropriate involves, to a large extent, a sensitive professional judgment. The fact that inappropriate practice under the new Professional Services Review Scheme will be measured by a legislative standard which leaves the issue entirely to the profession reinforces this concept.[89] Private services are heavily subsidised from limited public funds and this raises the question whether the limitations in resources to meet the increasing demand for services should be considered in assessing whether a doctor has engaged in "inappropriate practice" under Medicare. This is particularly important in diagnostic testing, which is increasingly available and often costly. This difficult question, part of the wider debate about resource allocation in health care, can only be touched on here.[90]

Judicial review of MSCI decisions has acknowledged to a very limited extent that there are interests at stake in an overservicing inquiry which go beyond a narrow construction of what constitutes "medical necessity", although the cases have been overwhelmingly concerned with procedural fairness.[91] This general lack of attention to competing interests can be explained by the legislative scheme itself, which emphasises the individual rights of the doctor under review and lacks any guiding statement of policy.[92] It is explained also by the concern of traditional judicial review with individual grievances, at the expense of more general questions of "policy-making, administration and resource-allocation".[93]

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number of patients in deciding whether there was evidence of excessive servicing: *Freeman v McCubbery* (1986) 65 ALR 361 at 370.

88 Section 86.

89 This is not to say that what the profession considers appropriate cannot encompass broader considerations than medical necessity, and doctors are now more likely to appreciate the dilemmas of competing priorities between the individual patient and taxpayers. However, there is little if any guidance, legislative or otherwise, on how these broader considerations should be taken into account at either the individual level or in the health system generally: National Health and Medical Research Council, *Discussion Paper on Ethics and Resource Allocation in Health Care* (1991).

90 For a detailed analysis of the issues, see B Gaze, "Resource Allocation — the Legal Implications" (1993) 9 *Journal of Contemporary Health Law and Policy* 91.

91 *Minister for Health v Thomson* (1985) 60 ALR 701; *Freeman v McCubbery* (1986) 65 ALR 36; *McIntosh v Minister for Health* (1986) 17 FCR 463; *Freeman v McKenzie* (1988) 82 ALR 461; *Taylor v Minister for Health* (1989) 23 FCR 53; *Sinja v Asher* (1989) 22 FCR 423; *Peverill v Australian Minister for Health & Ors* (1989) 85 ALR 257; *Minister of State for Health v Peverill* (1991) 100 ALR 73; *Tiong and Another v Minister for Community Services and Health* (1989) 87 ALR 723; (1990) 93 ALR 308 (Full Court); *Edelsten v Health Insurance Commission & Ors* (1990) 93 ALR 711; (1990) 96 ALR 673 (Full Court); *Hill v Minister for Community Services and Health and Ors* (1991) 30 FCR 272; *Romeo v Asher* (1991) 100 ALR 515.

92 Although it has been argued above that at least in terms of procedure there is a better balance in the new scheme between the rights of the person under review and the efficiency of the review system.

93 P McAuslan, "Administrative Law, Collective Consumption and Judicial Policy" (1983) *46 MLR* 1 at 6.

Some judges have acknowledged openly the need to balance the "serious consequences for a doctor of a finding of persistent over-servicing" with the "possible waste of public monies" and the "threat to the integrity of the health scheme if excessive services are unchecked".[94] The Federal Court has held that the question whether services are reasonably necessary is not a purely medical one, although regard should be had to acceptable practice in the medical profession in determining whether there has been excessive servicing in a particular case.[95] Medical services are not "excessive" unless they constitute unnecessary servicing by the medical practitioner "at the expense of the health system".[96] In *Romeo v Asher*, Burchett J elucidated this statement:

> What is reasonably necessary ... may well involve economic questions. Much may depend upon whether a doctor's concept of what is reasonably necessary is to be determined, as Hippocrates would have had it (see *Oxford Companion to Medicine* (1986) — *Hippocratic Oath*), by the exercise of the doctor's ability and judgment solely "for the good of [his] patients", or whether the economics of Medicare must be allowed a significant role.[97]

The important question of how the two considerations are to be balanced has received no specific consideration, although there are examples where "the economics of Medicare" have affected the Court's assessment of the meaning of "necessary" in the Act.[98]

There is a lack of legislative policy and only limited judicial guidance about how the need to protect public revenue might be taken into account in operating the professional review system under Medicare. This is one illustration of the increasingly important issue of resource allocation in health which is only just beginning to be addressed.

Pathology fraud

Medical fraud may be prosecuted under the Health Insurance Act, which provides for general "dishonesty" offences and specific offences in pathology,[99] as well as under the Crimes Act 1914 (Cth).[100] The pursuit of medical benefits fraud generally has been

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94 *Freeman v McKenzie* (1988) 82 ALR 461 at 472-473 per Woodward J.

95 *Tiong and Another v Minister for Community Services and Health* (1990) 93 ALR 308 at 315 per Davies J.

96 Ibid.

97 *Romeo v Asher* (1991) 100 ALR 515 at 532.

98 For example, in *Taylor v Minister for Health* (1989) 23 FCR 53, Pincus J held that services could be regarded as excessive if they could have been provided in a smaller number of consultations; the legislature did not intend the medical necessity of the services to be the only criterion of excessiveness.

99 Sections 128 (false statements in relation to Medicare benefits), 129AA (bribery and inducements to request pathology services) and 129AAA (prohibited practices in relation to the rendering of pathology services). The inducements offences will be the subject of new legislation in the near future.

100 Sections 29A (false pretences), 29B (false representations), 29D (fraud) and 86 (conspiracy to defraud).The prosecution policy of the Commonwealth is that the specific offence provisions in the subject legislation will be applied, unless they do not deal sufficiently with the criminality of the offender. In practice, this means that more serious examples of fraudulent conduct will usually be dealt with under the Crimes Act: D Sweeney and N Williams, *Commonwealth Criminal Law* (1990) at 224.

marked by a very low rate of prosecutions. Between 1985-1986 and 1991-1992, 43 medical practitioners were successfully prosecuted, resulting in the recovery of about $5.6 million. In 1991-1992, there were 77 successful prosecutions of the public and eight of providers.[101] The $1,005,131 recovered represented 0.027 per cent of the total Medicare benefits processed in that year.[102]

The pursuit of medical benefits fraud faces the same difficulties as public fraud generally. Detection "is a matter of extraordinary difficulty" and difficulties in investigation and prosecution arise from the fact that fraud cases are generally of great complexity and the legal system within which those responsible for tackling fraud must work is both antiquated and inefficient.[103] The complex corporate arrangements in pathology aggravate these difficulties. This was illustrated nicely by the recent discharge of a pathology prosecution at the committal stage, on the grounds that the defendant's complex financial arrangements made the case too difficult for the prosecution to present effectively to a jury.[104] This outcome gives added incentives for unethical pathology companies to extend their area of abuse, encouraged by "the large amounts of money involved and access to legal advice that allows the pathology legislation to be bypassed."[105]

The legal difficulties in prosecuting medifraud successfully have arisen as a result both of the inadequacy of the legislation controlling investigation and of problems of proof at the prosecution stage. Existing legislation does not provide an adequate base to support investigative action into significant cases of fraud or inducements for the ordering of pathology.[106] The HIC lacks the power to access and investigate records held by third parties under transaction-splitting arrangements, or complex corporate structures.[107] Secrecy provisions prevent the disclosure of information between agencies (for example, the HIC and the Tax Office) which would assist investigation.[108] The Government has accepted recommendations that the powers of the HIC to investigate fraud should be significantly enhanced and legislation passed in June 1994 gives the Commission greater powers to investigate breaches of the Medicare benefits scheme. Where there are reasonable grounds to suspect that evidential material exists, the HIC may seek warrants to search for and seize relevant documents and to inspect premises and equipment. The Act also imposes more stringent conditions on pathology providers with respect to the maintenance, retention and production of records.[109]

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101 HIC, *Annual Report 1991-92* at 38.

102 *Audit Report No 17*, above n 7 at 2.

103 I Temby, "Impediments to Tackling Fraud" (1988) *56 Canberra Bulletin of Public Administration* 77.

104 The case is cited anonymously in *Audit Report No 17*, above n 7 at 14.

105 *Audit Report No 17*, above n 7 at 14.

106 The Government has acknowledged that greater measures are needed to address inducements by pathology providers to other doctors to order unnecessary tests. New measures are currently being developed, but "the problem has too many dimensions to enable the issue to be resolved in the short term": Sen Deb 1993, Weekly Hansard No 15 at 4765.

107 *Audit Report No 17*, above n 7 at 13-15.

108 I Temby, above n 103 at 80.

109 Health Legislation (Powers of Investigation) Act 1994 (Cth). Senate amendments have weakened the proposed powers of the HIC, particularly in respect of the powers of

The inadequacies of the legislation relating to investigation and prosecution do not fully explain the poor record of medifraud prosecutions. A recent review of the HIC's fraud detection programme concluded that legislative deficiencies were aggravated by administrative problems with the fraud detection and prosecution function in the HIC, which lacked a high-profile, consistent, co-ordinated national policy and a specific budget allocation for planned fraud control activity. There were too few staff allocated to fraud control and some were not adequately trained in the necessary investigative skills.[110] These administrative shortcomings go some way to explaining why the prosecution of doctors (and the investigation of them through the MSCI process) has not been emphasised as a regulatory strategy of the Commonwealth. This facet of benefits expenditure control is examined briefly below.

Administrative culture and the compliance model of regulation

The lack of emphasis on disciplinary proceedings and prosecutions under the Health Insurance Act has been a policy decision of the Commonwealth health administration, which has preferred to address abuses of the payments system, especially excessive servicing, through conciliatory intervention to modify practitioner behaviour and minimise inappropriate practices.[111] A recent study of the enforcement strategies of Australian regulatory agencies has found that most were characterised by a propensity for non-adversarial regulation. Most did not see themselves as primarily concerned with enforcement of their Acts and overwhelmingly supported consultation, education and persuasion as more important functions than law enforcement in achieving compliance.[112] These findings are supported by other studies. One writer who compared regulatory agencies with police forces, has commented that

> [R]egulatory agencies ... do not see their task as "catching criminals" but as containing deviants. They do not seek to prosecute and stigmatise their subjects but rather to obtain compliance through negotiation. Most crucially, for non-police bodies, the criminal law is regarded as a last resort.[113]

This assessment is borne out by a recent comment by the Department of Health that the need to refer doctors to MSCIs for formal investigation or to prosecute them was a measure of failure of the system rather than one of its success.[114]

Some theories and reasons posited for the prevalence of "compliance models" of regulation, explored elsewhere, include the power and dominance of the medical profession in Australian society[115] and the "capture" of the regulatory agency by the professional group being regulated.[116] An important influencing factor on regulatory

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authorised officers to enter premises for the general purpose of monitoring compliance with the legislation.

110 *Bates Report*, above n 44 at 25-30; HIC, *Annual Report 1991-92* at 38-39.

111 *Audit Report No 17*, above n 7 at 44. It has been recommended that counselling be confined to cases of minor overservicing only. At present there is no such restriction.

112 P Grabosky and J Braithwaite, above n 69, esp chs 1, 15 and 16.

113 A Freiberg, "Enforcement Discretion and Taxation Offences" (1986) 3 *Australian Tax Forum* 55 at 68.

114 *Audit Report No 17*, above n 7 at 44.

115 P Grabosky and A Sutton, above n 66 at 88.

116 P Grabosky and J Braithwaite, above n 69 at 207-210 and Postscript to ch 14. In an area as politically sensitive as health, the co-operation of the professional groups is vital to the success of most Government initiatives and the Government has emphasised the

policy is the strong public perception that white collar crime is less serious than other crime. An Australian Institute of Criminology survey in 1986 found that fraud on the social security system was rated more seriously by the public than either individual tax fraud or Medicare benefits fraud.[117] This public perception is reflected, for example, in Commonwealth prosecutions — for every tax fraud case dealt with in court, 20 social security fraud cases are prosecuted.[118] These statistics say a lot more about the priority of policy-makers, or about the ease of investigating particular sorts of offences, than about the prevalence of social security offences over other frauds on the Commonwealth. Where fraud investigations have been actively pursued in the HIC, they have been directed also at less sophisticated fraud by members of the public.[119] This has left the HIC open to the criticism that it is "chasing the minnows while the sharks go free".[120] The courts, at least in the past, have treated medical fraud less severely than social security fraud, with doctors who are actually prosecuted being much more likely to be acquitted or to receive a good behaviour bond. Where there is a conviction, however, doctors are more likely to be ordered to pay restitution and receive a custodial sentence than social security recipients.[121]

The relative effectiveness of the compliance approach versus a strong prosecutorial approach to abuses of Commonwealth payments in the health area has been debated for some time.[122] There is room for both as part of the regulatory strategy to manage Medicare abuses. The balance needs to be clearly and carefully drawn. Recent research on regulatory strategies argues that the achievement of regulatory objectives is most likely when agencies display both a hierarchy of sanctions and a hierarchy of regulatory strategies of varying degrees of interventionism. Regulators will do best by indicating a willingness to escalate intervention or to deregulate in response to the industry's performance in securing regulatory objectives.[123]

An effective fraud and overservicing control strategy which strikes an appropriate balance between administrative compliance mechanisms and tough enforcement has been lacking in the administration of pathology under Medicare. The approaches taken over the last decade have lacked the necessary deterrent effect. Recent reviews have concluded that overservicing and fraud are not abating, although excessive ordering of tests by general practitioners may be being stemmed. On the contrary, abuses in pathology are becoming more systematic and entrenched, "protected by corporate veils and the best advice money can buy".[124] The government has acknowledged the current weaknesses in the system by introducing a range of new measures in 1993-1994,

importance of AMA consultation and co-operation in developing its new system of overservicing and fraud control measures. At what point involvement constitutes "capture" is a debatable issue worthy of further study.

117 D Challinger, "Fraud on Government A Criminological Overview" in (1988) *56 Canberra Bulletin of Public Administration* 18 at 19.

118 Ibid at 22.

119 *Bates Report*, above n 44 at 16.

120 P Grabosky and J Braithwaite, above n 69 at 112.

121 P Cashman, "Medical Benefit Fraud: Prosecuting and Sentencing of Doctors" (1982) *7 Legal Service Bulletin* 58-61 and 116-121.

122 R Sarre, "Alternative Remedies for Fraud Rule of Law Versus Administrative Remedies" (1988) *56 Canberra Bulletin of Public Administration* 110.

123 I Ayres and J Braithwaite, *Responsive Regulation Transcending the De-Regulation Debate* (1992) at 6-7.

124 *Audit Report No 17*, above n 7 at xiii.

discussed above. It will be some time before it is clear whether they will answer the real challenge to the efficient and effective use of the health budget posed by excessive servicing and fraud. [125]

Setting the level of benefits

The Commonwealth has adjusted the level and structure of fees in the pathology schedule as a policy strategy for controlling its benefits expenditure. Increases in schedule fees for pathology have been much less than for other medical services over the Medicare period and fees for some common tests have been reduced.[126] The schedule has also been restructured, which has also reduced the financial incentives to overservice.[127]

Because the main cause of expenditure growth has been the rate at which the number of pathology services provided under Medicare has increased, curbing schedule fees has not been the complete answer to expenditure control. Amendments to the schedule have inevitably lagged behind changes in the industry, as diagnostic medicine has been revolutionised by technology. The Government lacks information about the cost structures of pathology laboratories and the actual costs of providing services. These factors impede the effectiveness of the schedule as a regulatory tool.[128]

There have been legal impediments to the restructuring of the schedule, exemplified by the successful challenge by an unincorporated association of private pathologists to the Minister's decision to introduce a new schedule in 1988: *Queensland Medical Laboratory v Blewett.*[129] The case is important in the context of examining the difficulties in controlling pathology expenditure, because it exemplifies how certain health policy decisions designed to control public expenditure may be vulnerable to adverse judicial review, with serious implications for the health budget. Before the decision is discussed, it is necessary to outline the background to the case.

The Queensland Medical Laboratory case

In November 1988, the Minister for Health made a determination pursuant to s 4A of the Health Insurance Act 1973 (Cth)[130] which introduced a new, temporary pathology schedule on which benefits for pathology tests would be calculated. Many items in the old schedule were combined and the new schedule contained reduced fees for many tests. A full revision of the schedule was under way at the time, but the urgent need to address long-standing anomalies and deficiencies in the current pathology schedule, and consequent abuses by some providers, prompted the introduction of an "interim" schedule which was expected to operate for about a year.[131] The Minister's

125 The "crackdown on overservicing and fraud" is expected to reap savings of $25 million in 1993/94 and $64.9 million in 1994/95: *Australian* 18 August 1993 at 4.

126 J Deeble and P Lewis-Hughes, above n 6 at 19. Schedule fees for pathology rose by 8.9% on average between 1984-85 and 1989-90, compared to 39.4% for other medical services.

127 *Audit Report No 17*, above n 7 at 44.

128 J Deeble and P Lewis-Hughes, above n 6 at 50-52.

129 (1989) 84 ALR 615.

130 The provisions referred to in this section are those added to the Act by Act No 75 of 1986 and are set out at (1989) 84 ALR 615 and 619-621. They were subsequently repealed by Act No 95 of 1989.

131 (1989) 84 ALR 615 at 642.

determination implemented the recommendation of the Pathology Services Advisory Committee (the PSAC) which had been established in 1986 pursuant to s 79B of the Act to consider whether a new table should be substituted for the current pathology services table and, if so, to make recommendations in writing to the Minister.[132]

The Australian Association of Pathology Practitioners (the AAPP) challenged the validity of the Minister's determination under the Administrative Decisions (Judicial Review) Act 1977 (Cth) and s 39B of the Judiciary Act 1903 (Cth).[133] The AAPP argued successfully that the PSAC had failed to make a "recommendation" within the meaning of s 78C of the Act. The Federal Court held that the PSAC had not complied with the principles developed by the Minister to guide its discretion in reaching a recommendation about a new pathology table.[134] A condition precedent to the making of the determination by the Minister not having been satisfied, the determination itself was invalid.[135]

The Federal Court decision

The first issue in the case was the nature of the principles which structured the PSAC's discretion. They were very detailed and included stringent costing requirements in all cases where the PSAC reviewed fees for pathology services.[136] It was accepted that the PSAC had an obligation to perform its functions in accordance with them. Justice Gummow held that the principles "covered the field" and that the PSAC was not permitted to operate outside them. Different sections of the principles applied according to whether the review was a "periodic" or a "general" review of the pathology table. Although the PSAC's recommendation concerned an interim schedule, Gummow J held that the schedule was the product of a "general review" within the principles and assessed the PSAC's performance against the principles for such a review; these included a requirement that the PSAC provide the Minister with "all relevant financial and other information relating to the recommendation".[137]

The main concern of the Court was the uncertainty of the financial impact of the new schedule on private pathologists. The AAPP asserted that practice incomes would drop by as much as 15-20 per cent, compared to the PSAC's assessment of a 3-5 per cent reduction, based on limited statistical sampling and its expert view that the new fee levels were "closer to correct levels than the existing schedule" and there was ample

132 The PSAC included nominees of the Minister, the Royal College of Pathologists of Australia and the Australian Medical Association and was chaired by a Deputy President of the (then) Conciliation and Arbitration Commission. Its functions were set out at s 78C(1): see (1989) 84 ALR 615 at 620.

133 The Federal Court held that the proceedings under the ADJR Act were not competent as the Minister's determination, being a decision of a legislative rather than an administrative character, was not a decision to which the Act applied. The Court nevertheless had jurisdiction by virtue of a claim by the AAPP for prohibition under s 39B of the Judiciary Act: (1989) 84 ALR 615 at 634-6.

134 Section 78C(2) made provision for the Minister to determine principles to be applied by the PSAC in the performance of its functions. These principles, which ran to 10 pages, formed a Schedule to the Act.

135 (1989) 84 ALR 615 at 636, citing as authority *Bread Manufacturers of New South Wales v Evans* (1981) 56 ALJR 89 at 93 per Gibbs CJ.

136 The principles are set out at (1989) 84 ALR 615 at 621-624.

137 (1989) 84 ALR 615 at 640-641.

evidence that further development of new technologies had reduced costs in some areas.[138] Justice Gummow held that this failed to satisfy the requirement to provide "all relevant financial information". In his view, the principles required a detailed cost study of the effect of the new table on practice incomes and this had not been performed.[139] The PSAC had not assessed the effect of a number of specific cost components, such as labour and material costs of pathology services, in reaching the new fee levels.

The absence of detailed costings of the new table resulted from substantial practical difficulties in the pathology area. First, the PSAC had tried a number of approaches to costing the new table, but in its view a detailed cost study was unable to be performed, mainly because "the present system was in a chaotic state with the result that cost comparisons would have been unable to produce worthwhile data".[140] Second, a new table was urgently needed to address existing ambiguities and anomalies which were fostering abuses.[141] Third, the table was a temporary, interim measure which would operate for about a year, pending a full and thorough review of the table, with full consultation, over the ensuing 12 months.

Justice Gummow acknowledged these difficulties but, consistent with his strict, legalistic approach to interpreting the Committee's functions, he refused to allow that these factors relieved the PSAC from its obligation to comply strictly with the principles. Accordingly, the determination introducing the pathology table in 1988 was held to be invalid. The financial effect of the decision was that benefits for pathology services reverted to their 1986 values, the 1986 table being the most recent valid table. This resulted in unexpected payments of pathology benefits of $28 million that year.[142]

The lessons for resource re-allocation policies

The decision in the *Queensland Medical Laboratory v Blewett* case is an example (one of several in the health area)[143] of the difficulties which can arise in judicial review of administrative decisions which seek to re-allocate public funds between competing interests in the community. Such decisions are an important feature of the modern welfare state, in which there is a collective gathering of resources in an attempt to better allocate them for their collective consumption via new and more centralised

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138 (1989) 84 ALR 615 at 627 and 630.

139 (1989) 84 ALR 615 at 627.

140 Ibid at 630. The difficulties of obtaining information about cost structures and cost comparisons across the pathology industry are not new and still impede health policy-makers today: J Deeble and P Lewis-Hughes above n 6 at 45.

141 The HIC was at the time disbursing an average of $1.88 million each day in payments for pathology services: (1989) 84 ALR 615 at 619. By implication, any delay in stemming acknowledged abuses would affect the level of public expenditure, given the sheer volume of claims.

142 Auditor-General, *Audit Report No 32* 1990-91, *Department of Community Services and Health — Administration of the Medicare Benefits Schedule* (1991) at 44.

143 For example *Pharmacy Guild of Australia v Riordan* (1989) 18 ALD 446 (tribunal decision to reduce dispensing fees paid to pharmacists under the PBS); *Nagrad Nominees v Howell* (1981-2) 38 ALR 145 (departmental decision to reduce payments to nursing home proprietors).

administrative processes.[144] In the Australian health system, the fact that major public health and welfare programmes are delivered by subsidised private sector groups causes tension when budgetary pressures prompt the Government to change the funding of programmes and the level of subsidies paid to professional groups. Many of these decisions are reviewable by courts and raise important questions of policy which the courts are arguably ill-equipped to address.

It has been argued persuasively that there is a "predisposition towards individualism" among some judges when reviewing decisions which embody a conflict about how resources should be allocated. This predisposition, fostered by the historical legacy of judicial review of administrative action, makes it very difficult for them to hold an even balance between the competing ideologies of collective consumption and private interests, or in some cases to acknowledge that such a conflict exists.[145] In the *Queensland Medical Laboratory* case, the Court had open to it a "restrained and contextual" interpretation of the PSAC's functions, one that called attention to relevant factors other than logic and the literal approach to statutory interpretation.[146] Such an interpretation would have allowed the important policy considerations with which the PSAC was grappling in undertaking its task to be fully acknowledged and weighed. Instead, the Court preferred, and could justify on strict legal grounds, an interpretation of the Committee's functions which largely overlooked the competing public and private interests at stake in the case. [147]

The *Queensland Medical Laboratory* case also provides some insights for policy-makers into the best mechanisms to achieve policy change. The Government chose an expert committee to consult upon and recommend changes to the pathology schedule and then set down very detailed principles in statutory form to structure the exercise of its discretion. The outcome of the case suggests that highly structured discretions are very vulnerable to adverse judicial review; the general trend to structure the exercise of governmental discretions can only serve to facilitate increased judicial examination.[148] The decision in this case implies also that legislation which establishes expert bodies to recommend changes which reallocate resources should state the broad principles governing the allocation of limited public funds. This may promote greater recognition of those issues by courts in judicial review.[149] Both of these matters are important for the Government to bear in mind when it establishes formal consultative and advisory bodies to make recommendations which have the effect of redistributing public resources away from powerful private sector interest groups.

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144 P McAuslan, "Administrative Law, Collective Consumption and Judicial Policy" (1983) 46 *MLR* 1 at 4.

145 Ibid at 12.

146 J Barnes, "Reflections on the Chemists' Dispute" (1990) 18 *Australian Business L Rev* 254 at 258-9.

147 For a more detailed discussion of this thesis in the context of decisions on nursing homes funding, see K Wheelwright, "Nursing Homes — Policy, Profit and Litigation" (1992) 2 *Griffith LR* 103 at 146-151.

148 J Barnes, "Administrative Law" in R Baxt and G Kewley (eds), *An Annual Survey of Australian Law 1989* (1990) at 21.

149 A recent example of such statements of principle in health legislation is the Medicare Agreements Act 1992 (Cth), which confirms the Medicare principles of choice, universality and equity in service provision: Department of Health, Housing and Community Services, *Annual Report 1992-93* at 46.

CONCLUSIONS

The growth of pathology expenditure under Medicare has been the result of a complex range of factors, many of which are outside direct Commonwealth control. Where Commonwealth regulation has been implemented, it has been characterised by complex legislation subject to frequent and piecemeal amendment, apparently unguided by a clear and consistent policy. The implementation of the legislation has been uncertain and inadequate and some policy changes have been adversely affected by judicial review. These difficulties are exacerbated by the social, economic and political pressures which impinge constantly on policy development and implementation in health, and by the rapid changes occurring in health service delivery, particularly in diagnostic services. The legislative measures being introduced as a result of the 1993-1994 Budget reveal a fresh commitment on the Government's part to the development of a more co-ordinated and responsive approach to the problems of overservicing and fraud, particularly in pathology, although their impact cannot be assessed at this stage.

The Commonwealth's heavy reliance on its limited health and welfare power in s 51(23A) to regulate pathology provision under Medicare has resulted in a scheme which focuses narrowly on the provision of monetary benefits to subsidise individual services. Within this narrow regulatory framework, the main response to the increasing volume of pathology services has been to expand the conditions which a service must satisfy to be eligible for a benefit. The difficulties in monitoring compliance with some conditions, coupled with poor legislative and administrative control of overservicing in pathology, have made this approach to expenditure control problematic, especially within the fee-for-service system. There has been some creative use of other constitutional power to support health measures, but it is clear that, "Commonwealth regulation still falls far short of the most optimistic constitutional boundary".[150] Political factors, in particular the Government's policy on federalism, explain why the current extent of Commonwealth control over health falls far short of its legal potential.[151]

The corporations power in s 51(20) provides probably the greatest potential for more comprehensive regulation of the pathology industry. Since the decision in *Strickland v Rocla Concrete Pipes Ltd*, the High Court has adopted a consistently expansive approach to the scope of the corporations power, permitting Commonwealth regulation of a wide variety of commercial entities.[152] The corporation to be regulated must be a "trading, financial or foreign corporation". In identifying a "trading corporation", the focus is on its activities.[153] "Trading" includes those activities which produce revenue and extends to business activities "carried on with a view to earning revenue".[154] The Commonwealth has power to regulate both the trading activities of

150 J McMillan, above n 12 at 1. Examples include the Smoking and Tobacco Product Advertisements (Prohibition) Act 1989 (Cth), based largely on the corporations power in s 51(20) and the Narcotic Drugs Act 1967 (Cth), based on the external affairs power in s 51(29).

151 J McMillan, above n 12 at 77.

152 (1971) 124 CLR 468. See P J Hanks, *Constitutional Law in Australia* (1991) at 290.

153 *R v Federal Court of Australia; ex parte Western Australian National Football League* (1979) 14 CLR 190 at 233.

154 Ibid at 235.

the corporation and those activities undertaken for the purposes of trade.[155] Companies formed to provide laboratory services on a fee-for-service basis would fall within the concept of "trading corporations". All those activities which form part of the trading activities of a pathology corporation could be the subject of direct Commonwealth regulation to the point of prohibition and any legislation based on the power would have an extensive national coverage.[156]

Section 51(20) has been held by the High Court not to include the power to compel incorporation.[157] Accordingly, any comprehensive scheme would have to be based also on other heads of power, to cover the other forms of business entity, such as partnerships, which are commonly used to deliver medical services. There has been little attempt to date to base health legislation on multiple heads of power. A danger is that the more "patchwork" the constitutional basis of a regulatory scheme, the more vulnerable it is to challenge.[158]

The capacity to regulate pathology using a different constitutional basis is an issue worthy of further exploration. The constitutional foundation of health law is only one of a range of legal issues which warrants closer attention by policy-makers and lawyers who have a public policy focus. As the Government explores new policy options which will better ensure the provision of accessible and high-quality services under Medicare at an affordable cost, there will be a need for more critical analysis of how effective health legislation is in achieving its ostensible public policy goals. Legislation, after all, is the most important, but often undervalued, instrument of public policy.[159] This analysis needs to include careful consideration of the judicial review of administrative decisions taken under health legislation; these cases, which are overwhelmingly challenges by private providers to Government moves to reduce the level at which their services are subsidised from public funds, provide some insights into how legislation can be drafted to ensure that Government policies about resource allocation are less vulnerable to adverse judicial review. The major challenge of ensuring that limited public funds are used equitably in a health system in which there are many competing demands will be met more successfully if the legal implications of public policy implementation in the health area are recognised.

155 *Commonwealth v Tasmania* (1983) 158 CLR 1.
156 J McMillan, above n 12 at 35-37.
157 *NSW v Commonwealth* (1990) 90 ALR 355.
158 J McMillan, above n 12 at 18-19.
159 R Cranston, *Law, Government and Public Policy* (1987) at x-xii.