Medical fraud and inappropriate practice in Medibank and Medicare, Australia 1975-1995

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MEDICAL FRAUD AND INAPPROPRIATE PRACTICE
IN MEDIBANK AND MEDICARE,
AUSTRALIA 1975-1995

A thesis submitted in fulfilment of the
requirements for the award of the degree

DOCTOR OF PHILOSOPHY

from

UNIVERSITY OF WOLLONGONG

by

Kathryn Flynn

Science, Technology and Society
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# Table of Contents

<table>
<thead>
<tr>
<th>Title page</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of Contents</td>
<td>ii</td>
</tr>
<tr>
<td>Glossary</td>
<td>vii</td>
</tr>
<tr>
<td>Definitions</td>
<td>viii</td>
</tr>
<tr>
<td>Abstract</td>
<td>xi</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>xii</td>
</tr>
</tbody>
</table>

## Introduction

1. The philosophy of insurance            3  
2. The politics of health                 5  
3. Accountability to the public purse     7  
4. Methodology                            9  
5. History of health fraud                11 
6. Thesis structure                       12 

## Chapter One – Some themes in the literature

1. A hospital system in crisis            15 
2. Defrauding Medicare – the size of the problem 17 
3. Regulatory practice                    19 
4. Rationale for the thesis               20 
5. Key terms – fraud, doctor-shoppers, criminal fraud, overservicing, moral hazard and fee-for-service 23 
6. Some themes in the literature on fraud and overservicing 32
Chapter Two – Accountability and social control in an age of neoliberalism

1. Introduction
2. The Enlightenment
3. Representative government
4. The separation of powers
5. The problem of accountability
6. On the value of audits – three case studies
7. The criminal sanction
8. Foucault of governmentality
9. Government at a distance
10. Social security
11. The risk society
12. Social control
13. The new regulatory state

Chapter Three – Prior to 1975

1. The growth of health care financing in Australia
2. The 1920s and 1930s and the failure of national insurance
3. The 1940s and constitutional change
4. The Pharmaceutical Benefits Scheme
5. The 1950s – the Page National Health Scheme
6. The 1960s – The shaping of the health policies of the
Australian Labor Party 114
7. The Nimmo Report 121
8. Labor wins Power 128
9. Scotton – Canada 131
10. The legislative base - Health Insurance Act 134
11. The AMA aims to defeat the Health Bills in the Senate 136

Chapter Four – Goldrush: 1975 to 1981
1. Liberal-Country Party Coalition winds back Medibank 139
2. Medibank Review Committee 143
3. Medical fraud emerges as an issue on the political agenda 144
4. The establishment of Medibank Private 146
5. The Pathology Services Working Party 147
6. Parliamentary debate and media analysis 150
7. Australian Medical Association 153
8. The position of the General Practitioners Society of Australia on fraud and overservicing 156
9. Health Insurance Commission 158
10. Setting up a system to manage fraud 162
11. First skirmishes in the ‘minor war’: Dr. Geoffrey Edelsten 163
12. The Royal Commission into Deep Sleep Therapy 165
13. Blue-collar crime discovers medical fraud 167
14. Inadequacies of the legal system 168
15. Dr. Shik Aun Low 171
16. Different perspectives on measures to contain fraud and overservicing 174

Chapter Five – Whistleblowing: knowledge without power
## Chapter Six – Medicare and medical militancy: 1983 to 1985

1. Introduction
2. The Hawke government-neoliberalism
3. Labor’s health policy
4. What Medicare offered
5. Background to the response from the medical profession
6. The NSW doctors’ dispute
7. The Penington Inquiry
8. The Federal Election November 1984
9. Government backs down on fraud and overservicing
10. The summit
11. The terms of the settlement of the doctors’ strike
12. Media reaction
13. The fraud and overservicing function is transferred to the HIC
14. Softening of the legislation in fraud and overservicing

## Chapter Seven - Policing Pathology
1. Introduction – pathology offered the greatest opportunities for fraud and overservicing 269
2. Inducements 275
3. Early signs of the abuse of medical benefits 276
4. The Approved Pathology Practitioners Scheme 279
5. The JCPA – report 236 – Pathology 283
6. Macquarie Pathology Services 286
7. The Bates Report 298
8. The Bachich Case 300
9. The Audit Office and the media respond 301
10. A new legislative approach 303
11. The culture of kickbacks continues 305
12. The view from the Department of Health and Aging 306

Conclusion 309
Interviewees 315
Bibliography 323

Appendices 373
A Media attention to fraud and overservicing 1975 – 1981
B Media attention to fraud and overservicing 1982
C Department of Health - staff memorandum on whistleblowing
D Letter to Michael MacKellar from Kevin Newman Minister for Administrative Services
E Quinn document
F Letter to Neal Blewett, Minister for Health from Thomas Wenkart
G Letter to staff from Thomas Wenkert and Ross Sutton
H Macquarie Professional Services – Office Minutes written by Ross Sutton
Glossary

Abbreviations

AAPP  Australian Association of Pathology Practitioners
ABC  Australian Broadcasting Corporation
ACOA  Australian Clerical Officers’ Association
the Act  Health Insurance Act 1973
AFP  Australian Federal Police
AFR  Australian Financial Review
ALP  Australian Labor Party
AMA  Australian Medical Association
allocative efficiency The extent to which resources are allocated to best effect among competing programs. Allocative efficiency is concerned with choosing to allocate resources to those programs that yield the highest benefits.

bulkbilling Where doctors accept 85 per cent of the scheduled fee as full payment for a medical service.

coning The reduction of fees and benefits for identical services which are either performed together or sequentially, rather than as individual items.
co-payment A payment made by a consumer at the point of service which is a contribution to the cost of providing that service.

corruption Usually defined as the exploitation of public office for personal gain or the abuse of power for institutional ends, where there is no explicit personal gain for the offender. In this thesis the definition is broadened to include laws and administrative systems that foster illicit behaviour.

efficiency The production of health services at a minimum cost and in a way that improves health outcomes.

entrepreneurial medicine A group medical practice involving vertical integration, where both general practitioners and other referral services are linked in some form of financial interrelationship, either individual or corporate, often with the involvement of commercial risk capital.

economics The art of choice in the use of scarce resources.

fee-for-service The doctor charges the patient for the cost of the medical service provided. Medicare reimburses this cost, either in part or full, to the patient.

fraud (against medical benefits) This occurs when a doctor makes claim is made for a service not rendered to a patient, or where the service is incorrectly described when billing the patient. Patients and other members of the community can also defraud the system in a variety of ways including lodging false claims and computer crime.

groupthink A deterioration of mental efficiency, reality testing, and moral judgement that results from in-group pressures.

health care inflation The extent to which medical price inflation exceeds general inflation.

health economics A specialized study into the allocation of health resources and how valued goals are achieved.

Health Maintenance Organisations An insurance system prevalent in the United States providing managed care. Many believe that managed care eliminates the problem of fraud. This is not the case.

managed care The arrangement whereby an organisation assumes responsibility for all necessary health care for an individual in exchange for fixed payment.

medicaid (United States) State funded health insurance for the poor.
**medicare (United States)**  Federally funded health insurance for the elderly.

**medicare (Australia)**  A system of universal health insurance providing free access to public hospitals and access to the services of general practitioners and specialists. Specialist services are available on referral from a general practitioner. It includes services by pathologists and radiologists.

**moral hazard**  A term used in the insurance industry that refers to the recklessness induced by the security induced by insurance cover. Fraud is also part of moral hazard but poses different problems, in being a deliberate exploitation of the insurance contract. Moral hazard has been more broadly defined as the ways in which an insurance relationship fosters behaviour by any party in the relationship that immorally increases risk to others.

**opportunity cost**  Every time resources are used in one way in health care, opportunities are forgone to use these resources in some other way.

**overservicing**  Medical services that were not reasonably necessary for the adequate medical care of the patient concerned.

**qui tam suits**  (Latin for “who as well”; that is, who sues for the state as well as for him or herself). It is a civil and not a criminal statute. The statute authorises private citizens to sue on behalf of the government, and to share in any recovery of defrauded funds eventually recovered by the government. In the United States more than half the settlements awarded the Department of Justice in health care fraud cases arise from qui tam suits.

**resource allocation**  The extent to which resources are allocated to best effect among competing programs.

**symbolic power**  Activities and resources gain in symbolic power, or legitimacy, to the extent that they become separated from underlying material interests, and hence go misrecognised as representing disinterested forms of activities and resources.

**symbolic capital**  Symbolic capital is a reformulation of Weber’s idea of charismatic authority that legitimates power relations by accentuating selected personal qualities of elites as supposedly superior and natural.

**universal public health insurance**  Health insurance which provides coverage to the entire population.

**white-collar crime**  This term excludes conventional street crimes. An early definition of white-collar crime was deviance committed by people of high status or repute in the course of their occupation. The definition has been broadened to cover illegal acts committed by non-physical means and by
concealment or guile to obtain money or property or to obtain business or personal advantage. The term includes deviant behaviour by corporations or officers of corporations in the service of the organisation.

Abstract

The Australian system of universal health insurance has enjoyed great electoral popularity but the system has been open to abuse and has been beset by administrative inertia, a reluctance by governments to establish reliable estimates of the extent of fraud and overservicing, lack of adequate legislative policy and a very low rate of prosecutions.
The aim of this research is to provide an historical and sociological account of institutional responses to medical fraud and overservicing and the media’s engagement with this issue over twenty years from 1975 to 1995.

Archival sources and interviews with key politicians, public servants and whistleblowers are used to tell the story of how universal health insurance was accepted as a necessary part of the social fabric from the introduction of the Pensioners Medical Scheme in 1951, Medibank in 1975 and Medicare in 1984 but measures to deal with the financial abuse of these systems did not have the same priority. The pathology industry provided the greatest scope for illicit profits through offers of kickbacks and inducements from pathology companies to referring general practitioners and this practice fuelled the growth of entrepreneurial medicine. Whistleblowers in the late 1970s and early 1980s campaigned for legislative and administrative change, but the reform agenda was more successful when it was led by a managing director of the Health Insurance Commission committed to change. These events are contextualised by several theoretical perspectives, including Foucault’s theory of governmentality, the sociology of insurance and of whistleblowing.

The challenges for the 21st century are to maintain the level of resources needed to provide the intensive policing required for the regulation of the financial abuse of medical benefits particularly in the area of electronic fraud and sophisticated criminal fraud.

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