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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

School of Social Sciences, Media and Communication

2004

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Glossary

Abbreviations

AAPP	Australian Association of Pathology Practitioners
ABC	Australian Broadcasting Corporation
ACOA	Australian Clerical Officers' Association
the Act	<i>Health Insurance Act 1973</i>
AFP	Australian Federal Police
AFR	<i>Australian Financial Review</i>
ALP	Australian Labor Party
AMA	Australian Medical Association

ANAO	Australian National Audit Office
ATO	Australian Taxation Office
APA	Approved Pathology Authority
APL	Approved Pathology Laboratory
APP	Approved Pathology Practitioner
CPD HR	Commonwealth Parliamentary Papers, House of Representatives
CT	<i>The Canberra Times</i>
the Department	Commonwealth Department of Health and Ageing
DPP	Commonwealth Director of Public Prosecutions
DRS	Doctors' Reform Society
FODS	Fraud and Overservicing Detection System
FOI	<i>Freedom of Information Act</i>
HIC	Health Insurance Commission
JCPA	Joint Committee of Public Accounts
MBR	Medibank Review Committee
MBS	Medical Benefits Schedule
MJA	<i>Medical Journal of Australia</i>
MPRC	Medicare Participation Review Committee
MSCI	Medical Services Committee of Inquiry
NATA	National Association of Testing Authorities
OECD	Organisation for Economic Co-operation and Development
OP	other pathologist (Medicare benefit rate)
PM&C	Department of Prime Minister and Cabinet
PSR	Professional Services Review
PSWP	Report of the Pathology Services Working Party
RCPA	Royal College of Pathologists of Australasia
SH	<i>The Sun Herald</i>
SMH	<i>The Sydney Morning Herald</i>
SP	Specialist Pathologist (Medicare benefit rate)

Definitions

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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Introduction

If I had to sum up the immediate future of democratic politics in a single word I should say, "Insurance"...because I am convinced that by sacrifices which are inconceivably small, which are all within the power of the very poorest man in regular work, families can be secured against the catastrophes which would otherwise smash them up for ever.

(Winston Churchill 1909 cited in Rose 1999: 80-81).

This thesis analyses how fraud and overservicing became entrenched in the Australia's publicly funded health insurance system, firstly within Medibank and later within Medicare. It addresses the factors operating within health policy and the broader context of Australian politics and history, which were defeating measures to deal with fraud and overservicing. It then explores why formal structures of accountability in the public sector failed and the way in which one of the informal structures of accountability, the media, responded.

The thesis then offers an assessment of the media's effectiveness in this area of medical politics.

In Australia, in the mid 1940s, Health and Treasury officials looked askance at the developments in the New Zealand health system where fraudulent schemes of different kinds were defeating best efforts at cost containment. This knowledge did not prepare the federal government in Australia for a similar eventuality with the Pensioner Medical Scheme, which it introduced in 1951, nor for the universal publicly funded health insurance program, Medibank of 1975 and of Medicare in 1984. The much needed administrative and legislative measures were an afterthought. While it was considered that measures to deal with fraud could be implemented at some distant point in the future when the patterns of abuse became apparent, such a policy approach made life difficult for fraud investigations to deal with fraudulent behaviour without the necessary legislation at hand. Dealing with fraud in the present was a different matter to dealing with it in the future when such a framework might be implemented.

Hampering efforts to implement best practice in fraud investigation and control has been the response of officials who have tended to ignore the amounts 'leaking' from the system. It has been left to whistleblowers to sound the alarm and the media and concerned parliamentarians to remind officials of its reality. An example of this media action was seen in 2004 on the current affairs

television program, *Four Corners*, produced by the Australian Broadcasting Corporation. On the program, Dr. Janet Mould, general manager of the Program Review Division of the Health Insurance Commission claimed the amount lost from medical benefits was less than one per cent. But experienced fraud investigators estimated the minimum figure that could be assigned to fraud and abuse against Medicare to be ten per cent or two billion dollars per annum (Fullerton *Four Corners* 2004). If there is no reasonably accurate estimate of fraud losses it is impossible for health administrators in the Health Insurance Commission to mount a case for the resources they need to effectively manage the problem. These resources include well-trained investigative staff and the purchase and application of the most appropriate technology for fraud detection.

The origins of regulatory failure lie in the lack of knowledge of health insurance fraud. Fraud control measures were little understood; they still are not well understood and there is little academic research in this area. For instance, there is a difference between fraud investigation and fraud control. Fraud investigation focuses on cases that are uncovered the normal investigatory processes. Fraud control is concerned with the vast mass that are not apparent through this process. This is where the bulk of fraud resides and it is largely invisible. It was hard initially to place health fraud on the policy agenda when the extent of it, who committed it, how it was done and how to manage it were not known.

The philosophy of insurance

This lack of understanding of the nature of health fraud is exacerbated by problems in the nature of insurance. It entails a philosophy that is less concerned with apprehending the individual criminal offender and more with crime deterrence across a broad population. It assumes that crime is inevitable and the most practical approach is to put in place mechanisms to reduce opportunities for its occurrence. This translates into regulatory efforts being directed at education and counselling rather than the expenditure of resources on legal redress. Also within the insurance industry is a work practice in regard to 'efficiency', a belief that the efficient payment of claims ranks as a priority over the checking of claims for fraudulent activity, as the checking process causes delays to the payment system. In the private insurance industry the slow refund of cheques can give a competitive advantage to other insurance firms and in publicly funded insurance can cause public discontent with the system.

Insurance operates as a mechanism to offset the financial losses imposed by natural disasters, unemployment, theft or ill-health that are all a feature of life. As Winston Churchill was aware, insurance cushioned against the blows of outrageous fortune for even the poorest in the community, so families are not left destitute and entrapped for generations in poverty. Insurance serves a political function: it is the safety net to prevent people becoming economically dispossessed and a source of political discontent. Insurance spreads risk and mitigates the worst economic aspects of modernity.

Capitalism for all its focus on the individual has found an apparatus of risk management so losses are carried across whole populations. In as far as insurance relies on the spreading of losses across all contributors, insurance is a socialist system, but one successfully aligned to capitalism.

A perennially popular insurance product is health insurance. For most people their only source of wealth generation is income derived from the sale of their labour, so health insurance is a way of ensuring that the costs of health care will be shouldered, not by the individual, but by an insurance company. Governments have been aware that health insurance, despite Churchill's optimistic appraisal, is a financial burden on the poor and the cost of high technology medicine makes it a costly exercise for other social classes. In a measure that softened the edges of capitalism and worked towards a more equitable distribution of income, in western countries, in the aftermath of World War Two, a welfare state, modelled on the social outlook of economist John Keynes, assumed responsibility for providing publicly funded health insurance.

However, for all its benefits, one side effect of health insurance, both privately and publicly funded, has been its vulnerability to fraud and overservicing. One component of this vulnerability is the characteristic of insurance being a contractual arrangement based on trust. The ideal is that neither party will abuse the relationship either through the insured making

false claims or the insurer failing to pay out on real claims. If this fraud occurs it is termed moral hazard. In terms of publicly funded health insurance, policy makers have been desirous to implement health insurance but have been tardy to implement the regulatory measures to protect funds from these abuses for a number of reasons.

The politics of health

Apart from this structural problem in the nature of insurance itself was added another. The Australian Labor Party (ALP), under the leadership of Gough Whitlam in the 1970s, aimed to introduce universal health insurance but also to gain greater control over the medical profession. There were significant sections of the medical profession who objected to this arrangement. The Keynesian welfare state was a beneficial concept for some but for most medical practitioners it meant greater control over income and disciplinary action by government, not the profession itself. Control over fraud and overservicing was an aspect of a greater evil: unnecessary government interference in their professional autonomy. The result was that the issue of the abuse of medical benefits became aligned to fights between the government and the profession over health insurance and became an integral part of the medical wars of the 1980s. From the inception of universal health insurance in 1975 the power of the medical profession was reduced but the profession's counter attack with the doctors' strike in New South Wales won them at least one victory with the reduction of measures to deal with the abuse of medical benefits in the period 1985 to 1994.

The profession was the object of the Labor Party's design to reduce the autonomy and power of medical practitioners. Dentists, by contrast, were allowed disciplinary power on fraud and overservicing with the full complement of legislative powers to control errant members of the profession. In New South Wales, the Dental Board in NSW, when it heard cases under Section 46 of the *Dental Act*, had the powers of a Royal Commission. These powers were retained up until 2002 when the Act was changed. Having the powers of a Royal Commission meant that it did not have to abide by the rules of evidence of the criminal jurisdiction. They were a protective jurisdiction and so the standard of proof was not as high. It was based on the balance of probabilities as opposed to the concept of beyond reasonable doubt. Under Medicare someone could be billing for services performed over thirty-six hours in a day and the case could still be thrown out of court on a procedural irregularity. Here the Dental Board would not only win the case on its merits but the case would also be published in the book of the Board's deliberations (Dale 1994, 2002; Dale *pers. comm.* 2002).

These differences between the disciplinary powers given by governments to the two professions are inconsistent and inequitable. For the medical profession it has meant that it has had less control over its members than the dental profession and it has been another entry point for government control over the practice of medicine.

Accountability to the public purse

Neither the medical profession nor the medical bureaucracy was given the legislative powers to deal with the abuse of medical benefits. This left a problem of accountability that emerged prominently in the 1970s and 1980s. However, the formal structures of accountability have become a problem. As governments have taken on new responsibilities it has become more onerous for parliaments to oversee these functions. Formal accountability under the Westminster system resides with the Minister but in practice is delegated to the bodies of review: the Auditors-General, the public accounts committees, senate estimates and parliamentary elections. Unfortunately, accountability too often falls between the cracks of the different government departments charged with this task. There are some who would argue that only formal accountability has legitimacy and others that the informal measures of accountability, including the media, have the same standard of legitimacy in a democracy. There are merits in both sides of this argument but in any case, the media has been a player in this arena, and has been effective.

This thesis looks at this conflict-ridden political process in the implementation of controls over fraud and overservicing. It is structured around a longitudinal study of the interaction between the Departments of Health and the Health Insurance Commission on the one hand and on the other the regulatory authorities, the media, whistleblowers, the Australian Medical Association, the specialist medical colleges, the Australian Association of Pathology Practices

and other stakeholders in the battle over this facet of cost containment. Because the issue is scandal driven, it is instructive to examine the scandals in more detail, including their policy outcomes and the historical circumstances that encouraged media interest in the issue.

This thesis is original over a wide range of areas but more by default than design. It is original in the use of social theory, history, politics and notions of accountability, in the documents collected and the interviews received. It is original also in that there has been little written in this area, apart from the work in Australia of criminologists Paul Wilson and Russell Smith and legal academic Karen Wheelwright. Almost without exception universities are not interested in this topic and do not teach fraud control or the politics of this area of health policy.

This is the first study to focus on a group with little institutional power, whistleblowers and unauthorised confidential sources in the Department of Health, who in the late 1970s and early 1980s formed a co-operative alliance with journalists in the hope that publicity would push governments into the enforcement of its own regulations and the generation of more effective legislation. However, the initial imperatives that drove the Health Insurance Commission into a vigilant stance on fraud and overservicing in the early 1990s eased with the election of the Liberal coalition government in 1996. The fraud game recommenced with renewed vigour with the result has been that ever-

larger financial resources are being drained from Medicare, as testified by accounts given by current staff in the HIC to me in their interviews.

Methodology

When I was first started researching how medical fraud became entrenched within the health system, I found it difficult to make progress. The relevant government departments were prepared to answer questions but I had to know the right questions to ask initially. I could not ask the right questions without the appropriate knowledge. Those holding the knowledge worked in the government departments. I had neither worked inside the Department of Health, the HIC or the Office of the Director of Public Prosecutions, nor knew anyone who did. I believed that the best information would reside with those who worked in the middle ranks of these organisations and preferably within the then named Professional Review Division of the Health Insurance Commission or the medical fraud branch of the DPP. As I did not have any contacts the next best approach was to keep learning about the health system and accessing all public documents on the medical fraud subject.

It was a method reliant on persistence and luck and has been a model that has worked well and has been refined with some additions to the list borrowed from academe. The research material was gathered from original confidential documents, parliamentary debates, legislation, government reports, documentary and media archives, industry publications, newspapers and oral

histories. It included interviews with individuals who have imparted their historical knowledge of events and their own key role in them. It travelled down the paths of professional self-regulation, regulations and their effectiveness, the self-assigned task of the media as a participant in the regulatory process, the nature of moral hazard, and health care inflation. In the search for understanding of this issue there has been a need to range across a number of disciplinary areas including Australian history, economics, health economics, politics, public policy, journalism, criminology, constitutional, administrative and regulatory law, Australian health policy and its history. It is primarily an empirical study, but the theoretical framework that has proved useful in the thesis has been that developed by Michel Foucault in his lecture 'Governmentality' delivered in 1978 as well as the sociology of the media, of whistleblowing and of insurance.

The interviews I conducted varied in length and type. Most interviewees agreed to a face-to-face interview. The interviews that were conducted during the time I was researching this topic at university were tape-recorded and the typed transcription returned to the interviewee. This allowed the subject to delete, alter or add material to the original interview, and forward the amended transcription to me as the one to be used in the thesis. The interviews varied in duration, some were brief but most were between one to two hours. The longest interviews were from whistleblowers and were longer than six hours. There were also interviewees who could give information by telephone or email.

Interviewees included former members of Parliament and health ministers, medical politicians, former Presidents of the Australian Medical Association, former managing directors of the Health Insurance Commission and staff of the Commission, health fraud investigators, academicians, journalists, former whistleblowers as well as others who preferred to give their interviews off-the-record. I was fortunate in that many of the interviewees had retained documentary records pertinent to the events they described and in some cases this was material that was not available on the public record. These records were aids to the memory of historical events for the interviewee and were useful as primary source material in its own right.

I made use of personal interviews, a miscellanea of documentary material, and relevant academic literature and together these primary and secondary sources helped to construct an historical portrait of the events that have shaped the way in which fraud and overservicing have become part of the fabric of publicly funded health insurance in Australia.

The history of health fraud

It is of value to reflect on the development of health policy in Australia, the way in which health insurance has grown alongside it, sometimes with and sometimes without, the regulatory measures to deal with the abuse of medical benefits. It provides a key to grasping why it has been that timely ways of handling this policing issue have been neglected. It gives an insight into the

legal, political and social frameworks that have prevailed at different times and are still reflected in current public policy. Jennifer deVoe, an eloquent advocate for historical understanding in the area of health policy, argued that, “it is crucial for policy makers to understand yesterday’s historical context of today’s political realities in order to craft tomorrow’s potential policy reforms” (deVoe 2003: 79). For once certain choices have been made, once certain methods have been adopted, habits set in and lock this historical choice into place (deVoe 2003: 83). Once patterns have been established change is difficult but from time to time they are openings, there are windows of opportunity for reform. In Australia the media have been one of these agencies of change and another has come from strong leadership by committed public servants.

Thesis structure

Chapter One lists definitions of terms that are used in this thesis and provides an overview of some of the themes in the literature on this subject. Chapter Two examines the problem that if fraud is proliferating then what has happened to accountability to the public purse? It argues that accountability needs to make use of all structures for overseeing public spending including that of the media. This chapter looks at modern systems of government and why the reach of the state has moved into new areas under arrangements determined by the welfare state. In this respect the framework developed by Foucault is useful for understanding the nature of modernity, with its interest in insurance and the

health and well-being of populations. Chapter Three outlines the early history of health policy and health insurance in Australia, the end of the Friendly Societies and the movement towards universal publicly funded health insurance under the Whitlam Labor Government. The issue of the abuse of medical benefits in this new system and its better containment under a government funded health insurance than under private health insurance was one of the tools of persuasion used by the ALP to win acceptance of this program.

Chapter Four covers the years from 1975 to 1981 when fraud and overservicing became endemic in the health insurance system and white-collar and blue-collar criminals exploited its weaknesses but in different ways. Chapter Five reviews how whistleblowers in alliance with the media and the formal institutions of accountability responded to the problem. The result was the establishment of a joint committee of public accounts into medical fraud and overservicing, and an examination of the performance of the Department of Health into its performance of its regulatory function in this area. This amounted to a kind of bureaucratic war among health officials, with few positive outcomes. Concurrent with this war was one between the medical profession in New South Wales and two Labor governments, federal and NSW. This is discussed in chapter six.

Pathology was the one area of medical benefits that governments had long recognised offered favourable opportunities for financial abuse and it was the subject of the second half of the public accounts committee's hearing into medical fraud from 1983. This is the subject of chapter seven, which analyses one area of conflict for the government, what its position would be in regard to entrepreneurial medicine.

The history of Australian publicly funded health insurance as charted in the following chapters had been marked by the belated and haphazard measures to deal with the abuse of medical benefits. The challenge for the future is the implementation of a program of regulatory risk management and intensive policing, and ensuring that it is sustained for the long term. This is particularly relevant in meeting the challenges of the 21st century in the defrauding of Medicare through electronic funds transfer and sophisticated criminal fraud.

Chapter 1

Some themes in the literature...

19 Needless Deaths...The Search for Truth Starts Now
(*Totaro and Pollard SMH 12 December 2003: 1*)

Hospitals Stretched too Thin Before the System Snapped.
Ten of Campbelltown Hospital's most senior physicians, among them obstetricians, surgeons and pediatricians...argued that political imperatives not clinical need, have driven long-term funding and resource decisions (*Pollard and Totaro SMH 18 December 2003: 6*).

Children's Hospital in Funds Crisis
The Carr Government has admitted a looming funding crisis in children's hospitals but defended the use of charity money to pay salaries at the Children's Hospital, Westmead (*Davies: SMH 19 January 2004: 1*).

Hospital Budgets Plunge into the Red (*SMH 24 January 2004: 1*).

A hospital system in crisis

The headlines signalled a hospital system in crisis and the drum roll for a Federal election. In 2003 five former nurses from two south-western Sydney hospitals, Campbelltown and Camden, alleged that due to gross negligence in case management, hundreds of patients had died and thousands were inadequately treated. The Health Care Complaints Commission investigated nineteen of these deaths. The whistleblowers attributed the dire conditions in the hospitals to under-funding, mismanagement and other systemic problems

(Jopson *SMH* 12 December 2003: 4). Campbelltown and Camden are not the only hospitals in straitened circumstances. Many are affected. The outcome of this crisis was the calling of seven official inquiries into these hospital disasters (Mitchell *SH* 1 February 2004).

The problem is not of recent origin. The *Medical Journal of Australia* reported in 1999 that misadventures in health care contributed to 50,000 Australians suffering permanent disability and the deaths of 18,000 annually. The first part of the problem is the hospital system itself whereby too much of the workload falls on the shoulders of under-trained, exhausted and overworked junior interns and the second part is the lack of resources to effect structural improvements (Walton *SMH* 4 March 2004: 13). The financial impoverishment of New South Wales public hospitals is the by-product of political decisions to exert tight financial discipline over hospitals, the most costly sector of the health system (Palmer and Short 2000: 6). It is a harsh method of controlling expenditure while simultaneously creating demand for private health insurance (Scotton 1999: 83). Hospital and health administrators, doctors, nurses, patients and their families are the passive observers of a system under increasing pressure. They are aware that there is insufficient funding to maintain present levels of service or plan for future increases in demand (*SMH* 17 December 2003: 13).

But the headlines are also part of the periodic eruption into public consciousness of the cost of the public hospital system, the failure of governments to adequately fund it and the consequences of this failure. An

annual Australian health budget of \$60 billion supports this hospital sector and the private funding of health care, on a fee-for-service basis, through publicly funded health insurance. Governments are concerned with containing public expenditures and in the area of public hospitals are particularly cost conscious (Moore & Tarr 1988: 5). But although one end of the public health spectrum comes under tight fiscal scrutiny, it would appear that at the other end, where Medicare funds health services provided by the private sector, fiscal scrutiny is loose and regulatory control arduous.

The Commonwealth government funds Medicare, which is administered through the Health Insurance Commission. This is a statutory authority that administers the medical benefits scheme under Medicare, the Pharmaceutical Benefits Scheme and other health programs for the federal government. The HIC is also charged with protecting the public purse by the prevention, detection and investigation of medical fraud and inappropriate practice by health-care providers and the broader population. Those who are aware of the vulnerabilities of the system and who wish to exploit it include practice managers, receptionists, ancillary health-care workers, and computer hackers as well as enterprising criminals who have honed their skills in gaol: that finishing school whose curriculum covers the scams that are easy to execute and go undetected. These frauds are committed at the individual, syndicate and corporate levels (Graco *pers. comm.* 2001) and find their richest

rewards in pathology, diagnostic imaging, pharmaceutical benefits and doctor shopping (HIC *Annual Report* 1997-98: 70).

Size of the problem

As against the public hospital sector where costs are largely known, public health insurance carries significant costs that are not quantified. The Australian National Audit Office in its 1996/97 audit of the HIC put the figure at 1.3 to 2.3 per cent of medical benefits, yet in 1997 the Commission estimated the cost of fraud and overservicing at between \$600 and \$700 million a year (Gray, *Sunday Age*, 1 December 1997: 5). Staff of the Health Insurance Commission whom I interviewed expressed concern at the amounts lost through fraud and overservicing. Warwick Graco, former head of research with the HIC, said, "The practice profiles I have examined over the years suggest that people underestimate the extent of the problem. But the informed guesses of experts in general have one thing in common and that is, the size of the problem is huge: that it is in the billions" (Graco *pers. comm.* 2001). Geoff Proban and Paul Irwin, with many years experience as fraud investigators, put their conservative guess in the range of ten percent to fifteen percent of medical benefits as the amount defrauded (Proban and Irwin *pers. comm.* 2001). Other staff members put the figure at twenty five percent or higher of the government's eight billion dollar annual Medicare budget. There were none who put the amount defrauded at

lower than ten percent¹. Dr. John Nearhos former general manager, of the Professional Review Division, estimated the minimum figure to be ten per cent of medical benefits (*Four Corners* 6 September 2004). They all commented on the fact that the base rates for fraud and abuse are unknown: that the HIC does no measurement of it in dollar terms.

In private insurance the cost of fraud is carried by higher premiums and in public health insurance by additional burdens placed on the public purse. It means health expenditure is directed away from those with the greatest need of health care and into criminal activity (Sparrow 2000a: viii). In order to minimize the amounts lost through opportunistic fraud, insurance needs regulatory management, the technologies of surveillance and intensive policing (Graco 2002: 2-3; Ericson *et al* 2000: 542; Sparrow 2000b).

Regulatory practice

The HIC delivers services but also has a regulatory function. It is this function that distinguishes it from the rest of government. It is the regulatory function that is concerned with obligations and duties rather than services (Sparrow 2000b: 2). The HIC has traditionally given its first priority to the fast and efficient payment of medical benefits claims. It has relegated the risk management of medical fraud and overservicing, also termed inappropriate practice, to a secondary position in its hierarchy of responsibilities. The HIC,

¹ Malcolm Sparrow estimated that the amount lost through health care fraud against the U.S. Medicare and Medicaid programs could be as little as ten percent or as much as forty percent and is therefore counted in the hundreds of billions of dollars (Sparrow 2000: 71).

like the public sector in general, has mimicked the private sector in setting a high valuation on efficient service, customer focus and process improvement. There are other benchmarks for good governance that are no less important. They are managing compliance, controlling risk and exercising discretion in the application of enforcement options (Sparrow 2000b: 2). In controlling individuals, companies and institutions, regulatory management has a range of sanctions at its disposal. These include persuasion, education, coercion and, failing that, the civil and criminal law. The ideal of civil society is that the law is upheld and regulations enforced. Appraising the relationship between governance and regulation, Warwick Graco reflected,

Regulations are the legal instruments that connect the policies of government with the day-to-day activities of individuals and institutions. They make government policies operational and hence perform a key role on the process of government. The effectiveness of government is dependent on the framework of procedures put in place to develop, monitor, enforce and adjudicate regulations (Graco 2002: 3).

Karen Yeung noted that as there was no one single accepted definition of regulation that her own definition encompasses the salient features that are found in the literature. She argues

Regulation may be broadly conceived as the purposive, sustained and focused control by the state over socially valued activities to promote collectivist goals by addressing social risk, market failure or equity concerns through rule-based direction of social and individual action (Yeung 2002: 7).

Like Graco she stressed that regulation means not only the passing of laws but also their enforcement. She added that the legitimacy of regulations rested on

their instrumental nature and their public aspect. By instrumental goals she means the reduction, modification or elimination of conduct considered to be socially undesirable and which the regulatory regime seeks to address. Its public nature refers to the constitutional status of regulations. This means that public authorities should act in a manner which is “authorised by law, reasonably certain and stable, accountable and transparent, procedurally fair and proportional, consistent and rational” (Yeung 2002: 8).

Rationale

This thesis explores the transgression of this regulatory ideal in the area of public health insurance. The project started life some years ago. Some pathologists whose company was commercially disadvantaged by a pathology company that was offering kickbacks to general practitioners approached me with the evidence of their rival’s standard contract for inducements. Such kickbacks or inducements are illegal. The doctors had reported the matter to the HIC. The evidence was investigated and referred to the Australian Federal Police, who also investigated it and referred it to the Director of Public Prosecutions, where nothing happened. These pathologists recognised that the evidence was sufficient for a *prima facie* case and had heard from a contact in the DPP that the Attorney General had intervened to stop prosecutory action. The matter went from a viable case to legal limbo by the swift dispatch of the Minister.

Criminologists Professors Peter Grabosky and John Braithwaite heard, off the record, that of ninety-six commonwealth, state and local government regulatory agencies they visited in the course of research for their book *Of Manners Gentle*, twenty-six agencies had not pursued enforcement action. This was due to ministerial interference for political preferment (Grabosky & Braithwaite 1986: 196). In the introduction to *Business Regulation and Australia's Future*, Grabosky, Braithwaite and Clifford Shearing argued such practice was a reality of public life in the 1980s. "Political interference was pervasive; ministers were able to quash convictions quite readily, and did so". They found ministers declined requests for investigative resources, that agencies were under-resourced, there was an unending backlog of cases for investigation, and if by chance an offender was brought to court the penalties imposed were inconsequential (Grabosky et al 1993: 11). If fraud was to proliferate then this was the fertile environment.

Confidential documents given to me from different sources covering the period of the 1980s and early 1990s revealed how fraud and overservicing became entrenched in the health system in the first place. The problem for regulatory authorities was that if deviance was not addressed in the early stages it would be ever more difficult to deal with in the future (Grabosky 1995: 350). The analysis by Grabosky and his colleagues indicated that corruption gained ground because people allowed it. In addition regulatory controls were hampered by inadequate legislative and administrative structures and a

Constitution which did not give the Commonwealth the powers it needed to regulate health. The problem was manifested in the Pensioners' Medical Scheme set up in 1951, in Medibank introduced in 1975 and continued under Medicare.

This thesis addresses the problem of fraud and overservicing in relation to health policy and within the broader context of Australian politics. Grabosky argued that regulatory policy, like public policy generally, takes place within the complex interdependencies of social life. Like an ecological system, interventions in one area will have repercussions in another (Grabosky 1995: 357). At play are forces working in dynamic interaction with each other and evolving over time and are best viewed from an historical perspective (Crichton 1990: 7). James Gillespie made similar observations about health politics. For all the dominance that is usually attributed to the medical profession, the state too has a large measure of power. This leaves the state and the profession in mutual interdependence (Gillespie 1991: 167), with health policy a site for disputation. Vested interests with varying degrees of power and organisational leverage shape the policy process. Sidney Sax, a former health policy advisor to the Commonwealth government, described it as a "multi-person drama which is continuous, conflict-ridden and more political than rational" (Sax 1984: xi).

This thesis looks at this conflict-ridden political process in the implementation of controls over fraud and overservicing. It is structured around a longitudinal

study of the interaction between the Departments of Health and the Health Insurance Commission on the one hand and on the other the regulatory authorities, the media, whistleblowers, the Australian Medical Association and other stakeholders in the battle over this facet of cost containment. Because the issue is scandal driven, it is instructive to examine the scandals in more detail, including their policy outcomes and the historical circumstances that encouraged media interest in the issue.

This is the first study to focus on a group with little institutional power, whistleblowers and unauthorised confidential sources in the Department of Health, who in the late 1970s and early 1980s formed a co-operative alliance with journalists in the hope that publicity would push governments into the enforcement of its own regulations and the generation of more effective legislation. However, the initial imperatives that drove the HIC into a vigilant stance on fraud and overservicing have eased, with the result that ever-larger financial resources are being drained from Medicare, as testified by recent accounts given by current staff in the HIC.

Key terms

Fraud

At the centre of the issue of control of fraud and overservicing is the question of definition. For those drafting the Health Insurance Act 1973 and for the committee members of the Joint Committee of Public Accounts Inquiry into

Medical Fraud and Overservicing, fraud meant a breach of sections 129, 129AA or 129AAA of the Health Insurance Act. It occurred when

a claim is made for a service not rendered to a patient, or where the service is incorrectly described when billing the patient; doctors can also be charged with fraud under the Crimes Act 1914 (JCPA 203rd Report 1982: 17).

Sometimes the frauds are honest mistakes: confusion over the schedule, an accounting error, a befuddlement over the office paperwork, but it can also mean a calculated intention to defraud. Those successfully cheating the system keep their avarice in check. They take small amounts and often. They write accounts for services not delivered, and to patients never seen, they double-bill for the same patient, they claim a simple procedure as a complicated one, where a short consultation was given they claim it was a long consultation, or if a short consultation then so brief that the patient is not adequately treated, and they give or receive kickbacks or inducements (Wilson 1986: 98-105; Wilson, et al 1986: 237; Jesilow et al 1993: 105-106; Sparrow 2000: 205). They know how to bill correctly, in accord with the average billing pattern for medical practitioners, and are savvy in avoiding pre-payment and post payment utilisation review. They know which areas of billing are being scrutinised, and which not, by regulatory authorities (Sparrow 2000a: 41).

Those formulating the Health Insurance Act definition had in mind that those committing fraud are doctors. But the medically unqualified also know the

weaknesses of the medical benefits system and how to assail it. In describing fraud and overservicing in the American Medicare and Medicaid systems, Malcolm Sparrow observed

The general public, and most members of the medical profession, may not be aware of the extraordinary range of characters queuing up to defraud the system, nor the unlimited creativity of men and women determined to steal from the health care complex (Sparrow 2000a: 1).

Doctor shoppers

Any definition of those defrauding Medicare needs to include doctors, members of the general public and a group well known to doctors, pharmacists and the HIC: the doctor shoppers. Illustrating this point were two flamboyant examples of doctor shopping that were drawn to the attention of the Australian National Audit Office in the compilation of its 1992 project audit on medical fraud and overservicing. In one year, one patient was busy visiting 463 different general practitioners and another managed to convince doctors that they needed 52 prescriptions over the course of 27 days (ANAO 1992: 9). They join the ranks of over eight thousand doctor shoppers (HIC Annual Report 2001-02: 74) who on average consult fifteen or more GPs, in different geographic locations, in a single year. They request prescription drugs, usually codeine phosphates (mild pain killers), narcotic analgesics (strong pain killers), and benzodiazepines (tranquillisers), and with prescriptions in hand they head to a variety of pharmacies to obtain drugs for personal use or to sell on the black market (Graco 2002: 3, 4, 18).

The conundrum, as an editorial in the *Medical Journal of Australia* noted, is that doctor shopping by patients is legal, but doctors can face disciplinary proceedings if found guilty of over-prescribing drugs of addiction (Kamien 2004: 204). Doctor shopping was costing the federal government \$30 million annually. In order to curb it the HIC set up the Prescription Shopping Project with a dedicated hotline that provided information to time-pressed general practitioners on known doctor shoppers. It provided doctors with one way of quickly identifying substance abusers so that other treatment methods could be attempted. It was a successful program and won for the HIC the Government Technology Productivity Award, but unfortunately the Project was shelved in 2002 for budgetary and privacy considerations (Kamien 2004: 205).

Criminal fraud

Sparrow has developed a sub-set of fraud, criminal fraud. The advantage of having this category is that it highlights those with advanced skills in defrauding Medicare. It is an area attracting the technologically adept, and those more rigorous in maximising their opportunities to defraud Medicare (Sparrow 2000a: 41). It is the province of a small proportion of doctors, the general public, computer hackers and those involved in organised crime (Butler 2000). In the United States and in Australia organised crime has discovered that controls over the abuse of medical benefits are lax. Medical fraud provides career opportunities for those keen to move out of the heavily regulated area of drug trafficking and into an area with minimal regulatory oversight (Stone 1998: 13). For those working in traditional areas of crime, medical fraud is one

way to launder funds gained through other criminal enterprises (Stone 1998: 14). Medical fraud is not only the domain of white-collar criminals. To the extent that groups other than doctors commit criminal fraud, regulatory control can be seen as not just an instrument of disciplinary power over the medical profession. It also signals that in terms of regulatory practice new approaches are needed to detect the vast amounts of money lost through fraud that is normally left undetected under current systems (Sparrow 2000a: xvii, 43). Criminals are actively engaged with the invention of new methods for defrauding the system. Those inventing fraud controls have to be equally ingenious in devising methods to defeat these schemes (Sparrow 2000a: 126).

Overservicing

Fraud is usually a matter of fact (Wilson 1986: 98-99), and in this sense it has a certain definitional purity compared to overservicing. However, no matter how overservicing is expressed - excessive services or inappropriate practice - its meaning is muddled, the definition ambiguous and the political outcomes contentious. Section 79 (1B) (a) of the *Health Insurance Act* defines overservicing as the delivery of “medical services that were not reasonably necessary for the adequate medical care of the patient concerned” (JCPA 203rd Report 1982: 17). But what is called overservicing can also be fraud. If the physician in question is aware that the services were not reasonably necessary then it is apparent that any medical benefit will have been obtained fraudulently (Cashman 1982: 117; Wilson 1989: 84).

One factor driving overservicing is that the patient is dependent on the specialist knowledge of the doctor to be able to identify if there is an illness and if so to recommend treatment and outline its likely effectiveness (Relman 1980: 966; Gillespie 1991: 16; Mooney 1998: 8). The patient differs from the consumer who in other situations exercises independent judgement over standards in service provision. The consumer decides whether the service is necessary and if so, whether performed to a satisfactory standard. In respect of medical services after the first consultation, which in the case of general practitioners is initiated by the patient, the doctor can generate demand for his services or for the services of specialists (Richardson 1989b: 227). It is this situation that gives rise to opportunities for abuse and when done on a large scale over whole populations fuels health inflation, this is inflation both of prices and of services (Relman 1980: 967).

The definition of overservicing covers a range of superfluous practices. They include defensive medicine, over cautiousness, patient-family pressure, pressure from recent journal articles, practices arising from differences of medical opinion, personal reassurance, legal requirement, research, insecurity, personal education, habit or hospital policy, unnecessary consultations to the elderly in nursing homes, pressure from a corporate employer or personal profit (Wilson 1986: 103; Deeble 1991: 54; Sparrow 2000a: 140, 154). Medicine is an inexact science and there are many ways of administering patient care; what might be a suitable treatment for one person might not be suitable for another

and finding effective treatment might be elusive (Sax: 1984: 186). For this reason the medical profession has always had strong objections to insurance regulators making rulings as to the way medicine is practised.

The flaw in the legal definition of overservicing was that the word 'adequate' was open to generous interpretation by those who were its arbiters, that is, individual doctors or the Medical Services Committee of Inquiry (JCPA 203rd Report 1982: 137). It was generally regarded that doctors determine what is "reasonably necessary" for patient care, however, in 1990 the Federal Court held that such a decision is not a purely medical one. A year later Mr. Justice Burchett argued, "What is reasonably necessary...may well involve economic questions" (cited Wheelwright 1994: 106, *Romeo v Asher* (1991) 1000 ALR 515 at 532). Medical services are not excessive unless they constitute unnecessary servicing by the medical practitioner "at the expense of the health system". Legal academic Karen Wheelwright concluded that the judiciary would not make a determination on the relative importance of either principle. She added

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 (Wheelwright 1994: 106).

Some commentators contend that regardless of the cost to the community, overservicing has positive outcomes for the health and well being of patients. However, in many instances the opposite is true. The overuse of antibiotics is

counterproductive as a health strategy (Moynihan 1998). So is the over ordering of computerised axial tomography (CAT) scans as it increases the risk of cancer. The fact that Australian physicians order double the number of CAT scans per population as their British counterparts suggests that this type of diagnostic testing is not always necessary. Graeme Dickie of the Royal Australian and New Zealand College of Radiologists said, "There was a temptation for doctors to order more CAT scans than might be necessary because they were quicker to do than traditional X-rays" (Wyld SMH 31 January 2004: 4).

Medical professionalism crosses over into normative values in the area of the medical conquest of the chronic diseases and disabilities of extreme old age (Sax 1984: 184). It gives rise to the questions is life better for being prolonged? Is the excessive prolongation of life overservicing? These questions are pertinent in relation to the poor life expectancy of those living in remote aboriginal communities, where under-servicing² is the norm, leprosy is not uncommon, hepatitis and renal disease are widespread and eye and middle ear infections are debilitating (Flynn 1996). The ideal of equal access to health care is circumscribed by the inequities in its distribution (Sax 1984: 185).

Moral hazard

² This is not to suggest that poor health in Aboriginal communities is due to underservicing. Poor health outcomes are the result of many social factors, however the doctor-patient ratio is lower in these communities than it is in urban Australia.

For health consumers using the services of bulk billing general practitioners and the public hospital system, Medicare provided an abundance of free health care. John Deeble calculated that in the first six years of Medicare “medical service use per person increased by 23.2%, with the largest increase (42.6%) in pathology” (Deeble 1991: 6). Sidney Sax foresaw an “almost unlimited scope for the continued escalation of demands for care” (Sax 1984: 191).

By the same measure insurance does not place a pressure on the populace to take personal responsibility for health care. People can abuse their own health through poor nutrition, lack of exercise, long-term over-exposure to sunlight and the excessive use of drugs, alcohol and cigarettes (Sax 1984: 193). Consumers proceeded with a blinkered vision. Medical consumption has increased in a population with a high valuation on health care, but minimal financial barriers to obtaining it. The third party payee was a government instrumentality, and in the public imagination it was visualised positively as possessing infinite financial resources and negatively as abstract, remote, impersonal, and anonymous. This fashioned a new consumption paradigm, one where personal responsibility for the prudent use of scarce medical resources did not weigh heavily on the collective conscience of the population. This continuing growth in the demand and supply of health services is a fundamental weakness of health insurance. Michel Foucault observed that the demand for health has no limits. It is a problem with no theoretical solution (Foucault 1988: 169-170). It is what insurers term moral hazard.

Moral hazard means that universal insurance disrupts the price signals to consumers and suppliers producing a rise in the quantity of services demanded and the quality supplied. It has also been defined “as the ways in which an insurance relationship fosters behaviour by any party in the relationship that immorally increases risk to others” (Ericson et al 2000: 537). It is not only a problem of publicly funded insurance (Deeble 1982: 455; Sax 1984: 193; Walsh 1995: 140; Tuohy 1999: 18; Leeder & McAuley 2000: 50), private insurance presents additional problems in moral hazard due to the way it sells its products, invests and insures itself (Ericson et al 2000: 542, 557). The problem of moral hazard does not arise where patients pay the physician directly for the medical service rendered and where there is no third party intervention is this financial relationship.

Fee-for-service

The weft and the warp of the fabric of fraud and overservicing is health insurance and fee-for-service. The primary problem of fraud and overservicing is that it is a function of insurance and secondarily that it is a problem of the fee-for-service system of medical remuneration (Sax 1984: 192). The third party intervention between doctor and patient for the payment of fees, as occurs under health insurance, creates perverse incentives for fraud and overservicing (Scotton & Deeble 1968 & 1989: 140). Once health insurance is in place and fee-for-service is retained as the method of medical remuneration then the policing of the abuse of medical benefits becomes difficult. Under universal health

insurance consumers are less aware of costs and doctors are less conscious of the need for efficiency (Sax 1984: 192). Fee-for-service means that as the patient receives a medical service they are charged for it. It encourages as much service as the consumer will accept and the provider is willing to give. This sets the conditions for overservicing and over utilisation (Rodwin 1981; Sax 1984: 219; Tarr & Moore 1988; Scotton & Macdonald 1994: 205; Palmer & Short 2000: 328).

Many commentators regard fee-for-service with opprobrium while insurance is hallowed as a social necessity. It has been apportioned more than its share of blame for the problems of cost containment. It has given rise to a discourse that fee-for-service is socially undesirable and doctors should rest content with remuneration either by salary or by capitation. Fee-for-service is not judged positively as the form of payment preferred by doctors that helps sustain their professional autonomy. Yet it is a common form of remuneration in the trades and the professions, and it is the financial heart of small business. It might well be that there are perhaps more appropriate forms of remuneration than fee-for-service in geriatric medicine (Sax 1984: 219) or pathology (Deeble 1991: 74), but it is still suitable in other branches of medicine.

There are others who indicate that fraud control is difficult under any insurance payment system. They argue that there are incentives for illegality built into fee-for-service but they do not of themselves explain these abuses (Richardson 1987; Wheelwright 1994; Sparrow 1996). The culture of Medicare administration

is also important because it has a significant effect on the way administrative and legal controls are implemented and the priority, which is afforded to either method of control (Wheelwright 1994: 4). Malcolm Sparrow argued that fee-for-service with all its faults is still preferable to the insurance system that has some popularity in the United States, Health Maintenance Organisations. His defence of fee-for-service is that it is manageable as long as it is recognised that such a system requires intensive policing (Sparrow 1996).

Some themes in the literature on fraud and overservicing

This thesis explores a moral landscape, a place where many academic disciplines have staked a claim. It is the territory for criminologists, lawyers and auditors and a place congenial to journalists, those broadcasters of the public's right to know (Carey 1974: 232). It was journalists who first drew attention to the organisational deviance that allowed medical fraud and overservicing to gain ground and become entrenched. This group of journalists, lawyers and auditors accepted the legitimacy of Medicare but used their moral authority to argue that the abuse of medical benefits was systemic, was unacceptable and needed to be controlled. For them prudent accounting practices, sound administrative practices, adequate legislation and the support of a sympathetic judiciary are the key ingredients for successful cost containment within publicly funded health insurance. For fraud specialists the question is the urgency of the need for reform, particularly at the administrative level (Sparrow 1996: 170) where it is argued that fraud control is complex and the health industry has never developed defences against it (Sparrow 1996: 212). For most health

economists and those involved in health policy development fraud and overservicing is a territory not often visited. Some are aware of the problems while others give it no attention at all. This neglect has profound implications for the implementation of regulatory strategies to deal with this area of cost containment.

Access, equity and efficiency

Sidney Sax, like other public health policy analysts, understood fraud and overservicing as a built-in feature of health insurance and the product of the failure of the market to impose price controls. Health insurance undermined market equilibrium but when the market is out of balance and the abuse of medical benefits is widespread then the ideals of universal health insurance are also undermined. Sax drew upon the ideas of Rashi Fein when he contended that this system of insurance had an underlying philosophy based on a platform of political rights. These were that access, efficiency and equity were the distinguishing features of the delivery of health care services. It means that all people have equal access for equal need to health care (Mooney 1998: 13) and should not forego medical care through impecunious personal circumstances (Sax 1984: 187). Efficiency means the production of health services is at minimum cost and in a way that improves health outcomes (Sax 1984: 187; Scotton 2000: 41) and equity means health care provision irrespective of attributes other than health needs, including the capacity to pay. Fraud and overservicing adds significantly to administrative overheads and therefore is an

assault on the efficiency of the health system, but it also has effects that are inequitable. Sax argued

Even if one is interested only in efficiency, the proper strategy requires that the first step should involve equity, for only a society with a fair sharing of both benefits and burdens can one call for sacrifices and restraints and hope they will be accepted (Sax 1984: 192).

He explained that once consumers have paid for insurance they expect the maximum amount of health care with the minimum delay. "This attitude illustrates the contradiction between equity and efficiency, and if both are valued, compromises will have to be struck" (Sax 1984: 192).

The health economists and health policy analysts

The co-authors of Medibank, Richard Scotton and John Deeble, were aware that Australian health insurance was financially vulnerable in key areas (Scotton 1974: 223). The reasons for this, argued John Deeble, were that the system is open-ended both in utilisation and doctor fee charging and Medicare was not designed with the regulatory system needed to manage it (Deeble 1991: 62). In addition, Jeff Richardson identified a conflict at the heart of health economics. At a conference on health policy in 1982 he opened his address with the observation.

Most industries would envy the historical record of the health care sector. Since 1950 its output has risen from 4 percent to 8 percent of gross domestic product and its future growth prospects are excellent. Despite this, the major shareholder – the government – is concerned with restraining further expansion (Richardson 1982: 81).

Economics and its sub-discipline health economics have divergent goals. Health is big business. Judged in terms of economics the business of health is succeeding in one of the areas capitalism values highly, ever-expanding growth. Judged in terms of health economics, expansion and growth are indicators of inefficient production (Mooney 1998: 4). Consumers and suppliers have few signals as to the price of health and this encourages over consumption and over utilisation. Health economists are left to create artificial barriers to escalating costs, but when they do it is with the tools used by economists. Lending their support to this approach are health economists, Gavin Mooney and Richard Scotton, who argued “the health sector now demands more of the discipline of economics – more examinations, more investigations, more techniques, more tools” (Mooney & Scotton 1998: xiv).

The tools health economists bring to regulatory theory and practice are inappropriate to enforce cost controls over fraud and overservicing. John Deeble, Richard Scotton and Jeff Richardson were cognisant that overservicing was a point of weakness in health insurance but they gave scant attention to fraud or how to deal with it (Deeble & Scotton 1968, republished 1989: 140). In dealing with overservicing the tool at hand was the manipulation of supply and demand. Demand could be controlled through patient co-payments. Supply could be reduced by limiting the number of doctors produced by medical schools (Richardson 1982: 81) and limiting benefits to service providers (Deeble & Scotton 1977: 354; Richardson 1987b: 9). The capping of the medical fee

schedule is another tool but it served a twin purpose, cost containment as well as financial control of the medical profession. Deeble and Scotton acknowledged the problem of overservicing and overutilisation in health insurance but disavowed any political intent.

We are not concerned with ideological issues: a compulsory and public-administered scheme is simply the most efficient and equitable method of achieving universally acknowledged objectives (Deeble & Scotton 1968:140).

Those engaged in regulatory and enforcement practice have developed their own tools of trade. They first need to know how much is lost through fraud and overservicing and then determine the resources needed to deal with the problem. Malcolm Sparrow found in discussions with health economists in the United States that as there was no data on the amounts lost through fraud then this data is not available to be included in their econometric models (Sparrow 2000: ix). A similar situation applies in Australia. Health economists are not proactive in urging the HIC for accurate data of the amounts lost through fraud and overservicing in dollar terms. The result is that they were unable to fully account for health care inflation. It also means that they approach expenditure controls by the methods used by economists. They lack an appreciation for the measures that have been developed by the regulatory theorists for cost control.

An example of this failure was in the area of diagnostic servicing. In 2000 Deeble wrote in the *Medical Journal of Australia* that in the area of pathology and radiology per person consumption had risen by 38 per cent over five years, compared with 5 per cent for all other medical services. The tools used to deal

with the problem were taken from the discipline of economics, to put a cap on the supply of services, but it had only a marginal effect (Deeble 2000: 47; Palmer & Short 2000: 209). It could well be that health economists are reliant on the conventional wisdom of economics, and need to think outside their disciplinary boundary, to learn less from the discipline of economics and more from regulatory and enforcement practice. When facts are actively sought and alternatives appraised the problems that arise in critical thinking, from what Irving Janis referred to as 'groupthink', are avoided (Janis 1972: 9).

What is more startling than a limited range of thinking about fraud and overservicing is no thinking about it at all. Gwendolyn Gray gave the issue one fleeting mention in *Federalism and Health Policy: The Development of Health Systems in Canada and Australia*. The health economists who contributed essays to Gavin Mooney and Richard Scotton's *Economics and Australian Health Policy* were silent on the subject. Professor Stephen Leeder's *Healthy Medicine: Challenges Facing Australia's Health Services* is an eloquent and innovative account of Australia's health system. It stresses the finite limits to health care expenditure but makes no mention that health care expenditure includes the opportunity costs of the vast amounts depleted through the financial abuse of medical benefits.

Stephen Duckett's most recent book on health policy does not discuss the abuse of medical benefits. He mentioned, "the most critical factor in service growth is

essentially unexplained practice pattern changes” (Duckett 2000: 202). This sounds like overservicing but Duckett does not acknowledge it. He noted that at the time Medicare was introduced there was an average of 7.2 services per head annually and by 1997/98 the figure was 10.8 per head (Duckett 2000: 195). Even with these figures he is sceptical of concerns over cost control.

Australia’s total health expenditure is not proportionally high when compared with other countries with a similar Gross Domestic Product per capita. Further, economists argue that control of health expenditure is an unusual and inappropriate objective from an efficiency perspective: what should be of concern is the extent to which marginal increases in health expenditure lead to marginal improvements in health outcomes (Duckett 2000: 43).

Duckett has a high standing in health policy by virtue of his academic positions and as a former Director-General of the Commonwealth Department of Health, so his avoidance of the issue of fraud and overservicing is noteworthy. For all the moral authority that criminologists, lawyers and the media can command, it is the health economists who have a disproportionate influence over public health policy. The views of health economists are augmented by a Canberra bureaucracy trained in the disciplinary logic of economics (Pusey 1991: 5–6). They have what Pierre Bourdieu would call symbolic capital, that is legitimacy (Bourdieu 1998: 44) and symbolic power (Bourdieu 1990b: 137), the power to construct reality, to have it accepted and for these ideas to suppress all others (Bourdieu 1991: 166). It gives health economists the power to define the problems in public health insurance, map the solutions and impose this vision on health policy. This means that the policing of the abuse of medical benefits is not afforded an automatic voice in how public health insurance is regulated.

Regulatory approaches

In contrast to the approach taken by health economists, where overservicing is dealt with through the artificial management of demand and supply, regulatory theorists and practitioners define the problem and its solution in a different fashion. The sledgehammer, in effect, is replaced by a finer set of tools. Fraud and overservicing are criminal behaviours and are dealt with by a risk control strategy, regulatory effectiveness and the management of enforcement (Sparrow 2000b: ix). This involves both the quality of regulations and regulatory practice. The quality of regulations refers to their scope and nature, and whether they be of state or federal origin. Regulatory practice refers to the strategies, policies and operational methods of regulatory agencies (Sparrow 2000b: 3). If these fail then government illegality needs to be examined to find out why regulations are not enforced. Failing this, the media can on occasion be an effective weapon in regulatory control.

Grabosky and Braithwaite's empirical study *Of Manners Gentle* critiqued the mild approach taken by regulatory authorities to the governance of the private sector (Grabosky & Braithwaite 1986: 1). It evaluated the ascending hierarchy of enforcement sanctions from the warning letter to the severity of criminal or civil law enforcement (Grabosky & Braithwaite 1986: 2), but its gaze fell on the extreme ends of this spectrum, on the bipolarities of persuasion and prosecution. The favoured strategy of regulatory agencies was to extend an invitation to business to act responsibly. If this failed then generally the

problem was ignored. The formal regulatory measures of prosecution, injunctions, seizure and adverse publicity were available, but in most instances were rarely used (1986: 188-190). Given this general stance the fact that three departments Customs, Tax and Health were prepared to take prosecutorial action was a noticeable departure from the practice of other regulatory agencies (1986: 168). The Department of Health for a brief period in the early 1980s, in the aftermath of publicity given to its inadequate procedures in dealing with medical fraud and overservicing, prosecuted fraud and publicized the fact. However, on overservicing it was “manners gentle”. It was counselling that was considered appropriate to deal with this grey area between fraud and all the discretionary variations in administering patient services falling under the rubric of overservicing (1986: 160).

Grabosky’s essay ‘Business Regulatory Enforcement in Comparative Perspective’ in *Business Regulation and Australia’s Future* reviewed regulatory practice in the eight years following the publication of the text *Of Manners Gentle*. Little had changed. Again the finding was that regulatory agencies were overwhelmed by their workload and again they shunned the use of tough law enforcement (Grabosky 1993: 10-11). Again the finding was that regulatory reform was precipitated by media activism (Grabosky 1993: 12).

Publicity as a regulatory tool

The Impact of Publicity on Corporate Offenders by Brent Fisse and John Braithwaite examined in more detail the positive regulatory impact of publicity on the

private sector. In all instances publicity acted as a deterrent against corporate criminal behaviour and was able to achieve some lasting reforms (Fisse & Braithwaite 1983: 243). The reason for this was that corporations, in fact, valued their public reputation for its own sake. It was the basis of their prestige and community standing and the means of attracting the most talented applicants for executive appointments (Fisse & Braithwaite 1983: 247-248). The authors suggested that publicity could be strengthened by the modification of the defamation laws and the legal protection of whistleblowers (Fisse & Braithwaite 1983: 283). Other control measures were the necessity for the reporting of corporate financial statements and the use of *qui tam* suits. This is a legal device available in the United States but not in Australia. It entitles a member of the public to initiate a private law suit against a corporation on behalf of the government, and that person is then entitled to a share in any of the defrauded monies recovered by the government. In the United States more than half the settlements awarded the Department of Justice in health care cases arise from *qui tam* suits.

The optimistic tenor of this work contrasts strongly with the pessimistic findings of Grabosky's study of regulatory enforcement in the public sector, *Wayward Governance: Illegality and its Control in the Public Sector*. It demonstrated that the threat of negative media attention and humiliation of a government department did not have a similar deterrent effect,

The risk of embarrassment appeared not to loom large in the consciousness of the actors before the event. Indeed, even after the event, principals in many cases remained unrepentant, or were at least able to rationalize their behaviour (Grabosky 1989: 297).

Public sector institutions were recalcitrant in the face of regulatory control. A similar situation applied in the United States where sources of institutional and political support could be mounted to deflect pressures for reform (Grabosky 1989: 307). In the private sector the media could patrol the boundaries of organisational life (Ericson 1989), due to its ability to threaten that which corporations valued: the maintenance of reputation, of the image of good corporate citizenship, and of the responsibility to shareholders (Fisse & Braithwaite 1983: 247-248).

However, the media lacked this influence over the public sector. The checks and balances operating on government agencies were in the areas of external and internal oversight. Exercising external control were the ANAO, the parliamentary committees, the Office of the Ombudsmen, judicial oversight as well as freedom of information legislation and civil litigation (Grabosky 1989: 311-327). Internal control was exercised through sound leadership in middle and upper management. However, problems could also occur where there was rapid organisational expansion and strong goal orientation (Grabosky 1989: 297). If the mechanisms of external and internal control failed then crime by government would go unchecked. The public censure provided by media attention was no guarantee of reform action. There were no sanctions in place

to ensure that government agencies implemented compliance programs. The troubling question was could “governments regulate themselves?” (Grabosky 1989: 307). Grabosky’s answer was that they could not. Others before had noted with resignation the flaws in the architecture of bureaucratic administration: the movement over time towards rigidity and inefficiency. The design flaw here illuminated was the sleight of hand between the bureaucratic ideal of service to the public and the reality of its self-interest, of vested interests, of the abuse of power (Bourdieu 1998: 35-63, 90).

Athol Moffitt, a former supreme court judge and Royal Commissioner, identified another issue. In surveying the results of five royal commissions into organised crime in Australia, he saw the structural forces giving rise to corruption as arising from an imbalance in the separation of powers between the legislature, the executive³ and the judiciary. The executive had too much power and the judiciary too little. The lack of a clear separation of powers resulted in a decline in the independence of institutions of government that allowed organised crime to go unchecked (Moffitt 1985: 209).

Braithwaite argued that even a strict separation of state powers was inadequate to provide for a system of government control that was self-correcting. In the modern world the private sector is, in many domains, more powerful than the

³ In the strict sense the executive in Australia comprises the prime minister and cabinet. This gives the political party in power a key role in the formation of policy, a power which is enhanced through the use of party discipline (Thomas 2002: 35-37). The definition of executive is blurred, as many understand that it includes the bureaucracy (Macquarie ABC Dictionary).

public sector. What are needed are powers that are separated between private and public and where the separations are many and transcend private-public divides. It would be a world where different branches of business, public and civil society power are all checking each other (Braithwaite 1997: 344).

This slide towards corruption was an idea pursued by Brent Fisse in his essay 'Controlling governmental crime: issues of individual and collective liability'. His solution was for the toughest sanctions on government illegality. His was a call for the benign big guns of regulatory control. He saw no reason why organisations in the public sector should be exempt from criminal liability (Fisse 1986: 138). His program was for a mixed strategy of collective and individual criminal liability for crimes by government agencies (Fisse 1986:121). He suggested that the punitive injunction could be used to ensure that government agencies implemented compliance programs (Fisse 1986: 128). He recommended formal publicity sanctions (Fisse 1986: 132), and in cases of reiterative crime, the agency can be eliminated altogether as was the case with the Crown Solicitor's Office and its replacement with the Office of the Director of Public Prosecutions (Fisse 1986: 135).

Regulatory practice

Regulatory practice concerns the way in which regulations are administered in individual circumstances. It is administrative law in action. Ian Ayres and John Braithwaite, in their work *Responsive Regulation*, argued the case for regulatory agencies being able to exercise broader discretion in the use of their powers: to

exercise their powers with flexibility. This was expressed diagrammatically in the form of a pyramid. At the base of the pyramid were the lightest and the most frequently used methods for obtaining compliance and at the apex were the toughest and the least used sanctions. The diagram illustrated the space and the scope available for a variety of responses to enforcement action. Ayres and Braithwaite supported the value of regulatory agencies having a strong enforcement capability. The more big guns at hand, then the greater the chance of these agencies achieving compliance, and paradoxically, of not having to use the big guns (Ayres & Braithwaite 1992: 19). It was a case of less fuss and more action. Ayres and Braithwaite spoke metaphorically of the power of 'the benign big gun'.

However, one bank robber was able to demonstrate that the power of the 'benign big gun' could have a literal application. In a television interview, Bernard (Bernie) Matthews, spoke of his method of winning acquiescence from the public without physical force.

In all my robberies, I use the voice and my mannerisms as the threat and the gun becomes an extension of that threat. It's not the primary tool...The whole name of the game was to get the person to do what you wanted them to do without physically hurting them (Matthews 2004).

In an era of deregulation and economic rationalism, the argument for the need for tough regulatory regimes can be harder to sustain. Ayres and Braithwaite maintained that tough regulatory regimes are always needed. The effectiveness

of these regimes was based on the awareness of the use of a hierarchy of sanctions. They illustrated this by their analogy of the capacity of the Australian sheepdog to muster sheep or to protect property by keeping an armed intruder at bay. The dog's minatory behaviour of barking, growling, stalking was usually all that was needed to maintain control. At play was an escalation of threats, with physical attack the final manoeuvre. Psychologically the dog displayed its greatest strength in its pugnacity in the face of those larger or even better armed than itself (Ayres & Braithwaite 1992: 44). Ayres and Braithwaite concluded that part of the regulatory art was a belief in one's invincibility and the refusal to be intimidated in the face of powerful interests (Ayres & Braithwaite 1992: 44-45). At base, boldness worked as a regulatory measure.

In *The Regulatory Craft* Malcolm Sparrow outlined what he saw as the key features of regulatory practice. Where older methods responded to crime after the event, newer approaches were pro-active and looked at patterns and trends in crime (Sparrow 2000b: 263). It meant a focus on risk control and problem solving (Sparrow 2000b: 9). It facilitated the ability to tackle important problems with the right tools for the job and using enforcement measures prudently (Sparrow 2000b: 14).

The Regulatory Craft was a general analysis of regulatory response and reform whereas his work *License to Steal: Why fraud plagues America's health care system* (1996, 2000a) was a study of the specificities of regulatory failure in the health

insurance industry. It was commissioned by the United States Justice Department because of concerns over the high rates of abuse of the Medicare and Medicaid programs. They wanted a set of practical guidelines for dealing with the issue at the administrative level. After a long-term empirical study of these programs in the public as well the private health insurance industry Sparrow made a list of observations and recommendations. Health care fraud was uncontrolled, he argued, and for the most part invisible. The amounts identified as defrauded are a small fraction of the real losses. It is these undetected amounts that inflicted large-scale financial damage to the health insurance system (Sparrow 2000a: xvii, 2).

He believed that computer analysis of fraud and overservicing was important yet too much reliance was placed on these systems. He argued the case for more human oversight in the claims checking process. It was all too easy for what appeared to be 'normal' claims to slip through the electronic checking systems. The criminally well informed are able to make claims for medical services that would not give rise to any investigative scrutiny as long as the diagnosis, the treatment and costing fell within the normal range. The use of electronic funds transfer made the task of defrauding both private and public health insurance systems all the easier. He speculated on what fraud detection systems Medicare might have to deal with \$100 million scams. The contractor explained that they had no contingency plans to handle such a scheme but in any case "it was just government money" (Sparrow 2000a: 32-35).

Sparrow concluded that some measure of control over fraud was possible when there were routine checks built into the system (Sparrow 2000a: 207). There was a need for investigative staff for these programs to be given appropriate training in fraud control, with instruction at university level. He argued for an accurate estimate of the amounts lost through the abuses of medical benefits using realistic audit protocols. He argued that fraud control was achievable. In the United States this was facilitated by *qui tam* suits, which gave those who blew the whistle on fraud a financial reward for their efforts. The media had a vital role in the fight against fraud for “only an appropriate level of public outrage will move things along” (1996: 3).

The media exposes scandal after scandal, and the Congress responds with hearing after hearing...Government officials respond...and then not much happens until the next set of embarrassing media revelations, when the whole circle turns once more (Sparrow 1996: 8).

Paul Jesilow, Henry Pontell and Gilbert Geis (1993) in their book *Prescription for Profit* noted the value of investigative journalism in bringing the issue of fraud and overservicing into the public sphere (1993: 51), but the intention of their work was to detail the history of fraud and overservicing. They argued that the government was reluctant to place legal constraints on the system because the government was catering to the demands of the medical lobby

As a result, Medicaid inevitably deteriorated to the point where structural reforms became necessary, but these reforms themselves only generated new forms of resistance from within the medical community (1993: 189).

This work also has an abundance of examples of fraud and an international comparison of approaches to this issue in the United States, Canada, and Australia. They argue that their study “highlights the relationship between structural arrangements, quality of care and fraud” (1993: 205). They argued that

In all three countries (Australia, Canada and the United States), despite different traditions and approaches to health care, the common forms of medical fraud and abuse seemed similar enough for one research team to suggest a similar susceptibility of all fee-for-service benefit programs to standardized criminal acts (1993: 213).

John Gardiner and Theodore Lyman (1984) in *The Fraud Control Game: State Responses to Fraud and Abuse in AFDC and Medicaid Programs* argued that publicity and the generation of scandal played only a minor part of the regulation of health care fraud. Fraud control was a dynamic system. They described it as “an ecology of games”, where the major players are political and institutional forces vying to win their preferred policy outcomes (Gardiner & Lyman 1984: 28–29). Fraud control could be thought of as being shaped by six basic games. These are derived from welfare policy, health policy, criminal justice, fiscal policy, intergovernmental relations and public administration. In addition fraud control policy is shaped by decisions made at federal, state and local levels. These six basic games changed over time and the media would periodically develop an interest in the subject to manufacture a scandal. This resulted in changes to the informal rules of the game.

While it may normally be understood that no player should rock the boat or publicly criticize other players, a scandal may lead to a policy of total warfare (“I know that we overlooked this in the past, but if we don’t get error rates down fast, we’ll all be out of job”) (Gardiner & Lyman 1984: 32).

They add, “a scandal may make it necessary to ‘do something’, but otherwise fraud control policies will be shaped by the interaction of the specialists” (Gardiner & Lyman 1984: 41).

Other legal and criminological approaches

Legal academics and criminologists Karen Wheelwright, Ian Temby, Rick Sarre, Anthony Moore, Anthony Tarr, Terry Carney, Peter Hicks, John McMillan, Paul Wilson and Peter Cashman argued that legal frameworks and regulatory mechanisms are essential for accountability of the public purse and from that basis explored the options for reform.

Cashman, representing the Law Reform Commission, writing in the Legal Services Bulletin (1982) drew upon two documents, “The Joint Discussion Paper issued in October 1981 by the Commonwealth Attorney-General’s department and the Department of Health” (cited in Australia, Parliament (1982), PAC 203rd Report: 236-254) and “Proceedings of a Seminar on Crime and the Professions – The Provision of Medical Services” (1981), in a critical essay exploring the barriers to the prosecution of doctors in cases of medical fraud (Cashman 1982: 58-61 & 116-121). The Commonwealth Government, he argued, has failed to deal with the problem of fraud by doctors in comparison with fraud by social

security offenders, and in this he agreed with the arguments put forward in the joint discussion paper that this can be attributed to the inadequacies of a legal system well adapted to the 19th century but not to the 20th century (1982: 121). Cashman pointed out that existing procedural mechanisms for the control of fraud and overservicing were cumbersome and overly secretive (1982: 120), that relatively few doctors were prosecuted, the acquittal rate for fraud was high and the penalties imposed were light. He also agreed with the recommendations for reform advanced by the discussion paper and added additional options including the use of non-custodial sentencing options, the greater use of orders for costs, the introduction of formalised incentives for pleading guilty and the use of adverse publicity as a sanction.

Four years later, criminologists Wilson and Grabosky revisited Cashman's analysis in the aftermath of the Joint Committee of Public Accounts final report on medical fraud and overservicing. Their focus was on the political failure of the inquiry, rather than Cashman's appraisal of the possibilities for legal reform. Wilson and Grabosky expressed concern that important recommendations of the inquiry had been ignored, that a key witness before the inquiry had met the usual fate of whistleblowers and had been subjected to personal abuse and organisational pressure, and that officers of the Department of Health in the area of fraud and overservicing were fighting to retain their positions (1986: 162).

Wilson in conjunction with Gilbert Geis, Henry Pontell, Paul Jesilow and Duncan Chappell explored the commonalities in the regulation of medical fraud and overservicing in Australia, Canada and the United States. In all three countries they found the criminal law did not adequately support the investigative effort, there was a lack of investigative resources and even when cases were established it was difficult to gain prosecutory action. The differences between the three countries lay in the differing rates of prosecution. In the United States several hundred physicians have been sanctioned including many who received custodial sentencing. By contrast in the province of British Columbia in Canada, no criminal charges had ever been laid (1985: 29).

Wilson, Chappell and Robyn Lincoln then looked at the anomalous position of the regulatory system in British Columbia and that of Quebec. British Columbia had a system distinguished by its ineffectiveness whereas that of Quebec was effective and well managed. Quebec had a resounding rate of prosecutions. The Quebec Health Insurance Board was able to win thirty convictions in its first three years (Wilson, Chappell & Lincoln 1986: 239). It seemed that the medical profession in Quebec accepted the Board would deal directly with cases of fraud and overservicing rather than handing it over to the profession for peer review. They also used a system whereby patients were given verification forms to sign to acknowledge that they had received a medical service. The study proved that with the co-operation of the medical profession and backed by a sound legal and administrative system the abuse of medical benefits could

be more handled with more efficacy. They concluded that the range of prosecutory options be widened, that adverse publicity be used more often, and that orders for costs be used as to deter defendants from prolonging their time in court (Wilson, Chappell & Lincoln 1986: 242).

In the 1990s Wheelwright published two articles on the failure of the legal system to contain abuses against medical benefits. Her work differed to of her predecessors in giving detailed attention to the constitutional impediments to the Commonwealth government's efforts to financially regulate health services. This is the deepest structural flaw in the legal apparatus to control medical fraud. 'Controlling Pathology Expenditure Under Medicare - A Failure of Regulation?' was written in 1994, shortly before new legislation was to be introduced strengthening the investigative powers of the Professional Review Division of the Health Insurance Commission. Her argument centred on the possibilities of the government's successful prosecution of complex fraud cases in pathology, which she argued necessitated the use of a different legislative authority, or head of power, under the Constitution to that currently employed. Her recommendation was to move away from a reliance on the Commonwealth's limited health and welfare power in section 51 (23A) of the Constitution and instead draw on the corporations' power of section 51 (20) as it offered the possibility of more comprehensive control over the pathology industry. It would cover corporate structures but other heads of power would be needed to cover partnerships. Her article 'Commonwealth and State Powers

in Health - A Constitutional Diagnosis' expanded on this theme of the Commonwealth's limited direct legislative powers over health. In contrast to the states' powers over health, the Commonwealth's powers over the area were indirect and fragmentary (Wheelwright 1995: 59). Again she argued that the Commonwealth's reliance on its health powers under section 51 (23A) was inadequate to address the financial pressures on Medicare particularly from entrepreneurial medicine.

Wheelwright in conjunction with Jeffrey Barnes and Beth Gaze in their article 'The Avoidance of Judicial Review: Lessons for Health Policy Implementation' focused on the way the private sector used the legal system to challenge policy decisions by government. Sectional interests used judicial review to legitimately shape public policy (Wheelwright, Barnes & Gaze 1996: 159). The solution was to design legal and administrative frameworks with an eye to their resilience from such attacks on health regulatory systems (Wheelwright, Barnes & Gaze 1996: 146).

Entrepreneurial medicine

One of these sectional interests was what Arnold Relman, editor of The New England Journal of Medicine, in 1980 termed the new medical-industrial complex. This was businesses formed to provide a wide range of medical services, including general practice medicine, pathology, radiology as well as those services normally provided by the local hospital emergency department (Relman 1980: 965). The idea was greater profits could be made by the

provision of these services under the one roof, with capital supplied for the high technology equipment needed for diagnostic services. The industry was highly profitable. Large profits attracted more investors into the industry, which in turn increased the industry's political influence. This had the potential to deflect the implementation of government regulatory measures, which would be contrary to its interests (Relman 1980: 969).

Legal academics Anthony Moore and Anthony Tarr argued that medical clinics that provided after-hours services were a source of overservicing. Traditional medical practices offer opportunities for overservicing but with medical clinics such opportunities are enhanced by the brevity of consultation times and the high proportion of referrals to specialists and specialist services like pathology. In reference to pathology were concerns regarding the prevalence of fee splitting and kickbacks. These practices were already prohibited by the terms of the *Health Insurance Act* but Moore and Tarr advocated specific provisions against these practices be incorporated into the *Medical Practitioners Act*. In addition they argued that there be a legal requirement for full public disclosure of the financial records of medical clinics (1988: 32).

Taking a different approach to the whole issue of entrepreneurial medicine was health economist Jeff Richardson. He argued that in regard to overservicing "there is only anecdotal evidence that this type of behaviour occurs and there is no evidence from which even the most rudimentary estimates could be made to

assess the prevalence and importance of these practices” (1987: 8). He is well satisfied that medical clinics delivered services efficiently but in regard to pathology there were maximum incentives for abuse with the minimum controls (1987: 12). Richardson is alone in advancing the argument that the States should regulate medical clinics, as they have the power to legislate for the disclosure of medical records, and they also have the constitutional power to control prices and incomes and for these reasons should be handed control of responsibility for the health care sector (1987: 62).

All these legal and criminological perspectives on fraud and overservicing have an awareness of the flaws in the administrative and legal structures for dealing with this area of white-collar crime. More recent work has focused on opportunities for fraud created by new technology. Grabosky, Smith & Dempsey on electronic theft (2001) and Smith on electronic Medicare fraud (1999) have sounded out new areas for abuse of government funds and of patient fraud that have not to date been significantly addressed.

Conclusion

A theme running through these legal and criminological studies on the problem of fraud and overservicing has been the problems of accountability that it poses for governments. Most analysts regard the media as an effective way of publicising the issue of medical fraud and this publicity is an important regulatory tool. Like Australia, studies in the United States indicate a similar

process of legislative change in response to unfavourable media scrutiny (Jesilow, Pontell & Geis 1993: 32; Sparrow 1996: 16).

Those qualifying this media efficacy were Wheelwright and Grabosky. Wheelwright noted that much change has come about because of this media activism, but in the legal sphere the resulting changes in Australia have been disjointed. This piecemeal approach has left in its wake a complicated legislative scheme vulnerable to loopholes. What is needed is more far reaching reform (Wheelwright 1994). Grabosky believed that when the formal apparatus of internal and external checks and balances on government failed, then governments were impervious to the social control provided by negative media attention (Grabosky 1989: 297).

This thesis explores whether in the area of medical fraud and overservicing publicity has had the capacity to change the organisational cultures of the Department of Health and the Health Insurance Commission and whether it has the capacity to precipitate legislative reform.

Medical fraud has been explored in different ways. The various approaches have contributed valuable understandings but the very nature of the approaches taken prevents the emergence of an analysis that incorporates the role of whistleblowers and journalists' unauthorised unofficial sources in accessing the media and the media in general in pursuing the subject. Professor

Carolyn Tuohy in her work *Accidental Logics* provided a model for the occurrence of health reform. She argued that a nation's health system is shaped by its internal logics and the "accidents" of its history (Tuohy 1999). Reform occurred when policy makers made use of "windows of opportunity". Reform in the area of fraud and overservicing occurs at key moments, at these windows of opportunity, when media pressure can be applied and be effective. Because the issue is scandal driven then it is instructive to examine the scandals in more detail, their policy outcomes and the historical circumstances that encouraged media interest in the issue.

Chapter 2

Accountability and social control in an age of neoliberalism

In a democratic society, effective accountability to the public is the indispensable check to be imposed on those entrusted with public power.

Report of the Royal Commission into Commercial Activities of Government and Other Matters, Part II, 3.1.1., (1992, W.A.), cited in Finn 1993: 50.

Introduction

This chapter looks at aspects of accountability and policing and was written as a response to observations on the nature of accountability by two of my interviewees, John Deeble, co-author of Medibank, and Michael Boyle, formerly of the Australian Security Intelligence Organisation. Deeble argued that the policing of medical fraud and overservicing was difficult in an age of neoliberalism with its attendant policies of deregulation. Michael Boyle believed that accountability was the role of parliament and a task delegated to the Australian National Audit Office and the Joint Committee of Public Accounts and Audit. In this regard investigations of the type conducted by the

ANAO, the JCPAA and ASIO were not a legitimate province of the media. The media in effect had no role as a check on the performance of parliament or the bureaucracy. That accountability could be so narrowly defined, but in different ways by two public officials well acquainted with the exercise of power, signaled that accountability was a contested arena in public governance. The question of accountability goes to the heart of this thesis, for failures of accountability have been a recurring theme in the administration of the function of medical fraud and overservicing by the Department of Health and the Health Insurance Commission.

The Department of Health and the HIC both found dealing with fraud and overservicing problematic, because it is labour and resource intensive, staff require specialist training, it needs the support of management and it demands co-operation from other agencies. In this context it is easier to understand that departments would have a preference for focusing departmental energy on printing cheques to claimants in the interests of 'efficiency' rather than developing expensive programs to contain the abuse of medical benefits (Ericson et al 2000: 539). However, at some point they will be accountable to parliament if the department fails in its duty of regulatory oversight. Parliament needs to be able to account to the people for expenditures undertaken on their behalf by their government however it cannot be said that parliament is at all times diligent in discharging this responsibility. So the problem of dealing with fraud and overservicing is not only one of a failure of

performance by the bureaucracy but also a failure of accountability by parliament.

The question of accountability has become more difficult by the expansion of government programs in the second half of the twentieth century. Big government has meant there are ever more areas of government to be checked on and made accountable, a process made possible through accountancy, audit and the tight control of budgets (Rose 1996: 54). In addition the rise of neoliberalism in the last two decades and its accompanying ethos of managerialism in the public sector have changed audit and accountancy practices. This has been termed the New Public Management. It has meant the introduction of performance audits so that auditors heuristically engage with current bureaucratic practice and performance to provide the Audit Office and the Joint Committee of Public Accounts and Audit with reports on ways to enhance managerial performance in the public sector. It would appear that these reports are not used to facilitate executive accountability but rather to reduce it. They open avenues for organizational change but their potential for dealing with fraud is not being fully realized. Malcolm Sparrow left a salient reminder that in regard to dealing with medical fraud and overservicing,

Serious research on this issue is not much appreciated. Scores of professionals are heavily invested in the status quo, will profit greatly if the health care fraud problem remains invisible and have powerful incentives to reject or ignore research findings that elevate the visibility of the issue (Sparrow 2000: ix).

While there are powerful incentives to reject serious research findings this chapter will not be preoccupied with the motives of professionals who may benefit from fraud but will explore the deep structure of regulatory failure that is embedded in the sociology of insurance.

This gives rise to the question that if processes for accountability are failing should constitutional accountability be strengthened or has the locus of accountability shifted to a combination of public and private checks and balances on government? If it is judged that mechanisms of governmental accountability have failed then can it be justifiably argued that the media has a legitimate function as an agent of the public interest in holding governments accountable to the people? If this is its task then is this a sufficient solution to the problem of accountability?

To explore these questions and understand them in their context I have taken a multidisciplinary approach, as this is a subject that is not embedded in one academic discipline but of necessity draws upon many. It is a cross disciplinary approach and one well suited to areas of study like criminology, regulatory theory and journalism. Edmund Wilson called it consilience, the “‘jumping together’ of knowledge by the linking of facts and fact-based theory across disciplines to create a common groundwork of explanation” (Wilson 1998: 8). In the spirit of consilience this thesis attempts such a valency as it treads lightly over disciplinary boundaries and draws upon some aspects of ideas developed

by the social theorists Michel Foucault, Pierre Bourdieu, and Jürgen Habermas. Foucault's analyses of the transformations of power that have shaped modernity - the movement across time from the rule of sovereignty to the rule of government - has provided a useful tool for understanding the new regulatory state and its challenge to older forms of accountability. This movement of social, political and economic change starts with the enlightenment. This chapter reviews constitutional accountability, liberalism, globalization, regulatory theory, the notion of insurance, the role of the media, the nature of audits and the enlightenment, and its creation of new values, new philosophies and new ways of governing.

The Enlightenment

Modern government has its origins in the enlightenment in the seventeenth, eighteenth and nineteenth centuries in Europe and the United States when a revolution in thinking was under way. The idea began to be spread that a man equipped with reason need not be in thrall of the authority of kings, courtiers or clergy. Men could govern themselves without an overarching authority, bound no longer to despotism and superstition (Dreyfus & Rabinow 1986: 110). The philosopher Immanuel Kant reinforced this message with his argument that the people could be autonomous through the use of reason and this he believed was the hallmark of maturity. "Immaturity", in this formulation, was a state of acquiescence to the authority of others (Foucault 1984: 34). Radical change of this magnitude was argued on the basis that the only right to rule is that which

flows from the consent of the people and it was this principle that formed the basis of representative government (Hall 1986: 49).

The works of Thomas Hobbes, Thomas Paine, John Locke, Adam Smith, Jean-Jacques Rousseau, Francois-Marie Arouet (Voltaire), Baron Charles de Secondat Montesquieu, Marquis de Condorcet, and Denis Diderot all enlivened the political discourse and fuelled demands for the replacement of a static social order based in hierarchy with one based on merit. These ideas were not just items on the wish list of a social class agitating for greater political power, but were achieved in the aftermath of the English, French and American Revolutions. It brought into play other ideas – individualism, liberty, equality and tolerance – that came to define this epoch known as the enlightenment. These were ideas that helped accelerate social change and provoked creative solutions to problems of government, law, administration, economics and scientific inquiry.

Individualism and liberty formed the mindset of an expanding social class, the bourgeoisie, made wealthy through commerce and industrialisation (Gay 1969: 4). Wealth generation was made possible due to changes in the economy. The stagnation of the feudal order was a relic of the past: individuals were now free to claim property rights, raise investment capital and speculate in property, capital and labour (Hall 1986: 43; Kramnick 1995: xix). This economic freedom created a dynamic, expanding economy unfettered by state interference in the

operation of supply and demand and propelled forward by a labour force made productive by the division of labour and its specialization (Hall 1986: 39-43). This was the nascent risk society that facilitated change, growth and competition.

The revolutionary temper produced a new political philosophy: liberalism. John Stuart Mill expressed its high idealism in the words “over himself, over his own body and mind, the individual is sovereign” (Mill 1985: 69). In the place of the sovereign was the sovereignty of the individual and the enthronement of self-interest. In place of authority was liberty (Himmelfarb 1985: 8). The love of liberty stood in contrast to the lesser qualities of the man judged to be a liberal. It was a personality style built on the atomized individual who was self-sufficient, competitive, ambitious, a self in the pursuit of happiness. Many have noted other related qualities: greed, selfishness and narcissism. The construction of a male political subject, alert to the opportunities afforded by capitalism, left in its trail his female counterpart who was not part of this new revolutionary order. The body politic was lobotomized into the free and the unfree; it was divided into individuals free to pursue their own interests and individuals bound to domestic responsibilities whose labour was not recognized in the market economy. The universalizing rhetoric of liberalism obliterated those who did not fit its model and the protestations of Mary Wollstonecraft and John Stuart Mill, at this exclusion of women from the architecture of liberal philosophy, were to no avail.

Representative government

Feminists objected to the enlightenment construction of the self that valorised the individual uninvolved in relationships with others (Kramnick 1995: xxiii). This was a personality type that would find no easy accommodation with the objectives of governance, of the need to work in concert with others for the furtherance of social goals. Nonetheless the compromise reached was that under a liberal form of government, there would be two types of association. The first was the state and the second was civil society.

Government is the instrument by which a population organises itself in regard to a number of agreed upon functions. It brings together individuals who, by a voluntary act of contract, are prepared to renounce some freedoms for the benefits of an orderly life and the protection of their rights (Kramnick 1995: xvi). The challenge for liberalism was to decide on the most effective government for the support of a private enterprise economy and one that would not intrude on the private and public life of the individual (Hall 1986: 34). What was wanted was strong government but not tyranny. The abolition of monarchies and aristocracies, in most Western countries, as the site of governance meant the authority of the state had to reside elsewhere and be exercised in such a fashion so as not to be oppressive. The problem with any form of government was that it had the capacity to inflict “every kind and degree of evil of which mankind are susceptible” (Mill 1948: 185). The answer to this dilemma was the election of a representative government and the implementation of measures to ensure the

dispersal of its powers. Under this arrangement all enfranchised people would elect deputies to represent their interests in parliament (Mill 1948: 228) and the government so elected would hold power for a limited time and then be re-contested.

The space where enfranchised people came together to discuss the performance of government and to support it, or mobilise resistance and replace it, was civil society. Jürgen Habermas called it the public sphere, that space between society and the state for the expression of public opinion (Habermas 1974: 49). It is a space where people are drawn together to freely participate in the public conversation and publish their opinions and it can take place in a community or town hall, a political demonstration or engagement with information on politics presented in newspapers, magazines, books, the internet, radio and television. In Western European countries the development of a free press has paralleled the development of democratic government. It commenced in England with the English Revolution and was defended over three centuries by the works of many writers including John Milton, Joseph Priestley, James Mill, Jeremy Bentham and John Stuart Mill (Keane 1991: 11-17). The argument variously presented was that the vigilance of the people, aided by a free press, was an integral part of the system of checks and balances needed to prevent the abuse of power. The nineteenth century utilitarian philosopher Jeremy Bentham reasoned that

Such is the nature of man when clothed with power...that ...whatever mischief has not yet been actually done by him to-day, he is sure to be meditating to-day, and unless restrained by the fear of what the public may think and do, it may actually be done by him to-morrow (Bentham cited in Keane 1991: 15)

In addition to the mechanism of frequent elections, a free press helped construct an informed public discourse on the probity of government action. It was another strut to the barriers against despotism. Government, without such surveillance Bentham argued, was like a farm on which “for eight months of the year, all sheep dogs were to be locked up, and the sheep committed during that time to the guardianship of the wolves” (Bentham cited in Keane 1991: 16). A free press is one of the checks on the behaviour of those with delegated powers who can advance their own interests over the welfare of those they govern. It is part of the movement towards the ideal of a democratic system of government where the common good for all takes precedence over the narrow interests of the few holding power (Funnell & Cooper 1998: 10).

The separation of powers

Under a democratic system of government the principle of the separations of powers is used to constrict opportunities for the growth of tyranny. In Australia this includes the separation of church and state, and the separation of the functions of the state into the executive, legislature and judiciary. It is also exercised through the establishment of a bicameral legislature, different levels of government within the Commonwealth, the division of the courts systems into lower and appellate courts, judicial review, and administrative appeals

tribunals (Braithwaite 1997: 344). Braithwaite notes that this principle of the separation of powers of government extended as far back as the Code of Hammurabi, Justinian's Code, and the Magna Carta and it was developed by Montesquieu in the *Spirit of the Laws* and in the debates surrounding the framing of the U.S. Constitution. The principle is that each branch of government cannot intrude upon the functions of any other branch, and no person could be a member at any one time of more than one branch (Braithwaite 1997: 305–307). The abuse of power by one branch is deflected by a counteracting power. The separation of the powers of state and the contestability of elections to ensure a smooth transfer of power to an alternative political party helps to offset the possibility of the long-term domination of the electorate by one person or one set of political interests.

The problem of accountability

Government once elected is accountable to the people for the revenue it raises on their behalf and its expenditure. It is an accountability enshrined in the constitution for the purpose of ensuring the legality of actions undertaken by the executive. Public sector accountability is the rendering of an account to the parliament and to the people of the behaviour of the executive and the bureaucracy (Funnell 2001: 19). Part of the structure of the Westminster system of government that has been adopted by Australia, is that the minister has the final responsibility for the actions of his department, and is prepared to stand down if malfeasance is uncovered in his portfolio. Funnell, in supporting the principle of ministerial responsibility, made reference to its defence by Justice

Isaacs of the High Court who argued that one of the duties of a member of parliament is

that of watching on behalf of the general community the conduct of the executive, of criticising it, and if necessary, of calling it to account in the constitutional way by censure from his place in Parliament – censure which, if sufficiently supported, means removal from office. That is the whole essence of responsible government which is the keystone of our political system and is the main constitutional safeguard the community possesses (Isaacs cited in Funnell 2001: 19).

It is a custom more honoured in the breach. The translation of this principle into Australian politics has resulted in a dilution of the ideal. It has meant that on the rare occasions where ministers have stood down it has been because of personal failings, not a failure by their department (Grabosky 1989: 289). Nonetheless, despite its mythical status ministerial responsibility stands as the enduring symbol of constitutional accountability. Its presence is more apparent in the reports written and presented to parliament by the independent bodies of review, the Auditors-General, public accounts committees and by the act of seeking parliamentary approval for expenditures (Funnell & Cooper 1998: 14, 165).

In Australia the Auditor-General uses financial audits and since the late 1980s performance audits to oversee the actions of government departments and present this information to the parliament. The function of financial audits is to prevent and detect fraud. Performance audits provide an opinion of the

management's performance in the conduct of its operations and the use of its assets (Power 1999: 21-23).

Unfortunately the powers of the audit office are beset by a number of limitations. It can make recommendations on changes to policies to enhance efficiency and accountability but it has no power of enforcement. Parliament does have this power and can act on the information given to it by the Auditor-General and enforce compliance. However, the audit office performance audits are written in a language so circumspect that only a careful reading will reward the vigilant of any improprieties that may have come to light. The situation in Australia is similar to that in Britain. Michael Power asks in his work *The Audit Society*, what function these reports serve if they do not clearly inform its readers of their content. He notes that it has been suggested that a matter needs to be sufficiently controversial to be referred to the audit office by parliament but not so much so as to split the parliamentary accounts committee along party lines. The result is that contentious revelations are sanitised so as not to provoke public debate. The reports are decoupled from their politically explosive potential, die for lack of attention and a useful line of inquiry is brought to a halt (Power 1999: 124-6). These reports give governments their legitimacy while closing off avenues for critique and reform (Power 1999: 96).

The Joint Committee of Public Accounts and Audit, from 1979, has been given powers to assess a department's efficiency and investigate claims of

departmental malfeasance. It reviews the audits that the ANAO indicates warrant further attention (Funnell & Cooper 1998: 69). To help ensure that the recommendations of the JCPAA are acted upon a Department of Finance Minute reports on the progress of the recommendations by the department in question. Additional avenues for the review of the bureaucracy are question time in parliament, royal commissions, Commonwealth Ombudsman, judicial review by the courts, the Commonwealth Administrative Appeals Tribunal, Freedom of Information, the media (Funnell 2001: 20-21) and on some occasions the actions of the independent whistleblower who might use any of the above levers to address failures of accountability.

Despite the fact that government is so organised so as to forestall the most egregious abuses of power, the presence of corruption is stamped on the public and private sector, in the area of environmental degradation and the oppression of those groups in the community who constitute its weakest members. In many respects constitutional accountability has always been problematic. However, the difficulties have been accentuated in the last two decades by the impact that neoliberalism and globalization have had on the public sector.

Liberalism has the advantage of being a political doctrine with a core concept of individual liberty but with sufficient flexibility to absorb different philosophical concepts. It can bend either towards socialism or towards conservatism as political and economic circumstances dictate (Hall 1986b: 57). This flexibility

has guaranteed its long-term survival. Neoliberal theorists, however, call for a reinstatement of liberalism in its purest form, to a commitment to laissez-faire and free trade and politically to smaller government, deregulation, reduced taxes, reduced tariff protection and the minimum of intervention by the state in the workings of the market. It is a doctrine which says, “that markets and money can always, at least in principle, deliver better outcomes than states and bureaucracies” (Pusey 1993: 2). This has less to do with competition enhancing efficiency but more to do with the speed with which markets can gather, process and respond to new information to facilitate the optimal allocation of resources (Funnell 2001: 58-9).

Political elites in the English-speaking world found in neoliberalism a more appealing philosophy than that of maintaining the welfare state. In the period from 1975 to 1985 this change of direction was fostered by conservative “think tanks”, media proprietors like Rupert Murdoch and journalists and found kindred spirits in Margaret Thatcher and Ronald Reagan. It gave a platform to economists Friedrich von Hayek, Milton Friedman, Robert Nozick and others to argue with conviction and plausibility that welfare was unproductive and slowing the momentum of capitalism (McKnight 2003). This concern had a strong influence on the development of neoliberalism in Australia, but a second strand articulated by American neoliberals, such as Norman Podhoretz, Daniel Bell and Irving Kristol, also came to prominence. This was the belief that a new class had arisen in the 1960s, radical, tertiary educated and antithetical to

capitalism. They not only promoted the welfare state but were also propelling the economic system toward ever increasing levels of government regulation. The Australian variant of this new class of socially disruptive radicals included anti-globalization protesters, feminists, Aboriginal rights activists, and environmentalists and they were well positioned to pursue their political agendas through their employment in schools, universities, the media and the bureaucracy (Cahill 2004: 79–82). A third strand within neoliberalism is an advocacy of de-regulation. Regulations, argue the neoliberals, place unreasonable constraints on trade, hinder competition and dampen the efficiency of the market (Cahill 2004: 85).

In many respects political elites would be naturally attracted to the possibilities of a world unencumbered by regulations and bothersome trade unions but they were mobilized into action following the economic stagflation of the 1970s, the oil shock of 1973 and the awareness of the inflationary impact of the welfare state. It was a problem common to many Western countries. In Britain Nikolas Rose and Peter Miller argued that it was this crisis of social security that facilitated the rise of neoliberalism. Neoliberal analysts warned of the overload and overreach of government programs, that this overload was a justification for empire building by bureaucrats, that big government was malign in fostering expectations in the electorate of the endless expansiveness of the public purse, and this in turn created a culture of dependency on social security (Rose and Miller 1992: 198). In France Jacques Donezelot argued that

expenditure on welfare was growing at twice the rate of gross national product. Sickness insurance was the largest part of the welfare budget and had an inbuilt inflationary pressures but no method for cost containment (Donezelot 1991: 271-2). As a policy social welfare had become self-defeating.

Hand in hand with neoliberalism was the globalisation of world markets that placed pressure on governments to reconsider the way they govern. They have been made to accept that they are only one player in a global market and one that can be overtaken by its economic competitors (Beck 2004: 218). For this reason governments have been pressured to align the public sector to private sector values of efficiency and effectiveness (Funnell 2001: 9). Under this regime accountability is not judged as an adjunct to efficiency where best practice can be acknowledged and problems addressed; rather it has been denigrated as an impediment to performance (Funnell & Cooper 1998: 112). These changes were named the New Public Management (Power 1999: 43; Funnell 2001: 9), under this ethos bureaucracies have become more entrepreneurial, joint ventures between the public and private sectors are encouraged, and government is reduced but governance retained. In effect governments do "more steering and less rowing" (Osborne & Gaebler 1992: 22-25, 45). The effect of this has been for governments to take less responsibility but for audits and accountancy to become more popular and pervasive (Power 1999: 44). Their function has less to do with accountability but more as guides to enhance managerial effectiveness (Funnell & Cooper 1998: 14; Power 1999: 44).

Funnell and Braithwaite agree that in the current era government is faced with severe accountability problems but they advance quite different solutions to this issue. Funnell is one who believes efficient and effective government is that which has its basis in constitutional accountability. It is incumbent that it be so, as public policy is political and expresses the values of the party in power and its implementation by public servants needs to be open and transparent through such a mechanism (Funnell & Cooper 1998: 114). Constitutional accountability has been a hard won product of historic compromises and the practicalities of everyday experience but it is a model that is not being allowed to live up to its potential (Funnell 2001: 2-4). Funnell looks back with regret that governments are losing their sovereignty. Braithwaite looks back and sees “200 years of ugly tyranny in nations with beautiful constitutions”. He argues that

it is no longer persuasive to suggest that a separation of state powers will ensure that the government ‘will be controlled by itself’...Checking of power between branches of government is not enough. The republican should want a world where different branches of business, public and civil society power all check each other (Braithwaite 1997: 344).

Braithwaite suggests that the constitutional model, while suited to the eighteenth and nineteenth century has lost its relevance, and in an article published in 1999 recommended the abandonment of constitutional accountability in Australian government and its replacement by an alliance of public and private governance (Braithwaite 1999: 93). He later modified this stance by saying that ultimate regulatory oversight still remained with the state

(Braithwaite 2000: 233). This is a line of argument influenced by Foucault's understanding of the nature of modern government¹ that power no longer flows from a centre, but has many centres. This is well demonstrated in the case of multinational corporations that hold more economic power than states, the state itself has divested many of its powers to private interests and the state is not only a regulator but is itself regulated by external agencies like the International Monetary Fund, Moody's, the Security Council, and the World Trade Organization. Braithwaite and others have termed it the new regulatory state and it opened the possibility for a new approach to the doctrine of the separation of powers so that government, civil society and the private business sector are all able to monitor each other (Braithwaite 1997: 344). In this way there are more factions in the system of government to prevent any one party oppressing the rest (Braithwaite 1997: 312) and power is dispersed so as to maximise freedom and minimise domination.

On the value of audits – three case studies

Funnell and Braithwaite present conflicting approaches to constitutional accountability. I believe that constitutional accountability should be retained and it would be better served when performance audits are conducted for both management purposes and accountability, and these reports are routinely presented to the JCPAA for review. Those promoting neoliberalism never intended that the legal system be denigrated. Even Hayek, neoliberalism's most well known ideologue, has defended the state's legitimacy to initiate and

¹ Outlined in his lecture 'Governmentality' delivered at the Collège of France in February 1978.

enforce regulations. While the state is being progressively minimized (Beck 2004: 216) it is worthwhile to refer to his argument in *The Road to Serfdom* that

In no system that could be rationally defended would the state just do nothing. An effective competitive system needs an intelligently designed and continuously adjusted legal framework as much as any other. Even the most essential prerequisite of its proper functioning, the prevention of fraud and deception (including exploitation of ignorance) provides a great and by no means yet fully accomplished object of legislative activity (Hayek 1944: 42–43).

The most stripped down public administration and the most aggressive free enterprise private sector still needs the infrastructure of a workable legal system. The public knowledge of fraud undermines trust and the capacity of people to conduct business in the knowledge that widespread corruption is not undermining its purposes.

If one of the results of neoliberalism has been the introduction of the New Public Management and with it the introduction of performance audits then it is useful to look in more detail as to whether these audits advance constitutional accountability. Audits are done over eleven months and auditors have open access to all documentation and are free to interview staff. It is a window on the bureaucracy that provides an insider knowledge that journalists would envy but Funnell and Power focus on different aspects of performance audits and its failures. Funnell argues that their purpose is to lift managerial performance and not serve constitutional accountability. Power argues that performance audits are written in a style that does not draw attention to maladministration. In Australia this means that when they are referred to the

JCPAA there would be few parliamentarians skilled in decoding the obfuscations.

Three audits of relevance to this issue and this thesis were performed in the 1990s in regard to the abuse of medical benefits. They were the Bates Report, an HIC internal audit; ANAO Audit Report number 17, 1992-93, Medifraud and Excessive Servicing; and Audit Report number 31, 1996-97, Medifraud and Inappropriate Practice. Audit Report number 17, the 1992-93 audit, was a project audit. A full performance audit was not done as there had been an earlier independent internal report commissioned by the Health Insurance Commission and carried out by Harvey Bates and Company in June 1992.

It was entitled a Review of Operations and Procedures for the Conduct of Investigations. The language was forthright: the evidence unequivocal. Among its findings were that there was no resource allocation for fraud control, there were no training programs for investigative staff and existing legislation did not support investigative action into major cases of fraud (Bates 1992: 2-6). The report concluded that since the publication in 1989 of Grabosky and Sutton's book *Stains on a White Collar* with its chapter by Paul Wilson 'Medical Fraud and Abuse in Medical Benefit Programmes' that the level of medifraud had significantly increased. Bates found that the HIC had reduced both resources and expert personnel to this function since it was transferred from the Department of Health in 1985 (Bates 1992: 3).

ANAO Audit Report no. 17 1992-93

The ANAO Project Audit that followed in December of 1992 expressed this sentiment with more caution when it said “The performance of the Commission, with the exception of the last twelve months, shows little improvement over that of the then Department of Health in the early 1980s” (ANAO Audit Report no. 17: x). The Project Audit supported the findings of the Bates Report and recommended that the HIC move to implement them (ANAO Audit Report no. 17: xiii). Its most significant findings were on the level of fraud and overservicing. It surmised that the amount of moneys lost through fraud and overservicing was at least that of the early 1980s, which was then estimated at seven percent of medical benefits expenditure. It noted that in the United States the figure estimated by the General Accounting Office was ten per cent of US Medicare and Medicaid expenditure (ANAO Audit Report no. 17: xi). The estimate of seven percent of the total Medicare and Medicare Private benefits being lost to fraud and overservicing would total \$461.51 million. The auditors were left to rely on their own guesswork that their estimate of seven percent was an accurate assessment. The auditors either did not request or were refused information on a precise calculation of the figures in dollar terms. It is surprising that key information on the level of fraud was not included in the audit report.

The audit report noted that the HIC had a significant problem in addressing organised corporate crime.

The emergence of organized fraud and excessive servicing, protected by corporate veils and the best advice money can buy, represents a real challenge to the efficient and effective use of the Health budget (ANAO Audit Report no. 17: xi).

The HIC was aware the practice was widespread and entrenched in the pathology industry but they had not gained one prosecution against pathology companies offering inducements to general practitioners.

ANAO Audit Report No. 31 1996-97

This audit, 'Medifraud and Inappropriate Practice', conducted in 1996-97 was undertaken to review progress on the implementation of the recommendations of the earlier Report no. 17 of 1992. In this performance audit the HIC's reticence to produce a figure on the amount lost through fraud was one commented on repeatedly by the audit team. Whereas in 1992 the percentage estimated to be lost through the abuse of medical benefits was seven percent, here through the use of source based audits, that is audits based on a small random selection of claims (ANAO 1996/97: 19), the percentage lost was calculated to be between 1.3 to 2.3 per cent. This was a considerable decline from the 1992 figures. In financial terms this places the amounts at between \$110 million to \$190 million (ANAO Report no. 31: xii). The Audit Report noted that the Australian Bureau of Statistics advised them that the sample size of the source based audits was too small to provide reliable estimates of the value of leakage from medical benefits (ANAO Report no. 31: 19). The HIC said that once three years statistics had become available they would publish the figures

in the Annual Report. There was no report of this in the Commission's Annual Report. The audit team was obviously uneasy at this subterfuge for, as they argued, it was important both for accountability and managerial performance that the magnitude of fraud be known so that resources can be deployed to fully deal with the problem (ANAO Report no. 31: 20)².

In contrast to source based audits are purpose based audits. These are targeted audits of problem areas that can involve an examination of doctor's medical profiles, documentation on medical benefits claims and any other material thought to be relevant. The Audit Report cited the case of an audit conducted in 1995 into the highest claiming Approved Pathology Authorities for four medical benefit items. \$16.8 million was paid out in medical benefits for these items of which \$4.8 million was paid out for fraudulent claims. The Report did not indicate that these purpose based audits were a more accurate indication of the prevalence of fraud against Medicare. But it did recommend that these purpose based audit reports could be published in summary form (ANAO 1996/97: 51).

The 1996/97 Audit Report was not referred to the JCPAA for further discussion despite the fact that the HIC had failed to produce a figure for the extent of fraud and overservicing. Perhaps credence was given to the HIC's assertion that one day it would furnish a reliable estimate through the use of source

² Curiously according to a newspaper article published in December of 1997 the HIC estimated that the annual cost of fraud and overservicing was between \$600 million and \$700 million and the figure was rising (Gray *Sunday Age* 1st December 1997: 5)

based audits and publish this figure in the *Annual Report*. In the same year that this audit report was produced Malcolm Sparrow's *License to Steal* was published in the United States. While it would be unfair to contrast a book of that nature as against an audit report some matters do stand out. The book has a sense of engagement with the issue and an urgency that the amount defrauded from the U.S. health system was of such a magnitude that it required intensive policing, well-trained personnel and other resources for its containment. This urgency was not apparent in this 1996/97 Audit. Australia and the United States have similar procedures for investigating fraud and overservicing within medical benefits. It could be well argued that the proportion defrauded against Medicare in Australia would be on parity with that in the United States.

While it is true that performance-based audits are concerned with providing direction to managers to better administer their departments, information is also provided that should alert parliament to shortcomings in accountability. Power and Funnell see performance audits as a deviation from the essential role of auditors and accountants which is to provide financial accounts of organisations. The three audits discussed here had differing results on attempts by auditors to gain accountability. The Bates Report resulted in the formulation of new legislation to deal with fraud and overservicing. The 1992 Project Audit Report focused parliamentary and public attention of the problems of gaining prosecutions against those offering inducements in the pathology industry. The

1996 Performance Audit illustrated the recalcitrance of the HIC in withholding information on an estimate of fraud against medical benefits. It had no positive outcome.

The criminal sanction

This failure by the HIC to disclose its financial losses through fraud and overservicing is not only a regulatory failure, but the lack of accountability is in fact part of the structure of fraud. It is also a failure of the mechanisms of internal and external oversight. Internal oversight is met when the chief executive officer and senior management act to ensure that accountability is met. It fails when there is a failure of leadership (Grabosky 1989: 308). The organs of external oversight are the ANAO and the JCPAA and in this case the failure of the JCPAA to review the audit report was a lapse of parliamentary scrutiny (Grabosky 1989: 312).

Fisse and Grabosky in surveying the effectiveness of measures available to promote governmental accountability, internal oversight and external oversight through parliament, the ANAO, the ombudsman, juridical oversight, political processes, freedom of information, the news media and whistleblowing both refer to one little used option, the criminal sanction. They argue that it is a legitimate but underutilised tool in ensuring that the public sector operates within the constraints of the law. It is underutilised but not without precedent as mandatory injunctions have been used in the United States to deal with the

government's abuse of constitutional rights (Fisse 1986: 133). It means that individuals, groups of individuals or the organisation could be held liable for deviant behaviour. They acknowledge that fines or imprisonment would be inappropriate, but one alternative with durable consequences would be the use of corporate probation. The organisation, for example, could be compelled by the court to design a compliance program and then to file reports on the progress of its implementation (Fisse 1986: 133, 137; Grabosky 1989: 322-327). Under this regime one would suspect that accountability and responsibility would be enhanced, compliance more forthcoming and the public sector no doubt agitated and alarmed if such a proposal became a reality.

Foucault on governmentality

In contrast to the model of constitutional accountability is the one enunciated by Braithwaite of the mix of private and public regulatory apparatuses. It derives from the model of the practice of modern government outlined by Foucault in his influential lecture 'Governmentality', with its outline of the evolution of government in the modern era. Here Foucault explained how the powers of the state have enlarged since the sixteenth century. Until that time the concern of a prince was for his territory. It was immaterial whether the land was fertile, productive or inhabited: it was land that counted. Sovereignty was all. But change was under way. There was a movement of power outwards from this sovereign centre and towards a new object, the population, which was to be subject to discipline and regulation. It was a disciplinary power that over time collected information on the population for its efficient administration, by

what is termed 'technologies of surveillance' and by the ordering of lives through organisational discipline in the workplace, in schools, in prisons, in hospitals, in courtrooms, in tribunals, by the police and the army (Foucault 1986: 263).

By the eighteenth century, land and its fertility and people and their productivity were the major concerns of government. The power of the state now reached more deeply into the lives of its citizenry. Foucault encapsulated this change by the use of the traditional metaphor to describe the state, that of a ship. The concerns of the sovereign state were for the ship and nothing beyond it. In the era of government what counted was the management the ship, its sailors, its cargo, dealing with the vicissitudes of the climate, and the safe steering of the vessel to its destination (Foucault 1991: 93-94). The reach of the state had been extended, not like an octopus with many tentacles to control its operations, rather in its capacity to shape and influence events distant from it (Rose and Miller 1996: 40). The functions of state were de-centred; it was a new regime of power that Foucault termed the "'governmentalisation' of the state", a power which was "at once internal and external to the state" (Foucault 1991: 103).

This expansion of the state would also entail broader opportunities for fraud to proliferate; yet Foucault's lecture on governmentality makes no mention of corruption as a feature of government. However, a theory of corruption can be

incorporated into Foucault's analysis. Foucault lists the ways in which governance is achieved, through the institutions of state that generate its procedures, documents, programs, mechanisms, expertise, calculations, and tactics (Foucault 1991: 102; Dean 1999: 31). Islam argues that these "discursive strategies, techniques and apparatuses of government" may also be a 'domain of immorality' and the site of corruption (Islam 2001: 3). It is within these rationalities of rule that corruption can take root and develop. It is these technologies of governance that make some forms of corruption feasible and practical and contribute to the spread of knowledge of corrupt practices (Islam 2001: 5-7). This is a significant shift away from the common understanding that corruption in the public sector means the abuse of power by public officials (Bourdieu 1998b: 60; Heywood 1997; Zimmerman 2001). Corruption is not only located in the opportunities that the individual may find for abusing public power but also in the broader framework of the legislative and administrative system itself.

Government at a distance

Foucault's lecture on governmentality resonated through the 1990s and among those who developed its concepts were Nikolas Rose and Peter Miller. They were interested in how the structure of government had mutated from its original form and the implications this had for health policy. When the state was first conceived its functions were limited and its administrative responsibilities emanated from one centre or locale. Modern forms of government have many centres and have a range of functions so broad that its programs can only be realized by working through private sector

instrumentalities like financial institutions, professions, non-government organisations, trade unions and individuals. Government is made possible through this alliance of public sector administration and the private sector and it is this assemblage that forms centres through which flows resources to its designated recipients. However, this degovernmentalisation of the state, this government at arms' length, was no guarantee of efficiency. These entities that have been mobilized by the government have their own loyalties and their own affiliations, and are not always amenable to the directives coming from the centre. It is this that makes of government a flawed enterprise. It is not a clockwork mechanism moving in synchronised harmony; there is no perfect regulatory apparatus, rather it is an odd contraption lacking operational efficacy. It is, as Rose and Miller observe, prone to failure and with failure comes "the constant injunction to do better next time" (Rose & Miller 1992: 191). The case study they used to support these conclusions comes from the British National Health Service. Health was not a coherent mechanism enabling the unfolding of a central plan. The problem was that of dealing with experts who claimed a necessary adherence to the methodologies of their own professional practice (Rose and Miller 1992: 193). These were often at odds with measures to reign in health expenditures. In addition the demand for health services had no upper limit and costs are strained by the growth of high technology medicine, an aging population, increases in life expectancy, and the expansionary pressure on wages from its health workers. Health was threatening to become ungovernable and costs uncontrollable.

Social security

Foucault explored these themes of health, health insurance and health inflation in an article entitled 'Social Security', published in 1983. In it he reflected on ways costs could be contained. He speculated on the idea of the capitation of services in some fashion, but there seems no way this would be equitable. The claim for public health insurance could be undermined by the philosophical argument that the individual had no automatic right to health care in a general sense, only in a specific sense of a right to work in a hazard-free and safe environment. The abolition of universal health insurance altogether seemed a "kind of wild liberalism", leaving private insurance to cater for those with the means to pay for it and the poor abandoned to the insecurity of a life bereft of this financial safety net. It was an intractable problem for which he could foresee no solution. He does not mention the option of a mix of private and public health insurance of the type that applied in Australia before 1975, in which fully subsidized public health insurance was available for the elderly and those living in poverty.

Foucault had here distanced himself from 'any kind of wild liberalism' but it could be argued that in his 1978 and 1979 lecture series 'Security, Territory and Population' and the 'Birth of Biopolitics', the hand of a skillful apologist for liberalism was at work. For Foucault the appeal of liberalism was that the practice of government regulated itself by critical reflection on its own practice. In this sense it was not utopian, but rather a form of government that has been

practiced, corrected and modified. Survival and success had been due to its adaptability to circumstances: to its chameleon qualities apparent even in neoliberalism and its variants (Foucault 1997: 74-79). Foucault was interested in liberalism both new and old and that part of its history from which emerged the question of population and the preoccupation with its management, health and wellbeing (Foucault 1997: 71).

Foucault saw the picture of state support for medical care as muddled by the state's ambivalence about the life and death of the population. On the one hand the promotion of life through a vast apparatus of medical care and public health measure was rational as a healthy workforce was a key resource for industry and the armed forces. On the other hand, this was also a site for irrational behaviour by the state. The mobilisation of mass armies for modern day warfare results in the deaths of millions on the battlefield or through the massacres, not only of the enemy but also of their own population, carried out in the name of eugenics or ethnic cleansing (Foucault 1986: 259-260). In an attempt to understand this irrationality Foucault put forward the idea that the possibilities for the enhanced life of the population and its death are two sides of the one coin. What was successfully conjoined here was war, a ritual of sovereignty with the rule of government, which together is harnessed to the machinery of war. Mitchell Dean described it as the creation of a truly demonic power (Dean 1999: 176).

Foucault was more interested in the life of populations rather than its death.

What was of interest was that a new regime of power was installed which worked concurrently with its earlier forms, the rule of sovereignty and the disciplinary order. As he explained,

We need to see things not in terms of the replacement of a society of sovereignty by a disciplinary society and the subsequent replacement of a disciplinary society by a society of government; in reality one has a triangle, sovereignty-discipline-government, which has as its primary target the population and as its essential mechanism the apparatuses of security (Foucault 1991: 102).

The state still wielded sovereign power to raise taxes, send troops to war, incarcerate criminal offenders, exercise the legitimate use of violence and the common good still meant obedience to the law. But a shift in emphasis has occurred. Foucault termed this new form of government 'biopower' and its principal object was the fostering of the prosperity, health and longevity of the population. It meant that the health status would be raised, not just the minority of those living on the margins, but of the whole social body (Foucault 1986: 277; 1991: 90, 100). One of the ways this was to occur was through measures taken to address infant mortality, epidemics, improve sanitation standards and provide adequate medical services (Foucault 1977: 71). Prosperity and health would also be advanced by 'mechanisms of security'. Foucault explained that this was to be implemented through natural regulation (Gordon 1991: 17). And by this he meant,

The setting in place of mechanisms of security...mechanisms or modes of state intervention whose function is to assure the security of those natural phenomena, economic processes and the intrinsic processes of population: that is what becomes the basic objective of governmental rationality (Foucault 5 April 1978 cited in Gordon 1991: 19).

One of the mechanisms of security is insurance and it operates to protect individuals against risk. Risks are associated with the possibilities of ill health, loss of employment, loss of life, property damage and the other negative contingencies of what has been termed the risk society (Beck 1992; Ericson 1997).

The Risk Society

Modernity brought with it urban settlement, factories and transport and with these the multiplication of opportunities for accidents and mishaps. Prior to the nineteenth century insurance did not cover the risks caused by third parties, for example by factory owners exposing their employees to the risk of injury. Foucault summarized the effects that an awareness of this problem had on the legal system. The courts deliberated on where blame and responsibility were to lie and decided that as the costs were too great for the individual to carry the best approach was to change to civil law. The solution that was devised was no-fault responsibility, which wiped out fault and acknowledged the place of risk in the legal framework (Foucault 1988: 146–148). Accidents, epidemics and other disasters were always a facet of life but a world now shaped by science and technology increased the likelihood of people's lives being crossed by ill fortune (Ericson & Haggerty 1997: 113).

One way to manage this was insurance, a technology of risk, made possible by an analysis of statistics and probabilities (Ewald 1991: 198-200). It works by judging the chance of accidents or disasters afflicting an individual or group of individuals, then calculating the probability of its occurrence and spreading the risk over a population. This population, by taking out a premium, is able to cover the costs incurred as a result of ill health, damage to property, loss, theft, unemployment, litigation, bankruptcy or other events. Insurance pays compensation for losses due to personal risks and converts the liability for risk into a liability to themselves (Strange 1996: 124). Insurance differs from legal thinking in some important respects. Under the law the individual bears the responsibility for accidents. Under the law an accident is an exceptional event. Insurance regards accidents not as the exception but the norm: they are events that could occur at any time to any member of a population. Insurance alters the idea of justice: causation loses relevancy to the concept that risks can be spread to reduce the burden of their costs (Ewald 1991: 203, 206).

Social control

Insurance also alters the idea of crime control. Older forms of crime control as outlined by Foucault's model of disciplinary power are ones that work upon the individual to correct and normalise behaviour. They involve the search for the individual criminal offender, the allotment of fault and subsequent punishment, to act as a deterrent to the offender and others from committing further acts of antisocial behaviour. However, with the management of

populations through mechanisms of security, these insurance or actuarial practices involve new approaches to regulation. They constitute a regime of security in which risk management is not preoccupied in the pursuit of individual offenders but is intent on reducing opportunities for crime to occur (Reichman 1998: 61). This approach assumes that crime is inevitable and the most practical approach is to spread the risk across the whole population. The consequences of crime are spread evenly and the whole population bears the cost. It is a technical solution to what insurances regard as a technical problem. It is both amoral and future oriented. It has been called situational crime prevention and looks to the opportunities for crime to occur and preventing it rather than the causal origins of crime (O'Malley 1996: 189). It is not concerned with changing the behaviour of deviant individuals but of forestalling opportunities for crime to occur. It is most likely to be used for the management of crimes within organisations where there is no victim in the normal sense (Reichman 1998: 52). This phenomena has led many commentators to speak of a decline in the relevance of the management of criminal behaviour from the coercive control of deviance to the risk management of populations (Ewald 1991; Simon 1987; Defert 1991). As Richard Ericson explained,

The concern is less with labeling of deviants as outsiders, and more on developing a knowledge of everyone to ascertain and manage their place in society...Coercive control gives way to contingent categorisation and population management...order gives way to security as the key concept for understanding how each institution defines the well-being of populations (Ericson 1998).

Pat O'Malley cautioned against this triumphalism with the reminder that in Foucault's model of governmentality the rule of sovereignty is not overtaken by the regime of security rather it exists alongside it, a fact borne out by prisons housing larger numbers of inmates than ever and an approach to their treatment that is punitive rather than corrective (O'Malley 1996: 190, 197). Of relevance to this thesis is this philosophy and practice of crime management and the space that is afforded to dealing with individual and corporate offenders, in the management of the abuse of medical benefits in Australia's public health insurance system.

The New Regulatory State

For Braithwaite and other like-minded criminologists, neoliberalism has meant the formation of a new regulatory state entailing the co-operation of government, private institutions and market forces to create a de-centred form of state regulation. It complements the style of preventative governance of the risk society which focuses on loss reduction that is the result of crime, or the extreme forms of risks associated with modern life. Braithwaite judged it more practical to mould policing techniques to neoliberalism than to critique the neoliberal state itself. Braithwaite leaves for the future the possibility of launching "a direct assault on the market mentality as a source of inequality" (Braithwaite 2000). Colin Scott took up this discussion of the regulation of public sector organisations by private regulators and grouped different non-state regulators in terms of the nature of their mandate or authority to scrutinize other organizations. He judged investigative reporting by the media

as holding no mandate, yet it can be effective as an organ of regulatory oversight (Scott 2002). The difficulty with this analysis is that investigative journalism is least likely to be a force for regulatory control at a time of neoliberalism. Its greatest effectiveness is at times when social and political reform is transforming the broader community.

The sociology of the media

The media is aptly named as a regulator without a legal mandate (Scott 2002) that operates outside of the formal structures of accountability of elections, parliament and the judiciary. The freedom of the press expands the scope for accountability and challenges the idea that closed government is rational and efficient (Ponting 1985: 206-7). This foregrounds a relationship between the media and government which is conflictual and ambivalent. The government can be prepared to act on disclosures of maladministration outlined in the press and set up judicial inquiries and Royal Commissions but on the other hand if the government is sufficiently antagonized by these disclosures it can retaliate in cutting off access to journalists of official information or even send journalists to jail for not disclosing the identity of their unauthorised unofficial confidential sources. In this sense governments do not recognise the media as part of the structure of accountability (Nash 2003).

The media has taken on for itself a function of checking the power of government and it is a power that has slowly accumulated since the beginning of the modern era. The English and French Revolutions ushered in

representative democracy and with it a citizenry to be informed of the policies of the competing political parties to be elected. This meant that political knowledge needed to be freely available through the press so as to create a space, a 'public sphere' for the development of public opinion.

In earlier times this meant that the public should be well informed of the proceedings of court cases and of parliament (Bentham 1843 vol. 2: 314; vol. 4: 316). However, governments also saw the value of communicating information to the public so as to mould public opinion. In such an instance the relationship between the media and politics is a co-operative rather than a combative one. Alongside the desire for those with political power to maintain hegemonic influence over public opinion was a counter movement to resist such control. The concept of the public right to know was expanded to mean that the public under the auspices of the media could scrutinise those who governed it and expose unnecessary government secrecy, corruption and the abuse of power at the expense of the public interest. These factors have contributed to the media becoming a power holder in its own right. Its power resides in the size of the audience it can command, the issues it highlights, its articulation of the interests at stake, and the direction it can provide to a community response (Nash 2003).

These developments fostered two styles of journalism, objective and investigative reporting (Miraldi 1990). Objective reporting is the staple of routine news production, which attempts to be balanced and impartial through

the presentation of two sides of an argument with the reader left to judge where truth lies. It is a journalism of facts rather than values, and gives primacy to information from official news sources (Carey 1997). Adversarial or investigative reporting has a moral vision and a reformist ambition and its journalistic style combines facts with values. The journalist is proactive in uncovering injustice, is prepared to confront institutional malfeasance and more likely to use unofficial, unauthorised sources. It is a time-consuming procedure and confidential information is difficult to access. Routine work practices involves finding sources through checking archived news clippings, checking listings in telephone directories, the use of organisational staff lists, audit reports, annual reports and any staff list information, notifications to the stock exchange and public searches. There are costs incurred in the salaries for journalists, litigation for defamation, and incidental amounts associated with *Freedom of Information Act* requests and use of the Administrative Appeals Tribunal. The economies of news production mean that investigative reporting is not guaranteed security in the face of cultural and political change (Westergaard 1977: 108; McKnight 1999: 156).

This characterized the 1960s, 70s and 80s but in the current age of neoliberalism, which is aligned to conservatism and political and cultural orthodoxy, there are today fewer opportunities in the quality press for a journalism which critiques political power (Keane 1991: 112; McKnight 2003). It is still supported in Australia by the public and private television corporations ABC, SBS and the

Nine network, but investigative journalism is weaker in the print media, with one newspaper group News Ltd, owned by Rupert Murdoch, giving it little regard and actively promoting a neoliberal philosophy. It is a philosophy which trumpets the values of the free market but not the free market in opinions and ideas (Keane 1991: 114). Noting the decline of investigative journalism since the 1980s, journalist Michelle Grattan commented that there have been fewer stories coming from bureaucracies. "No newspaper is giving us a really penetrating eye into the public service and most are telling us little at all" (Grattan 1995: 7).

Journalists' sources – leakers and whistleblowers

Whether the stories that discomfit those in power come in a flood during times of reform or in a trickle at other times, journalists are dependent on sources for information. While it is well recognised that journalists use information supplied by official sources, there are other sources that are prepared to release information to journalists that is confidential and unauthorised. These unofficial sources are called 'leakers' and whistleblowers. Broadly speaking leakers are defined as those who disclose information to the press, that has not been processed by official channels and there is an undertaking by the journalist that the identity of the source will not be revealed (Sigal 1973: 184; Ericson 1989: 135; Tiffen 1989: 96-97; Thompson 1995: 144). They operate within a work culture of the routine secrecy of information and if caught leaking may well expect punitive reprisals in the form of demotion or dismissal from their employment or legal penalties.

Whistleblowers are open in making public interest disclosures, most commonly internally but sometimes to the media. They soon suffer the consequences for their organizational disloyalty and poor understanding of teamwork. For these reasons disclosures from leakers and whistleblowers are intermittent in contrast to the steady flow of information disclosure from all other official sources. Yet such people are key information holders in their specialty. They usually reside within the middle ranks of the bureaucracy, the engine room of the organization, where journalists commonly find people “who are the most realistic, the most idealistic, the most committed, the most impatient with the system” (Young *pers. comm.* 1998).

Sources likely to leak are those located within organizations undergoing change or controversy (Gans 1979: 119; Tiffen 1989: 98; Perry 1998: 106). A reliable source can provide the impetus for an investigative story or add vital information to investigations in progress (Weir & Noyes 1983: 318; Weinberg 1996: 66-87). Once a story is underway new leakers, with more evidence, may come forward because they “sense that the walls are crumbling” (Parloff 1998: 102). They don’t have to do the work of attracting a journalist in the story, because it has already been done, and the information they provide will most likely be used. This information can have effects on public policy (Sigal 1973: 145; Hess 1984: 78; Tiffen 1989: 97) and governance (Sigal 1986: 37) and be explosive in its impact (Tiffen 1989: 98). It can provoke continuing media

attention on an issue that leads to it becoming a scandal (Thompson 1995: 144), and reveal “the second face of power” usually disguised in the routine political process (Molotch & Lester 1974: 111). They are an overt reminder to a fascinated public that accountability is at work in the democratic system.

Scandals

Scandals place on the record a particular kind of corruption in government, not that motivated by financial gain, but one where political power has been enhanced at the expense of due process (Thompson 2000: 92). Political power is then no longer transparent but covert and open to exploitation by interests serving their own agendas not that of the broader public interest. Scandals follow no predictable trajectory: some develop into a major crisis for the government and others pass without notice (Ettema & Glasser 1998: 187; Tiffen 1999: 2). Once on the media agenda the scandal is propelled forward by routine news reporting, and by the interest that either political party may take in the issue, and from here the scandal can progress to its domination of the news. The scandal places a demand on those holding power in government or the corporate sphere to respond in some fashion. Damage control by politicians and bureaucrats can include straight denials, or “lies, half-truths and strategic omissions” (Gitlin 1980: 74), or the setting up of parliamentary or judicial inquiry. This will ensure continuing coverage of the issue but there is no guarantee that any reforms that are recommended will be implemented. McKnight concluded that change can occur when it does not threaten entrenched power. Where Royal Commissions have dealt with police

corruption, racism or the abuse of power by intelligence agencies, they have not been successful, except in the case of the Fitzgerald Royal Commission (McKnight 1999: 166-167).

Publicity is an erratic component of the structure of accountability. Information provided by unauthorised sources, whether they be whistleblowers or leakers, may end up on the front pages and lead the nightly television news bulletin or disappear into oblivion. It can have a long-term durability that leads to action by government authorities and changes to public policy. In the case of the abuse of medical benefits the legislative changes occurred long after the first whistleblower sounded the call for reform. It is a reminder that news can set an agenda that is independent of the designs of politicians and policy makers and that the news like law serves a reform agenda and is part of the cultural production of moral authority and social stability (Ericson 1996: 196-197; Ettema & Glasser 1998: 190).

Neoliberalism has had profound implications for policing and accountability. Foucault's analysis of modernity and the risk society which has influenced regulatory theorists and complemented the writings of Hayek and his colleagues, but it has been an exposition that has met resistance. Foucault's account of the translation of power that has occurred in the modern age from the rule of sovereignty to a multifaceted system of governance provided a roseate picture of political life. For Foucault power were a productive discipline

(Foucault 1986: 61) and insurance a mechanism of social control in addition to being a necessary apparatus of security for protection of the population against hazards. His colleague at the Collège of France, sociologist Pierre Bourdieu, counterpoised this optimism with a different interpretation of political culture. His understanding of domination is that it is part of a structure of power that benefits some and exploits others. Foucault was interested in the development of a productive workforce and the apparatuses of security. Bourdieu was interested in the whole apparatus of insecurity in the contemporary workplace as neoliberalism replaced the welfare state and the workforce is increasingly segmented into those who are employed, those who have casual or part-time employment and those who are unemployed (Bourdieu et al. 1999). Expressing his heartfelt protest at this new utopianism he remonstrated,

In the name of a scientific programme of knowledge, converted into a political programme of action, an immense political operation is being pursued...The movement [is] made possible by the policy of financial deregulation, towards the neoliberal utopia of a pure, perfect market place (Bourdieu 1998a: 95-96).

Many voiced similar concerns. Boris Frankel was aware of the deleterious effects of neoliberalism's redistribution of wealth away from people on low incomes (Frankel 1997: 83). Habermas foresaw a rise in social inequality and societal fragmentation (Habermas 1999: 51). Bourdieu decided to take the fight against neoliberalism to the broadest audience and became actively engaged in

the political process. He addressed political demonstrations, set up a publishing venture, Editions Liber, printing small, accessible books on these matters of civic importance and produced a best seller, *The Weight of the World*, which documented the lives of those afflicted by this new economic regime. Although Bourdieu had developed a social theory for analyzing the structure of power it was Foucault's model, outlined in 'Governmentality', which was taken up by criminologists and regulatory theorists, who were faced with the task of devising a new regulatory models to complement the deregulated neoliberal state.

Conclusion

The following chapters will detail the history of public health insurance in Australia and the growing awareness that any policy of public health insurance would necessitate a regulatory architecture of some kind. The foundations were laid by the media. In an era when a journalism that challenged power structures was at its height, it brought to public attention the problems surrounding the abuse of medical benefits. Media attention to this subject was sustained and resulted in the setting up of a parliamentary inquiry. This initiated a reformist momentum, in at least one branch of medicine, that ensured that legislative and regulatory change continued for the next fifteen years. A leading pathology industry group commented in a report,

....there is no dispute that there was some abuse and that the pathology profession has never sought to defend the inappropriate use of laboratory medicine. Indeed the public image and standing of the pathology

profession has suffered. It has taken more than a decade of collaboration for the industry to rehabilitate its standing with government and the community (Submission of the Australian Association of Pathology Practices Inc. June 2000: 16-17).

Chapter 3

Prior to 1975

Health, which is highly factionalised, full of vested interests, high tech, a drain on Treasury and a service that the bulk of the population perceives as a core right, is inherently political.

S. Carter and S. Chapman *Review of position paper by J. Hall 'The Public View of Private Health Insurance'*

The development of health care financing in Australia

In the nineteenth century in Western countries, medical treatment was for the most part ineffective. The twentieth century witnessed the expansion of medical knowledge and with it the increased likelihood that medical interventions would produce successful results. As welcome as these advances have been they came at a price. Costs rose with the high price of medical technology,

diagnostic services, pharmaceuticals, medical equipment, the lengthy medical training of doctors and the development of new specialties (Rodwin 1993: 12-13). All these factors made it difficult for those not financially well endowed to meet the cost of medical care. It was a situation where a severe illness could spell financial disaster for those without the safety net of personal wealth or health insurance. Voluntary organisations provided some relief but political leaders began to realise these current remedies were inadequate and identified prolonged illness as a causal factor in determining poverty (DeVoe 2001: 3). In Britain at the turn of the century a population with a poor standard of health was increasingly recognised as a liability in times of war. There were “reports that almost one-third of volunteers for the Army during the Boer War had to be rejected due to physical inadequacy or ill-health” (Thane 1982: 67-8). If wartime military requirements were for healthy soldiers then the civilian economy also needed a healthy workforce to maintain high productivity (Starr 1982: 8; Sax 1984: 98; DeVoe 2001: 33). The perception that voluntary organisations could not meet all of the needs contributed to the “growing, if often reluctant recognition that that only the state had the resources to solve pressing social economic and political problems” (Thane 1982: 64 cited in DeVoe 2001: 33).

Governments have been keen to address the issue of access and equity and to meet this need different systems of health care financing have been tried and in many instances found wanting. The result in Australia has been a mix of private and publicly funded health care with a fee-for-service system of

payment. The disadvantage of this system is that it is vulnerable to fraud and overservicing. This chapter is about how the present system came into being and how fraud and overservicing became a feature not only of the current system, Medicare, but also earlier experiments with health insurance.

The problem of what insurers call 'moral hazard' or the issues of fraud, overservicing and over-utilisation does not arise where patients pay the physician directly for the medical service rendered and where there is no third party intervention in this financial relationship. Broadly 'moral hazard' refers to the phenomenon whereby universal insurance disrupts the price signals to consumers and suppliers producing a rise in the quantity of services demanded and the quality supplied. This occurs irrespective of whether it is privately or publicly funded insurance (Sax 1984: 193; Walsh 1995: 140; Tuohy 1999: 18; Leeder & McAuley 2000: 50). If the insurer places a higher value on the efficiency of the claims process than on investigating suspect claims and pays these 'nuisance payments' this creates moral hazard (Ericson, Barry & Doyle 2000: 539).

At the centre of the issue of control of fraud and overservicing is the question of definition. Medical fraud is taken to mean "the receipt of a payment by a doctor when no service has been provided, or when the claim for payment refers to a more costly item than the service actually provided. Overservicing, on the other hand, refers to the provision of services that are not reasonably necessary for

the adequate care of the patient concerned” (Palmer & Short 2000: 196). On first appearances it would seem that fraud would present no problems of definition, however, when the deception or misrepresentation relates to the question of medical necessity the distinctions between fraud and abuse (or between fraud and defensive medicine, or between fraud and well-intentioned over zealousness) become quite blurred (Sparrow 1996: 50). If the physician in question is aware that the services were not reasonably necessary then it is apparent that any medical benefit will have been obtained fraudulently (Cashman 1982: 117).

Health care finance in Australia in the first half of the twentieth century was based on solo private medical practice supported by charitable hospitals, that later became public hospitals. For the poor, hospitals provided free outpatient and dispensary services and medical costs were met by way of contributions to mutual aid societies known as Friendly Societies, clubs or lodges. Under this system members paid a small weekly sum to a Society, which in turn contracted with doctors to provide services. Doctors were paid an annual capitation fee for each person who was entitled to treatment, irrespective of the number of services actually provided (Gray 1991: 85; Gillespie 1990: 8; Sax 1984: 19; Scotton & Macdonald 1993: 5). The benefit of capped fees to the lodges and Friendly Societies was that fraud and overservicing did not occur and costs were contained. But the fee structure didn’t appeal to doctors, especially as their counterparts with an affluent client base could set their fee for each medical

service delivered. As early as 1861 complaints in the *Australian Medical Journal* were received regarding “the lodge system” offering such “a miserable remuneration...It is not only that the medical profession is degraded, but the public should be aware that the medical attendance given in such cases is not likely to be of a standard that will reflect credit on the profession” (Tracey 1861: 64). In 1913 the *Australian Medical Gazette* echoed these sentiments: “the wholesale conversion of private into contract practice ... must inevitably lead to the deterioration in the caliber of the medical man, to the lowering of the standard of work ... and increased suffering on the part of the sick” (cited in Gray 1991: 85). This situation was aggravated by the fact that by 1913, one third of the Sydney population received medical care through Friendly Societies (Sax 1984: 14) and 46 per cent of the Australian population was eligible to receive medical services from Lodge doctors (Gray 1991: 52).

The 1920s and 30s and the failure of national insurance

In Britain a compulsory contributory national health insurance scheme was established in 1911 and administered through the Friendly Societies and other approved societies (Gillespie 1990: 88). Under this scheme workers paid a weekly amount of four pence, their employer paid three pence and the government paid two pence (Sax 1984: 30-31). The adoption of this model in Britain led to a consideration of a similar scheme in Australia. It won favour with Liberal and Country Party groups, but Labor preferred a scheme financed by the whole community not just by those in employment (Sax 1984: 34). The medical profession in Australia was not adverse to the idea of insurance as long

as it was administered outside of Friendly Societies (Gillespie 1990:90) but there was no agreement from the profession on the terms of participation by doctors in the scheme, and a general lack of enthusiasm from its own supporters, the trade union movement and the Friendly Societies (Gillespie 1990: 105).

In 1928 an attempt was made to introduce a National Health Insurance Bill but lack of enthusiasm for the project by the electorate as well as economic depression focused political attention on more pending issues. The Bruce-Page government was defeated in late 1929 and with it died the idea of national insurance for another ten years (Sax 1984: 36-37; Gillespie 1990: 88). In 1938 the Treasurer, R. G. Casey in the Lyons government, proposed a National Health and Pensions Insurance Bill. It was a general practitioner service organised on a panel basis in which doctors were to receive a capitation fee for each insured person (Sax 1984: 39). It was confined to those in salaried employment and not for their dependents. It was restricted to general practitioner benefits and carried a means test that excluded the fifteen per cent of the population with the highest incomes (Scotton & Macdonald 1993: 7). However it also excluded women, the self-employed and the unemployed. These impracticalities ensured that this insurance proposal would fail; in addition there was strong opposition from the medical profession. But this proposal and its predecessor of the 1920s could well have failed on the question of its constitutional validity, a subject that was not explored at this time (Sax 1984: 42).

The 1940s and constitutional change

The 1940s saw more successful attempts to introduce health insurance. Robert Menzies was elected leader of the United Australia Party on the death of Lyons and he revived the 1938 insurance legislation. In July 1941 he established a Joint Parliamentary Committee on Social Security whose report was published in July 1943. It identified two problems at the heart of health reform - the middle class who were ineligible for free treatment but had difficulties in meeting the high cost of medical care and the inequitable geographical distribution of health services (Gillespie 1991: 150).

In October 1941 Labor won office and it too was committed to health reform. In November 1942 the British Medical Association¹ was invited to attend discussions on the feasibility of establishing a salaried medical service. They declined (Sax 1984: 50). However, advocates of fee-for-service gained ground at a NSW branch convention in 1943, which rejected its executive's recommendations for a capitation-based system. In Victoria, Dr. Charles Byrne, a general practitioner and member of the Victorian Council of the BMA, advanced the first plan involving universal fee for service as the basis of medical remuneration (Gillespie 1991: 190-2). Byrne understood that poor law medicine was no longer politically acceptable and nor was the neglect of the middle classes from relief with medical costs in times of illness. He also acknowledged the problem of fraud and overservicing within a fee-for-service

¹ At this time the medical association in Australia was called the British Medical Association.

system of health financing. He understood that the extension of fee-for-service would imply controls over these areas of cost expansion and that the medical profession would have to submit to new restrictions on their mode of practice (Gillespie 1991: 180).

The Australian Labor Party, long aware that the Constitution was ill equipped to fulfil the health policy objectives of the Party, set out to alter the Constitution. This it did with a constitutional referendum in August 1944, which was to cover fourteen areas of policy under state jurisdiction including 'national health in cooperation with the States' (Hunter 1969: 114). The Treasurer, Ben Chifley, explained the need for a comprehensive scheme:

In the past the need for coherence had been obscured by the division of social security and health functions between Commonwealth and the States. Developments in this field of policy have therefore been uneven and spasmodic. Only the national government can secure national standards and equity (Hunter 1969: 117).

The referendum was defeated (Hunter 1969: 121; Sax 1984: 52). A number of factors underlined this defeat. These included the natural caution of the electorate when asked to cede power to the federal government. The states, for their part, were alarmed at the wide range of powers involved. There was a suspicion that the government was using its war time powers in order to promote socialist policies (Sax 1984: 52) and this fear was reinforced by Chifley's announcement of his intention to introduce a salaried medical service (Sax 1984: 53-4).

In 1946 a referendum was again held and this time a more successful strategy was adopted. Instead of fourteen powers it sought three powers, which were put to the vote separately and one of these was on social and health services. On health the powers asked for, and subsequently given, were more specific. The words 'national health in cooperation with the states or any of them' had been replaced by 'pharmaceutical, sickness and hospital benefits, medical services (but not so as to authorize any form of civil conscription), benefits to students and family allowances' (Hunter 1969: 147). The amendment in parenthesis had been moved by the leader of the Opposition, Robert Menzies, on the suggestion of Sir Henry Newland, later president of the BMA (Hunter 1980: 197). Menzies insisted that the health powers, once passed, would give the Labor government power to nationalise medicine and dentistry. Evatt accepted the proviso in good grace arguing that "if industrial workers are entitled to be protected against conscription, members of the medical and dental profession are entitled to similar protection" (Hunter 1969: 150). This change to the constitution was of great significance. It allowed the Commonwealth to legislate in the area of health and dental services and could allow the Commonwealth to establish its own hospitals in the states. In this respect the Labor Party had triumphed over the states but not over the medical profession. The Menzies-Newland proviso constrained the Commonwealth from introducing a health scheme modelled on the British National Health Service with a capitated salary system. Doctors now could not be compelled to enter salaried employment with the Commonwealth (Sax 1984: 55). This

constitutional change was vital to Whitlam's health policy in the 1970s, but also set limits on it. It allowed Whitlam's plan for universal health insurance to be brought in but only on a fee-for-service basis.

It is curious that in 1948 in a private meeting with Sir Sidney Sewell, an influential member of the Victorian branch of the BMA, Menzies confided that "fee-for-service would not and could not be considered by any political party in the Federal Parliament". Sewell went further "Mr. Menzies expressed himself as being particularly anxious to have a British Medical Association Scheme for a salaried medical service and he undertook, if he received such a scheme from the Association, to support it" (Gillespie 1991: 243).

The Pharmaceutical Benefits Scheme

In 1945 Labor's Pharmaceutical Benefits Act of 1944 was challenged and declared invalid by the High Court. In 1947 the government passed a second *Pharmaceutical Benefits Act*. This act was amended to make it an offence for a medicine included in the formulary to be written on a non-government prescription form (Gray 1991: 70). The High Court declared the Act invalid because it authorised a form of civil conscription (Hunter 1969: 145; Sax 1984: 55). When the Menzies government won power in 1949, the Health Minister, Sir Earle Page, enacted regulations on pharmaceuticals in July 1950 under the National Health Service Acts of 1948-1949. The issue of government assistance to the cost of pharmaceuticals had received bipartisan political support so where Labor had failed the Liberal Country Party succeeded and they did so by

taking a different legislative route (Sax 1984: 59). This meant that medications could be supplied free of charge by approved chemists, but only on the prescription of a registered medical practitioner (Sax 1984: 61).

The BMA was against the whole concept. If government had adopted the suggestion of the NSW branch of the BMA then the problems of secret commissions and kickbacks in the pathology industry that emerged in later years might have been avoided. It expressed the prevailing sentiment of BMA members when it said,

The sums proposed to be spent on such a scheme, would be spent with greater profit to the community on the construction, equipping and maintenance of pathological and radiological diagnostic centres throughout Australia (Gillespie 1991: 215).

The 1950s ...the Page National Health Scheme

In 1948 Britain moved to a capitated health system, the National Health Service. Overall this system did not meet with the hostility in Britain that such a concept had for the BMA in Australia. Sir Earle Page had fashioned a health scheme and under its umbrella were medical benefits, a pensioner medical scheme, pharmaceutical benefits and hospital benefits. The Pensioners' Medical Scheme started in February 1951 and covered those on the old age pension and the invalid pension and was means tested (Gillespie 1991: 260). In a victory for the BMA there was no capitation system; rather remuneration was by fee-for-service. In 1949 the BMA in each state terminated all Friendly Society contracts

and announced that from 1951, private medical practice would operate solely on fee-for-service basis (Gray 1991: 90; Sax 1984: 60; Gillespie 1991: 271-276). The way this was achieved was by extending the list of excluded services, and tightening the means test (Gillespie 1991: 271). Under this pressure the Friendly Societies capitulated. Most of the Friendly Societies became registered insurance organisations and adopted the reimbursement system of paying benefits to members in respect of fees for services rendered (Sax 1984: 64-65).

In 1953 Page introduced the *National Health Act* that covered four areas: pharmaceutical benefits, medical benefits, hospital benefits and a pensioner medical service (Sax 1984: 60). In regard to medical benefits the aim was “to encourage the formation of new and strengthen the working of existing voluntary insurance organisations” (Page 1963: 431). It meant that people who were “insured with registered non-profit organisations were eligible for commonwealth contributions towards cash benefits obtainable from those funds” (Sax 1984: 64). The insured person having sent in his/her claim received not only the Fund benefit of that organisation but also a Commonwealth benefit from the government. On average the insurance organisation paid about 37 percent, the Commonwealth 27 percent and the patient 36 percent. The patient had to pay part of the bill and that share was never to be less than 10 per cent (Fox 1963: 877). The purpose of this co-payment rule was to prevent over-use of the system by patients (Sax 1984: 65). Sixty-eight percent of the population was covered by this publicly funded private insurance system. The remainder was

covered by the pensioner medical service, or by repatriation benefits payable to ex-servicemen. There was still a small percentage without any coverage and they funded their own health care. The main intended beneficiaries of the Page scheme were the middle-income group (Gillespie 1991: 265).

In promoting his health scheme Page was able to enlist the support of the BMA, the Pharmaceutical Guild and the Friendly Societies but struck difficulties on the political front. Labor had a majority in the Senate but Page manoeuvred around this problem by carrying through the various stages of the health scheme by regulation (Page 1963: 376). However, in regard to medical benefits he had to wait until his government secured a majority in the Senate. "Following the double dissolution of Parliament in 1951, the *National Health Act* was introduced and passed in November 1953" (Page 1963: 379). The Act's final acceptance by Parliament was the culmination of a long series of processes including publicity through press releases (Page 1963: 379). Administration of the scheme was through private insurance companies rather than the Commonwealth Department of Health. These companies were not-for-profit organisations like Friendly Societies and health benefit funds with costs regulated by a means test. The arrangements in regard to private medical practice were to remain in place but those who availed themselves of private insurance could be assured that the State would be paying for part of the doctor's fees.

This mix of private and public health care financing elicited these observations from Sir Theodore Fox, a visitor to Australia and editor of the British medical journal *The Lancet*:

To base a Government scheme on private insurance is in fact an experiment few of us would wish to repeat. Yet in Australia the hundred-odd insurance organisations seem to work in quite satisfactory partnership with the State (Fox 1963: 877).

One flaw in this arrangement was the problem of cost containment. Page had confidently asserted that “definite control [will] be secured over the amount of money to which the Government and the taxpayer are committed” (Page 1950 quoted in Gillespie 1991: 256). However, doubts over the possibility of containing costs within a publicly funded universal fee-for-service system had emerged as early as the mid 1940s. The then Minister for Health, Senator James Fraser, a party of senior health and social security officials, together with BMA personnel, travelled to New Zealand to view the progress of that country’s health system. They were alarmed at the level of financial abuse of the system and a costing far in excess of expectations.

The visiting officials were horrified at the cost explosion of publicly-funded universal fee-for-service systems. The example of New Zealand provided ammunition for both sides over the next five years, and its immediate effect was to increase the concerns of Treasury about costs controls in the national medical scheme (Gillespie 1991: 248).

The Page scheme too showed early indications of financial abuse (Gillespie 1991: 261-262).

The Pensioners' Medical Scheme and the Pharmaceutical Benefits Scheme were more expensive than anticipated (Gillespie 1991: 261) and in 1952 departmental investigations indicated that this was caused in large part by overservicing by some doctors (Gillespie 1991: 262). Both Cabinet colleagues and bureaucratic advisers, including Herbert Goodes, assistant secretary in Treasury, "saw cost containment as a central objective, warning of the dangers inherent in a subsidised fee-for-service scheme in the absences of rigorous - and politically unacceptable - policing of fees" (Gillespie 1991: 268-269). Arthur Metcalfe, the Director-General of the Commonwealth Department of Health, in 1952 expressed concern that:

At the present time the arrangements under the Pensioners' Medical Service are far too loose. In fact the absence of regulations makes effective control almost impossible.

Under the Pharmaceutical Benefits Act, we are almost powerless to deal with abuses by medical practitioners owing to the removal of penalties by the previous government. Unless, therefore, action is taken under the *Crimes Act* to deal with cases of collusion [between doctors and chemists] and other fraudulent practices, I am afraid our efforts to establish medical and pharmaceutical benefits on an efficient and economical basis will be completely frustrated (Gillespie 1991: 262).

Two measures were taken to deal with this. The first was the use of a more restrictive means test. This had the unfortunate result that, by the early 1960s, over one-quarter of pensioners were excluded from the service (Gillespie 1991:

264). The second measure was the setting up of Medical Services Committees of Inquiry, as a system of peer review to maintain financial discipline on doctors (Dewdney 1972: 48; Sax 1984: 65-66; Gillespie 1990: 262). Metcalfe suggested that these be strengthened so as to "limit the income now being derived by some doctors through 'services' to individual pensioners. Power might also be given to refuse payment in particular cases where the Department in association with the Committees, is satisfied that the payments are not justified" (Metcalfe cited in Gillespie 1991: 263). This system of peer review was judged to be a fairly ineffective measure, though it did produce some results. In 1968 a group of conservative doctors split off from the AMA in protest at the imposition of fines for overservicing pensioner patients. They called their organisation the General Practitioners' Society of Australia (Matthews 1988: 56) and its president, Dr. Peter Arnold, speaking in defence of their position reasoned:

We believe that the most satisfactory form of personal medical care, both for patients and doctors, is one in which the doctor has the right, where the patient himself pays for the attention he receives (with or without assistance from insurance) and where the doctor carries no onus of policing the extent of the utilisation of his services. The society has resisted all moves by government and other insurers, which tend to disturb this mode of practice (Arnold 1975: 6).

In the early 1950s Metcalfe sounded a warning to the profession that unless unethical conduct was controlled then:

If ever another government, favourably disposed to the nationalisation of the medical profession, comes into power, the medical men themselves will have their own actions used against them as justification for such a measure (Gillespie 1991: 262).

These sentiments were echoed by Sir Theodore Fox a decade later:

Quite a small change of voting might bring a very different government to power; and, since this is bound to happen sooner or later, I should myself suppose that the best chance of preserving the present system lies in detecting and controlling its abuses before these can be used as reasons for overturning it (Fox 1963; 878).

The issue of fraud and overservicing moved around closed official circles for three decades. It was not contested in the public sphere until Whitlam did so in the 1960s, nor was it during this time the subject of media interest.

1960s...Australian Labor Party - prelude to power

The predictions of Metcalfe and Fox were accurate. The Page scheme was overturned. This was achieved by the Labor Party under the leadership of Gough Whitlam. In his years on the opposition benches Whitlam set about the task of revising and formulating party policy. His idea of a health policy for Labor was one that would spell success at the ballot box and challenge the Menzies government health scheme. The health insurance system at this time was a voluntary one, there was no schedule of fees, the Federal Government paid benefits in accordance with a schedule listing a limited range of services, the difference between fees charged and the combined Commonwealth and health fund benefits was paid by contributors and access to free hospitalisation was subject to a means test (Repin 2000: 17).

During the decades from the 1950s to the 1970s Whitlam outlined the limitations of this arrangement in different arenas. He asked questions on notice in Federal Parliament about the high cost, high reserves and limited coverage of private health funds (Menadue 2000: 13). In the Chifley Lecture of 1957 he argued: "The Commonwealth now spends more on health than do the States but Australians still by Western European standards, have a medical service which is beyond the means of individuals". It was a scheme whose structural weakness in terms of medical care was that it encouraged under utilisation by those it was intended to assist: "The fear of debt deters many people from seeking medical attention sufficiently early or undergoing a full course of treatment". And it had a negative impact on the economy "The fear of ill-health is the greatest economic hazard in our community" (Whitlam 1957: 30).

In 1967 in his response to the Budget in the House of Representatives he explained that:

To obtain maximum health insurance cover for himself and family, a contributor has had to increase his contributions between 1955 and 1966 by 140 percent in NSW; 500 percent in Victoria; 130 percent in Queensland; 110 percent in South Australia; 120 percent in Western Australia and 33 percent in Tasmania. This is a serious indictment of health services in Australia (Whitlam 1985: 335).

At a post-graduate seminar at Sydney's Royal Prince Alfred Hospital in 1969 he noted that the average operating costs of the funds between 1953 and 1967 were 15.3% for medical benefits and 12.1% for hospital benefits. Commonwealth

benefits helped to mask the funds' extravagant use of executive aircraft, political campaigning and prestige office space. In addition 17 per cent of Australians had no health cover at all and 15 per cent had no hospital cover (Whitlam 1969: 2-3).

During this long campaign Whitlam reached many of his audience by reducing the economic abstractions of health insurance to the sphere of everyday practicalities by comparing his own situation to that of his Commonwealth drivers George Bevitt and Robert Millar. 'The tax rebate is worth twice as much to me as it is to my driver on a third of my income, so I pay much less for my health insurance than my driver' (Freudenberg 1977:105). Members of the public were becoming increasingly restive at the disparity between the growth of the health insurance funds and their demand for higher contribution rates and the unsatisfactory gaps in coverage (Scotton & Macdonald 1993: 19). For those with health insurance cover, the cost of contributions was rising because of increases in fees in an inflationary economy and the failure of the government to increase the share of benefits paid, so that the proportion of costs contributors had to meet reached nearly 35 per cent (Repin 2000: 17).

In searching for other approaches to health policy Whitlam considered the health policy championed by his parliamentary colleagues in the Labor Party: a socialised national health system. Socialized was here defined as the government having the power to compel doctors to work in their employment

under a payment system of either salary or capitation. Notwithstanding its merits Whitlam was well aware of the difficulties in implementing such a scheme. It faced the prohibition on civil conscription in section 51 (23A) of the constitution (Whitlam 1977: 60) and the need for a referendum to alter it.

Labor health policy at the time was given expression by Moss Cass, a medical doctor and member of the Labor health and welfare committee. Cass outlined his ideas in a Fabian Society pamphlet of 1964, *A National Health Scheme for Labor*. It considered hospital care as well as medical remuneration for doctors. Cass argued for a system whereby doctors were paid an adequate salary and would staff community health centres. Cass acknowledged that his scheme would be vulnerable to attack from the medical profession and the conservative parties as an attempt by Labor to introduce socialised medicine (Stubbs 1989: 97 cited in Scotton & Macdonald 1993: 42). The other alternatives were not appropriate. A fee-for-service system of remuneration to doctors encouraged overservicing (Cass 1964: 20; Scotton & Deeble 1968: 140; Scotton 1974: 216; Mechanic 1981: 4; Sax 1984: 76; Gillespie 1991: 188, 282; Rodwin 1993: 2,5,11,55; Scotton & Macdonald 1993: 42; Wheelwright 1994: 102; Sparrow 2000: 52-55). The capitation of fees led to underservicing and the exploitation of medical personnel:

With the capitation fee as in Great Britain, the doctor suffers from an excessive work load in order to obtain a still less than adequate income. The resultant demoralisation of the general practitioners again leads to the community paying, this time for excessive drugs prescribed as a sop to the

conscience of the harassed doctor who has not time to provide true personal medical care (Cass 1964: 20).

Bill Hayden was of a similar mind:

I would rather have had a system of free public hospitals, adequately funded, as then in Queensland, and there backed by the development of self-administered community health centres, staffed by salaried medicos and para-professionals. The cost of operating these centres, including staffing salaries, would have been funded by per capita subscriptions from voluntary subscribers supported by a government subsidy (Hayden: 1996: 214).

As considered as these proposals were, Whitlam was looking for a health policy that was electorally viable, constitutionally feasible, and sufficiently robust to withstand challenges in the High Court. The fate of the second *Pharmaceutical Benefits Act* of 1947 had led him to the conclusion that “it is impossible for an Australian government to follow the British and New Zealand health schemes unless it was prepared entirely to abdicate to the medical profession in determining the cost and method of running the scheme” (Whitlam 1957: 17). Whitlam judged that by this decision “the High Court had reached its nadir” so that:

Throughout the 1960s I gave much attention to methods of introducing a health system which would be equitable and complete and accessible as the systems to be found in all developed countries, other than the United States, and which would withstand High Court challenges by the States and vested interests (Whitlam 1997: 222).

Whitlam considered that the core of any health program would be the provision of free treatment in public hospitals and that in fact “while the

constitution precludes the socialisation of doctors, it permits the socialisation of hospitals" (Whitlam 1977: 60). Whitlam concluded that more electorally appealing than aligning the Federal government in support of the State hospital finance system was universal health insurance that preserved the fee-for-service model of service delivery.

It was Dr. Moss Cass who on the 6 June 1967 introduced Whitlam and key health policy advisors to the two economists John Deeble and Richard Scotton who were working at the Institute of Applied Economics and Social Research at the University of Melbourne. Cass was enlisting their help to critique the economic impact of the Liberal Government's voluntary health insurance and to make economic predictions about alternative health systems. Whitlam was impressed by their appraisal that a compulsory universal scheme would be cheaper than the current one (Menadue 2000: 13). Whitlam recalled "Deeble and Scotton were preparing an alternative health insurance program which built upon the criticisms, identical to my own, that they had developed of the existing system. Medibank (universal health insurance) was conceived that night" (Whitlam 1985: 336). Whitlam asked Deeble and Scotton to formalise their ideas and this they did in a short paper 'A Scheme of Universal Insurance' which they presented to Whitlam in May 1968. It was these proposals that were incorporated into his address 'The Alternative National Health Programme' at a post-graduate seminar at Sydney's Royal Prince Alfred Hospital in July 1968. Moss Cass recalled that this "wasn't a national health scheme...Gough just

picked it out of the air because he knew it would win a lot of votes" (Cass cited in DeVoe: 2001: 47). Whitlam caught many by surprise, including the AMA and members of his own party, as his new health policy was not yet approved as official Labor party policy (DeVoe 2001: 47).

His outline for the basic plan for Medibank was that the Commonwealth would replace the existing system of voluntary health insurance with one that was publicly funded. It would be administered by a new statutory body, a Health Insurance Commission which would be funded from a Health Insurance Fund. This fund would be financed by a 1.25 per cent surcharge on income tax. Representatives from the federal government, the AMA and the Health Insurance Commission, would negotiate medical benefits, designed to cover eighty five per cent of the scheduled fee. The Health Insurance Commission would also provide hospital benefits guaranteeing full coverage without a mean tests for patients in public hospitals (Whitlam cited in Freudenberg 1986: 104-5).

He was able to present a case that under his administration a health insurance system would be implemented where financial abuse would be contained. His suggested method was by patient co-payments: "Any risk of patients abusing 'free' general practitioner services or 'free' unreferral specialist services will be eliminated by imposing a scale of modest charges for these 'patient-initiated' services" (Whitlam 1968: 7).

The AMA responded with a detailed analysis and rebuttal of Whitlam's scheme in the *AMA Gazette* in an article entitled "Why Mr. Whitlam's Proposals Should be Rejected" (AMA 1969: 5-8) that was also printed in a pamphlet *Paying for Health Care*. This critique included references to Whitlam's suggested method for controlling overservicing and over utilisation. It argued that in those "countries which have adopted this method of health insurance, overservicing and over-utilisation has led to frequent increase in contribution rates" (AMA 1969: 5-8). In addition "co-payments would be difficult to administer and police" and in fact

these charges are not much different from what patients now pay after taking their fund rebates into account. These charges will bear most heavily on those in the lower income groups who Mr. Whitlam is most anxious to protect (AMA 1969: 5-8).

On 12 April 1969 Whitlam responded and critiqued the AMA's arguments in the *Medical Journal of Australia*. 'The Health Care Debate: Labor's Reply'. Whitlam said in regard to controls on overservicing: "In foreshadowing this possibility I intended no more than to recognise that the fear of over-utilisation is honestly held by among great numbers of doctors, even if my own view of it is ill-based. If the profession as a whole is unappreciative of the proposal then...I am more than happy to forget the whole idea". A week later E. F. Thomson, Secretary-General AMA, replied with a letter in the *Medical Journal of Australia*, 'The health debate: the AMA replies to Mr. Whitlam'

The AMA maintains that Mr. Whitlam's plan would inevitably lead to over-utilisation of medical services, because to a large extent the patient would be unaware of and not interested in the costs of the services supplied. This is certainly the case with pharmaceutical services. Doctors themselves would tend to over-utilise such a service (MJA 1969: 826-7).

Both Whitlam and the AMA were caught in the rhetoric of the debate, a point commented on by Race Matthews, private secretary to Whitlam (1968 to 1969), Richard Scotton and the AMA itself. Matthews noted that it was not long before the AMA was attacking Whitlam's health policy for its lack of deterrents on fraud and overservicing (Matthews 1988: 54). Richard Scotton observed that "the original Scotton and Deeble proposal had included utilisation fees ranging from 80 cents to \$2.50 to be deducted from general practitioner and unreferral specialist attendances....Whitlam rejected advice from Deeble to ignore the criticism...and declared that he would drop the utilisation charges" (Scotton & Macdonald 1993: 33).

The Nimmo Report

In the face of popular discontent with the now well publicised problems of the voluntary health funds, Prime Minister John Gorton in January 1968 set up an enquiry on health insurance under Mr. Justice Nimmo (Gray 1991: 97). The report was tabled in the House of Representatives in March 1969 and it confirmed Whitlam's critique of this system of health insurance. Its findings were that the health insurance scheme was unnecessarily complex, that contributions had increased to such an extent that they were beyond the

capacity of some members of the community to pay. The rules of some organisations included “special accounts” that permitted a reduction of claims for particular conditions. The application of these rules had caused widespread hardship. Both the reserves and the operating costs were too high (Nimmo 1969: 9).

The Gorton Coalition government acted on these recommendations and closed the gaps between fees charged and benefits, reducing the patient’s proportion from 34.7 per cent to 18.9 per cent. The subsidised health benefits scheme for low income earners, the unemployed and migrants was introduced, and changes to special account legislation increased benefits for long-stay hospital patients and patients with pre-existing illnesses to full benefits. Those not covered at any one time constituted less than 5 per cent of the population (Repin 2000: 17). George Repin, Secretary-General of the AMA from 1972 to 1987, argued that the government could have closed this gap with minimal change (Repin 2000: 17). Richard Scotton argued that these reforms failed because the government was not able to negotiate with the AMA on bridging the gap between medical fees and benefits and it was this that lessened the electoral impact of the reforms (Scotton 2000: 10). The Nimmo Report drew attention to:

The need for an effective fee stabilisation arrangement and for safeguards against the over-use of medical services by patients and over-servicing of patients by doctors which have presented the Commonwealth Government with problems in connection with its Pensioner Medical

Service...It is extremely difficult to devise safeguards of the kind required without imposing severe restrictions on the availability of a service (Nimmo 1969: 58).

The Nimmo Report noted that there are problems with the Pensioner Medical Service, but this awareness did not translate into strategies for dealing with it.

Evidence given by Scotton and Deeble before the Senate Select Committee on Medical and Hospital Costs in 1968 noted the criticisms usually directed towards universal health insurance. They suggest "The only medical services on which financial disincentives have a direct and obvious bearing are those which are generally initiated by patients and outside the control of doctors" (Scotton & Deeble 1968 cited in Butler & Doessel 1989: 140). Richard Scotton, in his book *Medical Care in Australia* based on his doctoral thesis of 1970, outlined the problem of health insurance system based on a fee-for-service offering doctors perverse incentives to increase their output to the limits of capacity:

The most profitable strategy for general practice, involving rapid throughput and cursory therapy, results in a poor quality of care, especially in the treatment of behavioural and psycho-social disorders....

There is a general bias in fee-for-service practice toward episodic treatment of symptomatic illness and away from the provision of regular and preventive care. But there is an even stronger bias in favour of particular types of therapy - notably specific diagnostic and surgical procedures for which separate fees are charged and against which separate insurance benefits are available. Demand for these services is price inelastic and manipulable and the pricing structure for procedures has always produced a net return per hour worked well above that of most other forms of medical activity (Scotton 1974: 216).

Historian James Gillespie argued that it was these factors, the difficulty of obtaining an accurate measure of overservicing together with the excessive proportion of funds expended on administrative expenses that provided the political setting for Labor's shift towards compulsory public health insurance (Gillespie: 1991: 283). The Scotton-Deeble plan was accepted officially as the health policy of the Labor Party at its federal conference in July 1969 (Scotton & Macdonald 1993: 32).

At the October 1969 federal election, Labor came within seven seats of winning office. There were now six medically qualified Labor MPs in the House of Representatives, five of whom became members of the caucus health and welfare committee (Scotton & Macdonald 1993: 42). This triumph was offset by criticism from the committee of the Whitlam/Hayden health plan as it was a system based on fee-for-service and would lead to abuse and overservicing. For these reasons they were reluctant to give it their support. Whitlam persisted: he knew that it was this policy that would bring victory at the 1972 election. One doctor said:

It's little more than a mechanism for subsidising private fee-for-service medical practice and private hospitals...Cass described Medibank as the very antithesis of a genuine health service for the community.....

Hayden was given the task of relaying the committee's misgivings to Whitlam, who was outraged. Grinding his teeth with anger he declared, quite accurately: 'Jesus Christ! I've just nearly won an election on my health package, you pissants' (Stubbs 1989: 97 cited in Scotton & Macdonald 1993: 42).

AMA - maintaining influence in a time of change

If the Committee was aggrieved with this proposed compromised solution so also was the AMA. For the AMA this solution pushed health policy in a more radical direction, as well as marking a turning point in its relations with the federal government. As an interest group the AMA was recognised as having a unique relationship to the executive arm of government, which was strengthened by an amalgam of its economic, social and political resources (Hunter 1980: 191; Sax 1984: 237). The Department of Health and the AMA during the Menzies years “were said to be in co-operative partnership with their sponsor departments” (Matthews 1993: 243). So close was the contact that Lionel Wilson, Federal Treasurer of the AMA from 1973 to 1976, commented “Before the election of the Whitlam government in 1972, the method by which the medical profession attempted to influence governments was by contact between the President of the AMA and the Minister for Health at the time” (Wilson 2000: 20). There was no need here for the professional lobbyist or efforts directed in other more uncertain and diffuse strategies to win political influence.

What the AMA was being faced with was that, not only in Australia, but also in other western countries, the dominance of the medical profession was being challenged, and there was an increasing acceptance of the role of government in the field of health care (Weller 1977: 451; Walsh 1995: 140; Blewett 1999: 38; Tuohy 1999: 5). Publicly funded health insurance set a limit to the economic opportunities and collective power of the medical profession and reinforced a

basic conflict of interest between them and their governments (Scotton & Macdonald 1993: 4). This has meant that the position of the doctors was being eroded while that of politicians and administrators was increasing (Weller 1977: 453).

The signs of its decline from power were that when Labor was in government it withdrew health insurance from the Department of Health, where it had influence, and transferred it to the Department of Social Security (Hunter 1980: 195); the AMA lost the battle to prevent the introduction of Medibank and Medibank itself was developed without any input from the medical profession (DeVoe 2001: 49). In fact, with the introduction of Medibank came an abridgement of the veto power by the medical profession over the structure of the health system (Scotton & Macdonald 1993: 269). To be sidelined in this way was not what Dr. George Repin, Deputy Secretary-General of the AMA, considered the optimal way to formulate health policy. The most productive approach was ongoing consultation with the parties affected by government's decisions. This Repin outlined in 1972 in his lecture series in the Department of Public Health at Sydney University where he argued

Planning for personal health services involves four steps – closely related to each other, but conceptually different

1. Elaboration of the plan
2. Its acceptance by those affected

3. Implementation, and

4. Subsequently evaluation, that is to say, study and assessment to determine the extent to which the plan has, in fact, achieved the results that it was intended to achieve (Repin 1972: lecture *Development of Australian Health Services*).

Not only did the organisation lose power within government but it was also losing internal cohesion. Canadian academic Anne Crichton notes that when the Nimmo Committee Report delivered its findings a process was commenced which “began to undermine the monolithic organisation of the AMA” (Crichton 1990: 189). Looking back over the years Repin recalled that when he was Secretary General of the AMA the organization represented 14,000 doctors being then ninety percent of the medical profession:

Where it all started to fall apart was with the introduction of the original Medibank because there were those in the profession who regarded the AMA as being too weak and not standing up to government. So they had already formed the General Practitioners Society of Australia and they were very anti-AMA, so they pulled membership away from us. Then the Doctors Reform Society was formed and was left wing and they felt the AMA was too reactionary and shouldn't be opposing these changes, so they left. So then the AMA support dissipated to some extent (Repin *pers. comm.* 2002).

One of the reasons for the GPSSA's departure from the AMA in 1968 was over the imposition of fines for overservicing pensioner patients (Matthews 1988: 56).

Other forces frustrating organisational cohesion were that the AMA was becoming fragmented by its increased size; it was no longer a relatively small group where members knew each other. There was a drifting apart of general

practitioners and specialist groups who each dealt directly with government (Thompson *pers. comm.* 2002; Report Chelmsford Royal Commission 1990, vol. 14: 1071). Lindsay Thompson believed the government supported a policy of “Divide and conquer ...[and] they encouraged individual groups to directly negotiate thereby diminished the power of the AMA and the collective clout of the profession” (Thompson *pers. comm.* 2002).

Repin concurred with this observation but added that when the Whitlam government was elected Bill Hayden was Minister for Social Security and so handled the introduction of Medibank. He started to deal with the professional groups separately but found himself in difficulties when the different groups told him different things

Finally I contacted him and I said... “you tell us what the problem is that you want addressed and I will deal with it internally within the profession. We will come up with a proposition for you...which reflects a consensus view that everybody feels that they at least can live with. Not everybody will get what they want but at least we’ll come to you and you’ll have one body to deal with”. He thought that wasn’t a bad idea after the experiences that he had had (Repin *pers. comm.* 2002).

Of all the factors leading to divisiveness of the profession Repin found the hardest to manage was the individualism of its members and the significant differences between the state branches. Leadership in the AMA was a matter of understanding and managing these differences. Repin argued that in terms of dealing with its own members or with government “the only power the profession has is if it can marshal its facts, present reasonable arguments and

persuade whoever is listening to accept those arguments" (Repin *pers. comm.* 2002). Both the AMA and politicians deployed various types of persuasion and argument in the early 1970s, in the struggle to gain command of uncertain political events in what Richard Scotton called "the bitterest episode in a saga of hostility extending over several decades" (Scotton & Macdonald 1993: xi).

1970 to 1974 ...Labor wins power

As the AMA entered the decade of the 1970s it was an organisation weakened by dissension within its own ranks, the real possibility of Labor winning power at the 1972 election and the loss of political influence that would entail. This would mean lack of ready access to the network of reliable Liberal coalition ministerial connections where policy differences could be discussed in private. On the suggestion that the AMA might now have to employ a professional lobbyist, Sir Clarence Rieger, a past president of the AMA, argued that not only was it beneath the dignity of the profession but "in any case, we know everybody" (Scotton & Macdonald 1993: 97). Such methods belonged to a bygone era, a time when the AMA "had achieved its policy objectives on an unprecedented number of occasions" (Gray 1991: 192-3) and the medical profession was most effective when these "negotiations with government [were] closed and private" (Gray 1991: 192-3). George Repin explained why this was the preferred approach:

The better you are doing in your dealings with government, the quieter you are. If you go public and make a lot of fuss in the press, it means you have lost. Once you go public and the government or other group goes

public their positions are clearly understood by everyone and if they make any move, any compromise, it's interpreted as backing away – losing. My aim was always to get the result without any publicity (Repin *pers. comm.* 2002).

There was recognition now within AMA ranks of a need for flexibility in its dealings with government and use of other methods of persuasion including the media. This new approach was put into place after the election of the Labor government to power in December 1972. Not only was the AMA thinking along these lines but so also was Labor. Labor used public relations consultants, lobbyists, opinion polls (Scotton & Macdonald 1993: 96) and its policies were explained in any venue that would receive media exposure: public speaking engagements, parliament, press releases, press conferences and letters to the editor (Matthews 1988: 66; Scotton & Macdonald 1993: 42). Whitlam had the advantage that his policies appealed to journalists and the electorate. Journalist Laurie Oakes explained that after twenty-three years of Liberal Coalition rule Whitlam's policies were relevant to the boom economy of the 1960s (Oakes 1973: 153-4).

It wasn't a question of being pro-Whitlam, it's just that Australia had been in a straitjacket for so long. It was a government doing things. People can't remember what Australia was like before Gorton started to shake it up and Whitlam finished the job. A lot of things should have happened earlier. We suddenly became very civilised and sophisticated very quickly. And it was good (Oakes *pers. comm.* 1998).

Three weeks after the election of the Labor government, Bill Hayden, Minister for Social Security, established a Health Insurance Planning Committee, with

four working parties, to turn Labor health policy into a government program that could be given legislative form (AMA Annual Report 1973: 12; Scotton & Macdonald 1993: 54). The report, a “Green Paper”, was tabled in Parliament on 2 May 1973.

Both the Report of the Health Insurance Planning Committee and the parliamentary debates on the Health Insurance Bill 1973 made reference to the problem of fraud and overservicing. The Green Paper noted problems within the area of pathology where

the number of services billed was rapidly rising. Accordingly, the Committee recommends that no fee-for-service medical benefits be payable from the Fund in respect of pathology and radiology services rendered by public hospitals and other organisations employing salaried doctors (Report of the Health Insurance Planning Committee 1973: 16).

This makes no suggestion about small or large private pathology laboratories employing non-medical staff. On the question of procedures to detect and control abuse of the insurance system the Report recommended:

Appropriate internal checks will need to be built into the system and adequate provision made for external checks. An investigation staff will be required to examine possible cases of malpractice such as fraudulent claims. Furthermore, some method of verification has to be introduced to limit payments of benefits to services which have, in fact, been provided. One method is to cross-check a sample of claims with doctors and patients (Report of the Health Insurance Planning Committee 1973: 19).

There were no submissions from the Australian Federal Police, the Attorney-General's Department, the Director of Public Prosecutions or other regulatory agencies, but the committee decided that these measures were sufficient to deal with crime against Medibank. It did not specify what measures were to be used in the interim period between setting the system in place, waiting for the accumulation of data to occur and then implementing control measures.

The Committee wishes to make clear that the creation of statistical data and analytical skills will take time, and that the development of appropriate procedures for control and review should be ideally an evolutionary process, in which the medical profession has to be involved in a 'peer review' sense (Report of the Health Insurance Planning Committee 1973: 20).

The profession had not been involved in the framing of Medibank yet the fiscal control side of the scheme was intended to gain the active involvement of the medical profession. The Committee chose to disregard the advice from the AMA in regard to bulk billing and the MSCI system.

The Committee found considerable opposition expressed to direct billing. This opposition was based on the view that direct billing involving no direct payment by the patient, would result in an undue interference with the independence of doctors and that it would lead to over-utilisation of medical services arising from patient demand... The Committee, while noting the views expressed by the medical representatives, could not accept their arguments as justification for proposing any variation in direct billing (Report of the Health Insurance Planning Committee 1973: 12).

In regard to the Medical Services Committee of Inquiry it said "this MSCI system has been criticised by the medical profession over a considerable period

of time” (Report of the Health Insurance Planning Committee 1973: 19). The MSCI system would be continued but modified.

Scotton - Canada

The challenge for the Whitlam government was pushing the Health Insurance Bills through parliament while it carried the liability of poor control systems over fraud and overservicing. To overcome this area of weakness Richard Scotton went to Canada from 1970 to 1972 to research computer systems and to collect information on utilization and cost statistics from the plans of the provincial governments and to discover methods for analysing data for utilisation review and cost containment (Scotton & Macdonald 1993: 43).

An information expert from the Manitoba Health Insurance Commission was brought out to Australia to help design the information and surveillance system for Medibank (Scotton *pers. comm.* 2002). Notwithstanding the fact that Whitlam’s general approach to policy implementation was forceful and confrontational, the controls on fraud and overservicing were intended to be incremental. Scotton recalled:

We were determined that the information base would enable effective scrutiny of aberrant providers to be detected would be included in the system design from day one. The administrative systems to undertake the controls might be rudimentary to start with, but the existence of a database would enable the development of the control system as soon as political and administrative constraints would allow (Scotton *pers. comm.* 2002).

Unfortunately at this time the issue of cost control was not understood as presenting unique difficulties. Malcolm Sparrow observed that decades later it still presents difficulties:

Fraud control – as a science or art – is scarcely developed and little understood. There is little instruction available from academia. And there is not much expert guidance in the field. Guiding principles or practical approaches to fraud control are almost impossible to find in any literature (Sparrow 1996: 19).

When the Health Insurance Bills came before parliament the Liberal Party politicians, as expected, argued that the Labor health scheme would create “over-utilisation of medical services” (CPD HR 8 November 1973: 2995). Philip Lynch argued “In those countries in which nationalised health services have been introduced there has been an instant needless utilisation of free services...A scheme which causes over utilisation of service logically leads to increased total costs to be met ultimately by tax revenue” (6 December 1973: 4415-6). Mr. Hamer argued for patient co-payments (CPD HR 6 December 1973: 4428). Mr. Fox noted the Report had no representatives of the medical profession nor of consumer interests. And he too argued that the scheme would promote increased demand for services (CPD HR 11 December 1973: 4503). Mr. Anthony: “There will be an inevitable over-use of services” (CPD HR 11 December 1973: 4511). Mr. Snedden: “The Deeble-Scotton scheme will cost more and the increase of benefits to the patient will remain obscure” (CPD HR 11 December 1973: 4520). Mr. Holton of the Country Party noted, “The health bills are in a vague and ill-defined form” (CPD HR 6 December 1973: 4409). This

was a point taken up by Bruce Lloyd of the Country Party who too argued that the legislation was “delightfully vague and contradictory in much of its detail” (CPD HR 11 December 1973: 4527). In the Senate, Dr. Shiel argued that “doctors will be gradually coerced into bulkbilling...if the doctor’s fee is fixed and low the only mechanism the doctor has to earn more money is to see more patients...The promise of free health care is a wild one. It is incapable of fulfilment because a promise like that immediately creates unlimited demand. To satisfy that demand there is a Government Budget. The two cannot meet” (CPD 123).

The Labor Party in its turn trivialised the issue of fraud and overservicing by arguing that patients would not be flooding doctors’ surgeries with demands for operations. Hayden asked “Are they going to buy bulk tonsilleotomies and hysterectomies and maybe inspections of sore throats” (CPD HR 8 November 1973: 3001). From Moss Cass: “to suggest that you will have an operation simply because it is free is ridiculous” (CPD HR 6 December 1973: 4407). Mr. Mackenzie: “Members of the Opposition have no evidence that such abuse would happen, only their apparent belief that all patients are potentially malingerers and all doctors potential cheats. I reject both these concepts” (CPD HR 6 December 1973: 4427).

The Liberal Party on its part did not refer to the problems of abuse within the Pensioners’ Medical Scheme as mentioned in the Nimmo Report, nor the

evidence for it from Ludeke Fees Inquiry nor most damning of all from the co-authors of the health scheme, Scotton and Deeble. Richard Scotton's argument that a fee-for-service system offers doctors perverse incentives to increase services, to offer poor quality care especially in the treatment of behavioural and psycho-social disorders and its neglect of preventive care for patients (Scotton 1974: 216) was not utilised in the parliamentary discourse.

Lending support to Scotton's prediction was the rapid growth of the pharmaceutical industry's development and marketing of psychotherapeutic drugs from the 1960s onwards. Mood altering drugs like Valium, Amytal, Tryptanol, Tofranil and Mogadon were advertised heavily in the *Medical Journal of Australia* (MJA March 21 1970: xxix; MJA March 21 1970: xii; MJA 16 May 1970: xxxv; MJA 1 August 1970: xiv; MJA 31 October 1970 xxvi) indicating that the industry was prepared to make a massive investment in persuading doctors that there was a pharmacological solution to patients' problems that were complex and difficult to treat (Valenstein 1998: 166). The advertising revealed an understanding that mental disorders were exacerbated by psychological factors, interpersonal relationships and other social stressors and that these were amenable to a biochemical solution, but did not suggest other therapies to be used concurrently or as an alternative to drug therapies. In terms of professional practice it facilitated rapid patient throughput underwritten by health insurance and the Pharmaceutical Benefits Act: a manifestation of the "McDonaldisation" of society (Ritzer 1993). For those who believed that best

practice involved the incorporation of the social context of ill-health rather than a reliance on medication, then this was indeed a retrograde step (Gillespie 1991: 216).

Legislative base

The *Health Insurance Act* itself was not rushed through parliament. In fact, this *Act* was, along with five other pieces of legislation, the subject of long debate and parliamentary discord. The Minister for Social Security, Bill Hayden, observed:

No bills ought to be better known or better understood than the *Health Insurance Commission Bill* and the *Health Insurance Bill*. They have been debated more extensively both inside and outside parliament than any other issue on the record of this Parliament (Hansard, Joint Sitting, 7 August 1974: 89).

Given this level of debate it is noteworthy that this piece of legislation drew criticism in the coming years. It was well known that fraud had existed in the earlier Pensioners' Medical Scheme. It was also anticipated that fraud and overservicing would be apparent in any insurance system using fee-for-service for doctors' remuneration (Cass: 1964: 20; Scotton & Deeble 1968: 140). One task for politicians debating the *Act* was to assess whether the *Act* would be an effective tool to prosecute fraud. Judging by the level of criticism it attracted over the years it was not effective. Peter Cashman drew attention to the poor drafting of the 1973 *Health Insurance Act* (Cashman 1982: 59). Similarly, the Joint Committee of Public Accounts detailed difficulties in prosecuting cases due to

the way the *Act* had been framed. Some of these concerned definitional problems over the use of certain words but the major issue concerned the admittance of generalised evidence to the extent of fraud to the courts. Under the current legislation “each individual instance of suspected fraud had to be proved, making it impractical to prove a large number of minor offences” (JCPA Report 203, 1982: 104-5). The Australian National Audit Office, the Bates Report and legal academic Karen Wheelwright noted nearly 20 years later that the legislation did not support any investigative action into serious cases of fraud (ANOA 1992: 33; Bates 1992: 14; Wheelwright 1994: 99, 107). As Harvey Bates argued

Offences of fraud and associated offences contained in both the *National Health Act* and the *Health Insurance Act* are complex, inconsistent and in some cases (eg pathology) unenforceable...It is somewhat incongruous that the *Health Insurance Act* acknowledges the possibility of serious frauds being committed in the area of medical benefits payments but is totally silent on the issue of powers which would support investigative activity (Bates 1992: 14).

The Audit Office noted that the *Health Insurance Act* of 1973 lacked the investigative powers of section 104 of the *National Health Act* 1953 (ANAO Report 1992:9; Bates 1992: 14). Further, the office noted that the legislation was inconsistent in its treatment of different medical professions, services and the public (ANAO Report 1992: 8).

AMA – aim to defeat the legislation in the Senate

The AMA reacted with a determination to defeat the government's proposals and this was to be done through a political and public relations campaign financed through a one million dollar "Freedom Fund" (*AMA Annual Report* 1973: 13). In the AMA's submission to the Health Insurance Planning Committee it argued that there was no public demand for change of the existing insurance system and that Labor's plan "was a blue print for the nationalisation of health care" (*AMA Annual Report* 1973: 14).

The aim was to defeat the legislation in the Senate where the government lacked a majority (*AMA Annual Report* 1973: 14). This was to be supported by a massive publicity campaign to create a climate of opinion conducive to Senators taking this step (Scotton & Macdonald 1993: 99). It was necessary, the AMA argued, to maintain "the noise level" in the media to sustain interest in the health controversy so that the public would be receptive to the arguments put forward (*AMA Annual Report* 1973: 14). The campaign was successful. On the 28 November 1973 the *Health Insurance Bill* was introduced into Parliament but rejected by the Senate on 12 December. On 24 April the Health Insurance bills were defeated for a second time by the Senate and on the 11 April there was a double dissolution of both Houses of Parliament. On the 18 May 1974 the Whitlam government was returned but without a Senate majority. On the 18 July the Health Insurance bills were defeated for the third time in the Senate. However, on the 6 and 7 August 1974 at an historic joint sitting of both Houses of Parliament the Health Insurance and the Health Insurance Commission Bills

were passed. The Health Insurance Commission held its first meeting on 25 September 1974. "It was in business at last" (Scotton & Macdonald 1993: 138).

This was a setback for the AMA. Nonetheless the confrontation with "Medibank", as it had now been termed, was ongoing. As Australia was entering a major economic crisis it was decided to gather evidence on the cost of the Government's scheme and its impact on the economy. Further, it was heartened by the announcement from the Opposition spokesperson on Social Security, Don Chipp, that the Opposition would disband the Government's health scheme if returned to power (*AMA Annual Report 1974*: 12).

Conclusion

One of the rationales for the extension of government activity into the area of universal health insurance was to more efficiently control fraud and overservicing. Scotton and Macdonald noted that: "Governments have more market power than private insurers, and more access to regulatory and legislative process. They are also more likely to be more strongly motivated to contain costs, especially as compared to private insurance organisations in which service providers have a substantial or controlling voice" (Scotton & Macdonald 1993: 4). The irony was that Medibank would expand the opportunities for fraud and overservicing yet was meant to control it at the same time.

Chapter 4

Goldrush:

1975 to 1981

The problem with Medibank and Medicare is that it's a sort of Rolls Royce of health insurance systems. It gets to the top of the hill but it has no brakes on the other side, because the method of controlling over-utilisation just isn't there. There is no incentive not to overservice. And there still isn't any incentive.

Dr. Ken Doust, Medibank Medical Director, 1976–1980, *pers. comm.* February 2002.

Liberal – Country Party Coalition government winds back Medibank

Medibank was born on 1 July 1975 into a turbulent political climate. It was a time when the long-term survival of Whitlam's health policies was in doubt. A time when the Senate blocked supply. A time a Labor government was dismissed from office by a Governor-General, producing a constitutional crisis. A time that saw the fall of Gough Whitlam and the rise of Malcolm Fraser, the end of the Democratic Labor Party and the creation of the Australian

Democrats. A time that bleached the meaning from Labor's 1972 election song its "time for better days to be here, it's time we moved, oh it's time..." (ALP political advertisement 1972).

The Fraser Opposition had blocked supply in the Senate. The Governor-General had sacked Whitlam's Labor government. Fraser was installed as caretaker Prime Minister and led his party to victory at the election with a fifty-five-seat majority. In December of 1975, Fraser's Liberal-Country Party coalition government assumed power and with it a determination to reverse the rapid pace of policy implementation by the Whitlam government.

Unprecedented levels of public spending combined with an economic downturn following the first oil shock of late 1973 were some of the factors driving the government to pursue a strictly monetarist policy (Castles 1989: 22-23). The principal objectives were a contraction of the public sector, reduction in taxation, the control of inflation and the restoration of investor confidence (Ayres 1987: 311; Kelly 2000: 361). The retreat from a program of progressive social policies in public policy provoked Whitlam's principal private secretary (1972-74), Peter Wilenski, to protest that "in every country we get backlash against reform but Australia is one of those unique countries where we get backlash before we get reform (Gray 1996: 587).

But Malcolm Fraser's objective was not only fiscal discipline of the economy but a realignment of the economy to his political party's philosophy. He gave expression to this position in an address to the South Australian State Council of the Liberal Party in 1980, where he championed free enterprise and its associated liberties as being superior to "the grey, imposed and shut-in collectivity of the socialist state" (Fraser 1980: 10). He warned of the dangers of the concentration of power in the State and the need to limit it by the maintenance of "vigorous, healthy centres of power and decision-making outside government" (Fraser 1980: 10, 11, 32; Gray 1984: 13). It was a clear statement of the party's move towards neoliberalism.

Fiscal restraint was the electoral mandate of Malcolm Fraser and Medibank was in his line of sight. Health was an obvious target as it was the only area where major savings could be achieved between the 1975 and 1976 budgets (Deeble 1982: 452-453; Wooldridge 1991: 130). The projected 1975/76 outlays for Medibank and other health benefits were \$1,591 million but the full-year cost, which would be the base from which subsequent outlays would grow, was \$1,647 million, compared with actual outlays in 1974/75 of \$435 million. Underlying these changes were concerns over the growth of health expenditure over the previous twelve years. It had risen from \$260m in 1963-64 to an estimated \$2,500m in 1975-76, being a rise from 5 per cent of Gross National Product in 1963-64 to 7.7 per cent in 1975-76 (Sax 1984: 127). This, as Health Minister Ralph Hunt explained in parliament, was an increase of nearly a 1000

per cent¹ (CPD HR 99, 20 May 1976: 2350). Bruce Lloyd, National Party, and Don Chipp, Liberal Party health spokesperson, had prepared a health policy that would have abolished Medibank and replaced it with a modified Page scheme. According to Ralph Hunt, this policy had been approved by shadow cabinet in 1975 (Wooldridge 1991: 5; Scotton & Macdonald 1993: 236).

Thus the coalition's health policy in the lead-up to this election was committed to abolishing publicly funded universal health insurance. Malcolm Fraser, then Caretaker Prime Minister, however, announced a sudden reversal of this policy five days before polling day in the face of a question by journalist, Paul Kelly, at the National Press Club. He said,

The scheme will be continued as it was introduced until we can assess properly its virtues and whatever faults might be revealed as a result of experience (Fraser 1989: 19).

Thinking on his feet Fraser had deftly exchanged policy commitment for policy vagueness with his declaration of the short-term retention of Medibank, but later re-examination of it, in the light of its strengths and weaknesses. While Fraser's intention was budgetary restraint he was conscious of the political realities, for universal health insurance was embraced by the electorate, as well as being a hard won victory for the trade union movement. A sudden abolition

¹ In dollar terms, not adjusted for inflation

of Medibank would have had unsatisfactory repercussions, so Fraser adopted a strategy aimed to deflect such opposition. As he explained in later years

there was a view among my colleagues that Whitlam's changes were popular but had got out of control. They wanted them brought back within the bounds of common sense without destroying what a lot of people saw as the advantages of the changes (Wooldridge 1991: 7).

Fraser had committed his government to retaining Medibank on the proviso that its efficacy could be proven in the fullness of time (Fraser 1975). The test period for Medibank was brief. On 13 January 1976, five weeks after assuming power, Fraser announced the establishment of a Medibank Review Committee (Sax 1984: 128). It made a number of recommendations including changes to Medibank, which led to the return of health insurance to the private insurance industry in 1981 (Gray 1984: 7; Sax 1984: 169; Wooldridge 1991: 38; Hagan 1981: 385–386; Jones 2000: 16).²

Medibank Review Committee

The Medibank Review Committee comprised Dr. Sidney Sax, seconded from his position as Chairman of the Hospitals and Health Services Commission, an Assistant Secretary from the Treasury, Neil Hyden, and committee chair, Austin Holmes, Director of the Priorities Review Staff of the Department of

² Jim Hagan "To the Labor party and the ACTU the Government's proposal seemed intended not to restructure but to dismantle" (Hagan 1981: 385).

Keith Jones "The Fraser Government did not dismantle Medibank. Instead, after implementing a succession of changes, which only confused the issues, it left in place the infrastructure, which allowed the incoming Hawke Labor Government to introduce Medicare rapidly" (Jones 2000: 16).

Prime Minister and Cabinet (CPD HR 98 1976: 109; Wooldridge 1991: 10; Scotton & Macdonald 1993: 238). There were no representatives from the Department of Health although they were invited to make submissions, but were not involved in the formulation of proposals (Gray 1984: 5; Wooldridge 1991: 10). Fraser was receiving separate policy advice from a Health Policy Unit established within the Department of Prime Minister and Cabinet (Wooldridge 1991: 21). Professor Chris Selby Smith, working in this area at the time, recalled that the Department “only became involved when there were problems – or when the Prime Minister wanted to change things” (Selby Smith *pers. comm.* 1996). There were a number of reasons for Fraser’s direct intervention including the fact that he regarded the Health officials as “of inferior capacity and doubtful reliability” (Scotton & Macdonald 1993: 237) and he was more trustful of the advice of his own department (Wooldridge 1991: 23). The objectives of the Medibank Review Committee were to reduce the Commonwealth’s share of expenditure by an estimated \$810 million (CPD HR 99 20 May 1976: 2342), to contain health-cost induced increases in the consumer price index (CPI) and to control escalating costs (Gray 1984: 5). What followed was the first of five changes to Medibank over the next five years (Gray 1984: 5-7; Wooldridge 1991: 25-32).

Fraud emerges as an issue on the political agenda

As Health Minister Ralph Hunt explained to parliament, Medibank was “a new and expensive program and it is appropriate that taxpayers can be assured that they are getting value for money” (CPD HR 98, 19 February 1976: 109). The argument repeated frequently from the media was that it was not. Stuart Simson in *The Australian Financial Review* expressed the general position, “six months after its introduction, Medibank, the most costly welfare reform in Australia’s history is a mixture of health cost relief, administrative success and public purse rip-off” (Simson AFR 12 January 1976: 1). Not only were the parliament and the media expressing concerns but so also were the medical profession and the Health Insurance Commission (CPD HR 98, 19 February 1976: 109). Hunt was aware the Federal Government was carrying the burden of both the legitimate and illegitimate expenditures in relation to Medibank. He argued

Because of Medibank’s great expense and because of the alleged abuses, rip-offs and over-use, we have always reserved the right to review its operation and methods of financing the scheme.

(CPD HR 98, 18 May 1976: 2106)

Further he argued that Medibank altered medical practice by encouraging overservicing.

It is clear that Medibank in its present form has serious weaknesses....It provides few incentives to economy in the use of health services, either on

the part of the consumer or, more particularly, on the part of the medical profession which has a key role in determining overall health costs (CPD HR 98: 20 May 1976: 2350).

The alleged abuses and the cost of Medibank are here conflated in this justification for the withdrawal of the federal government activity in the area of health care. The new health insurance arrangements came into operation on 1 October 1976 (Sax 1984: 129). Their goal was to move consumers from publicly funded health insurance to private health insurance with the incentive that for those who took out private health insurance the government would waive the newly imposed 2.5 per cent Medibank levy on taxable income (Sax 1984: 129; Carney & Hanks 1986: 181) but bulk billing would be retained. These changes also strengthened the position of the government in relation to the health funds. They now had to comply with the provisions of the National Health Act Amendment Bill and to maintain comprehensive membership records and benefits statistics and for these to be made available to the Department of Health and the Health Insurance Commission (Sax 1984: 129; Scotton & Macdonald 1993: 249).

Justifying the action of the coalition, Bruce Lloyd argued, "the review will be on the efficiency of the operations of Medibank in the sense of cost control. I think that is of interest to all Australians in view of the massive Budget deficit" (CPD HR 98, 19 February 1976: 113). Hayden pointed out that "It is one thing to say that Medibank will be retained, but it is another thing to specify in what form"

(CPD HR 98, 19 February 1976: 112). But a sceptical Gough Whitlam, now leader of the Opposition, not sharing even this level of optimism, predicted the demise of Medibank and declared that, “the most important single achievement of the Labor Government – [was now] marked for destruction” (CPD HR 99 18 May 1976: 2103). In order to gain further information on the details of the government’s intentions for the radical changes to Medibank, Whitlam asked Fraser to table the reports of the Medibank Review Committee. Fraser was not willing to oblige. “There is no one report of the committee. There are a number of reports...It is not intended that they be tabled” (CPD HR 99 26 May 1976: 2461). Notwithstanding this rebuttal, one report was leaked to the *Australian Financial Review*. The recipient of this information, journalist, Stuart Simson judged

While the Federal Government’s public justification for the Medibank upheaval is greater freedom of choice a confidential report of the Cabinet decision makes it clear that an object was to force people into the private health funds (Simson 3 June 1976: 1).

The Establishment of Medibank Private

The trade unions expressed their resolve in fighting for the retention of fully publicly funded universal health insurance by issuing the ultimatum of a national strike, unless Fraser’s policy was reversed (Martin SMH 1 June 1976: 3; Basile The Age 1 June 1976: 3). Fraser tried to defuse this volatile situation by extending the functions of the Health Insurance Commission to offer private

insurance, under the banner of Medibank Private. In this fashion it could be argued that Medibank was retained, not abolished (Sax 1984: 137; Gray 1984: 5; Ayres 1987: 308). Fraser's economic reform program required union co-operation, in other words, a limitation on wage claims in return for government concessions (Russell 1995: 49; *SMH* 1 & 8 June 1976). The union movement was not impressed with this subterfuge and on the 12 July 1976, the ACTU kept to its threat of industrial action in support of Medibank and proceeded with its first ever nation wide strike (*The Australian* 12 July 1976: 1 & 13 July 1976: 1; Hagan 1981: 385 – 386; Simms 1987: 26). Scotton and Macdonald noted that Fraser's decision to authorize Medibank Private was extraordinary at the time and suggested that Fraser's decision rested on additional factors. There was the need to protect his credibility given that he had pledged to maintain Medibank (Scotton & Macdonald 1993: 250); there was the need to ensure support for government policy from the private insurance industry (Scotton & Macdonald 1993: 248-249) and Medibank Private would act as a mechanism for ensuring the competitiveness of that industry, for as Ralph Hunt observed in Parliament: "Medibank Private with all its efficiency in the field – competition will be provided amongst all the private health insurance funds" (CPD HR 99 1 December 1976: 3034).

While the strike didn't alter government policy, the establishment of Medibank Private did have unexpected consequences. Medibank Private was a

responsibility of the Health Insurance Commission but by November 1978 all that remained of the Commission's functions was Medibank Private (*HIC Annual Report* 1979: 1). The fact that the Health Insurance Commission had not been abolished meant that the infrastructure still existed for the rapid reintroduction of universal health insurance when Labor gained power in 1983 (Scotton & Macdonald 1993: 248).³

The Pathology Services Working Party

The Medibank Review Committee had received a number of submissions, which indicated that the utilisation of pathology services had increased at a faster rate than for other areas of medical practice (Report of the Pathology Services Working Party, March 1977: 7). Benefits for pathology services for the six months to June 1975, that is, just prior to the introduction of Medibank, were \$21.3 million and a year later they had increased to \$44.7 million (Report of the Pathology Services Working Party, March 1977: 4).

The doubling of pathology usage over such a brief period was attributed to a number of factors. The numbers of people who could now gain medical benefits had expanded to include eligible pensioners and their dependents. The

³ On 1 October 1976 Medibank Private started but had two arms, Medibank Standard for those who paid the 2.5% health insurance levy and Medibank Private, a private health insurance fund competing in the marketplace. On 1 November 1978 Medibank Standard was abolished. The fraud and overservicing function was transferred to the Department of Health from the Health Insurance Commission.

numbers of people making claims on Medibank also increased as in some states there was a shift from public hospitals to private pathology. The introduction of Medibank itself and with it bulk billing meant an increase in the number of tests that were being ordered, especially as the system was without direct costs to patients (Cornfield, *The Australian* 3 February 1976: 7; *Report of the Pathology Services Working Party*, March 1977: 6, 7).

In order to gain advice on methods to correct this trend, Ralph Hunt established a Pathology Services Working Party, under the chairmanship of Sidney Sax, with committee support from the Australian Medical Association and pathology industry representatives (CPD HR98 1 April 1976: 1242).

The growth of technology

The Working Party noted the forces outlined above that were giving momentum to rising costs, but its particular concern was automated testing. The cost of tests had been lowered by the use of automated analysers but to gain greater profitability and economies of scale, pathologists performing work on a large scale offered commissions, inducements or “kickbacks” to referring general practitioners (Report of the Pathology Services Working Party, March 1977: 7). The inducements could be a financial benefit, staff, rent free premises, computer equipment or holiday packages. This provided pathology companies

offering inducements a commercial advantage of increased profits over ethical competitors not adopting this practice (Rodwin 1993: 25).

Left behind in the rush for large profits were the smaller laboratories doing the time-consuming and awkward services which the mass production laboratories did not offer (Broadbent 1977: 5). Dr V. Plueckhahn of the Royal College of Pathologists warned that pathology was becoming so commercialised that

referring doctors would appear to consider the various possible “kickbacks” received as important as the quality or medical usefulness of the tests ordered (Plueckhahn 1977: 8)

The dilemma was that the enhancement of profit was central to business practice but central to medical practice is care of the patient. There was a conflict of interest between profits on the one hand and medical ethics on the other. “When a health professional refers a patient for further care it is his duty and obligation to choose the best available under the circumstances, regardless of allegiances, personal preferences, or corporate connections” (Wohl 1984: 122).

Another factor is that when a pathology company has invested in expensive technology there is a tendency to use the machinery to its full extent and this drove extended testing and excessive ordering of tests by doctors and hence the

over utilisation of medical services (Wohl 1984: 134; Deeble 1991: 13). This gives rise to a situation outlined by Dr. Plueckhahn,

Pathology services are useless in patient care if the accuracy of the tests performed cannot be guaranteed and the tests performed are not significant to the condition being investigated or treated. A combination of inaccurate and unnecessary tests is a financial load Medibank was never designed to meet (Plueckhahn 1977: 8).

The application of technology to medicine had created formidable problems for the containment of health costs under Medibank. In later years Malcolm Fraser came to regret that the matter was not brought to cabinet attention. As he explained,

What we never came to grips with was the extent to which new and improving technologies were adding to the costs of health care... We never had a cabinet paper and never was an argument put to cabinet in defence of escalating expenditure (Wooldridge 1991: 46).

Parliamentary debate and media analysis.

During the period, April 1976 to October 1978, in which the Pathology Working Party was researching and preparing its reports, the issue of the problems endemic to the pathology area was kept alive by parliamentary deliberation and media discussion. Journalists succeeded in obtaining admissions from pathology companies of their use of kickbacks. Dr. Bronte Douglas, managing director of Douglas Automated Laboratories, told Ron Hicks of *The Australian* that he paid general practitioners \$7 for every blood test specimen and \$4.50 for

a urine sample and did not regard this as excessive (*The Australian*, 12 February 1977: 3).

Labor MP Dr. Richard Klugman alerted his parliamentary colleagues to a newspaper article that he considered was “closer to the facts of the matter than most of the articles that had been written on this topic” (CPD HR 17 February 1977: 192). It explained the history of kickbacks, their relation to the introduction of technology into the pathology industry and the government’s inadequate response to payments for automated pathology work. Its author, Janet Hawley, cited the case of one pathology laboratory in Sydney which was paying \$100,000 a month in kickbacks to doctors – and the average doctor was earning \$250 a month from pay-offs. But this situation arose in part because of federal government fees for automatic testing. The fee for automated testing was \$5 compared to \$100 for manual testing. In 1970 two private organisations headed by general practitioners introduced the first automated pathology equipment into Australia. The government introduced a special item number for testing done on it - \$15 for the equivalent manual testing done at \$100. The two laboratories objected, but instead of being raised the \$15 fee was lowered to \$5. So the laboratories decided to charge at the manual rate for the work, which had been done on machines. The laboratories then had the idea of implementing twice daily collection of samples from the GP’s surgery to save the patient a trip to the collection centre. They also provided a nurse to collect

the sample. In 1972 the general practitioners began to say they didn't want a nurse to do the collecting as they would do it. So the laboratories began paying the 20 to 25 per cent collection fee to the general practitioners and so began the era of kickbacks (*The Australian* 17 February 1977: 1).

Bill Hayden was at pains to point out that this practice was not a particular feature of Medibank. He argued that pathology rorts were a feature both of Medibank and private health insurance:

The fact is that the abuses and rip-offs flourished under the old system of private health insurance.... in the first medical fees tribunal there were startling disclosures of the way in which pathologists were ripping off on a massive scale and paying commission rates on a very generous basis to private practitioners who over-utilised in referring pathology tests to particular laboratories (CPD HR 98 19 February 1976: 2107).

Hayden, while knowledgeable of Medibank in general, was not versed in the regulatory difficulties attendant on health insurance in respect of fraud and overservicing. His optimistic appraisal was that,

Under Medibank, with the sort of utilisation profiles which can be accumulated by the Medibank computer, it is possible to identify exactly where this abuse is occurring, to sheet home the responsibility and to take effective action to prevent it in the future (CPD HR 98 19 February 1976: 21).

Such effective action can only be taken if the resources are allocated for this work and the legal mechanisms are in place to redress deviance. That this was not in place was evident in the following years. Medical practitioners and Labor

members of parliament Dr. Richard Klugman (CPD HR 99, 17 July 1977: 194), Dr. Harry Jenkins (CPD HR 99, 31 March 1977: 804) and Dr. Moss Cass (CPD HR 99, 1 June 1977: 2318) were united in their approach to the problem of pathology abuses. They argued that they could only be dealt with by the abolition of the fee-for-service system of payment to doctors. Dr. Moss Cass gave a cynical appraisal of the Liberal-coalition's justifications for winding down publicly funded health insurance. "The government's changes to Medibank – changes which were trumpeted so loudly as being necessary to prevent such abuse – have not eliminated this malpractice" (CPD HR 99 23 March 1977: 490).

The Working Party's recommendations

Parliament gave legislative support to the recommendations of the Pathology Services Working Party. These included that fee splitting be made illegal and an indictable offence, there be a reduction in fees paid for multiple automated tests and a completely new schedule of fees for pathology services, and in addition that the direct billing of Medibank for pathology services, except for pensioners and dependents, be discontinued (Sax 1984: 139). One idea not adopted was that put forward by Dr. Richard Scotton, co-author of Medibank. He suggested that

All pathologists' charges should be removed from the official schedule of medical fees. Pathology services were technical

services to doctors, not medical services to patients...the Government should provide capital subsidies for pathology laboratories, which should charge doctors for their services. Doctors would then charge patients for their services. This would force charges down dramatically (Broadbent & Wiles: 5).

These legislative changes were welcome and necessary but Stuart Simson of *The Australian Financial Review* had cautioned early in 1976 of the problems that needed to be addressed on the administrative side,

The dilemmas confronting the Fraser Government on the administrative side are the extent to which the system should be bureaucratised. It is a question of whether a 1 per cent rip-off rate, which runs to millions of dollars, is worth tolerating to avoid a tight bureaucratic system. How far the Fraser Government goes in tightening the scheme in order to clamp out malpractices has yet to be seen (Simson 1976: 7).

In the years to come the amount lost to fraud and overservicing was found to be much greater than one percent and the tensions between the efficient payment of claims and surveillance of leakage from the system were not addressed at this time and were a running thread through the history of fraud and overservicing.

Australian Medical Association

The Medibank Review Committee had conducted its inquiry in private but had invited submissions from interested parties (CPD HR 99, 20 May 1976: 2349).

The AMA responded to the invitation and in preparing its submission the Federal Council of the AMA decided that if bulk billing were abolished, except

for pensioners and low-income earners, this would be the most effective way to control rising costs and to “prevent medical standards slipping due to over-use of doctors’ services”. Keith Jones president of the AMA said, “We are much more concerned that under bulk billing the patient is unaware of the cost of the services he is receiving. The existence of the cost factor imposes a discipline both on the doctor and the patient, and is essential if over-use of services is to be prevented” (*The Australian* 2 February 1976: 3). Also included in the AMA’s submission to the Committee was support for “the application of due processes of the law against those who defraud Medibank” (1976 *AMA Annual Report*: 12). The problem of fraud and overservicing was an area of ongoing concern to the AMA and one it was keen to have dealt with.

The Medibank Review Committee did in fact find grounds for action over abuse. On 20 May 1976 Ralph Hunt announced that,

There have been a number of allegations of abuse of Medibank by both doctors and patients through the provision of excessive services or unnecessary services. This problem has been considered very carefully by the Government and the Medibank Review Committee. It is apparent there have been some abuses (CPD HR 99, 20 April 1976: 2351).

The solution favoured by the AMA (*AMA Annual Report* 1976: 12; *AMA Annual Report* 1977: 11) for the abolition of bulk billing was an option not taken up by the government. Hunt argued:

It has been widely suggested that direct billing of Medibank by doctors...should be discontinued in order to reduce abuses. On the one hand, direct billing is by far the least costly way for Medibank to process claims and it is convenient for many patients and doctors (CPD HR 99, 20 April 1976: 2352).

The merits in the case presented by the AMA for the abolition of bulk billing were not debated. Here was a triumph for 'efficiency' over regulatory control. It was an idea of efficiency that the short-term objective of convenience was more valued than the long-term containment of inflation within health budgets (Marmour, Wittman & Heagy 1976: 291–316; Cornfield 3 February 1976: 7). It was a problem that was to follow health insurance through the coming decades.

But if the Minister was interested in the question of fraud as well as overservicing there was one omission from this discussion and that was the regulation of overservicing. The Annual Report of the AMA for 1976 was aware that under the *Health Insurance Act* of 1973 there was provision for Committees of Inquiry to enquire into "excessive services" by doctors. The Annual Report noted that, "no request was received from the Minister for Health to nominate panels to serve on the Committees during the year" (*AMA Annual Report* 1976: 13-14), a statement at odds with a report in the *Sydney Morning Herald*. The government said it would give the Association three years to establish a review organisation (1 June 1976: 3). In fact it was the Health Department's

responsibility to set up the Medical Services Committees of Inquiry in all states, but this did not occur until August 1977 (*Annual Report DoH 1977-1978*: 94). In the meantime the Health Insurance Commission took over the function by default. The AMA was very supportive of the concept and by March 1980 had set up a working party to report on further ways to make the committee of inquiry system more effective (*AMA Annual Report 1979*: 9-10).

Hunt's disregard for the input of the AMA on the question of fraud and overservicing runs counter to the ideas that the AMA was a political force to be reckoned with by governments. It was a commonly held perception that this lobby group exercised a disproportionate influence over political life (Hunter 1980: 190-206; Hunter 1982: 2-16; Gray 1984: 11; Palmer & Short 2000: 46). It was a view reflected in this comment from journalist Philip Cornfield. He argued that Medibank was not pursuing fraud allegations in deference to the medical profession.

Medibank had handled its abusers with kid gloves...One reason for this soft approach is undoubtedly Medibank's desire not to take any action which would have provoked the already antagonistic medical profession. Medibank's administrators are conscious that the system can only operate properly with doctor co-operation and they have been bending over backwards to get it (Cornfield 1976: 7).

Cornfield does not cite the evidence for this judgment, but it is a suspicion that has pursued the medical profession over many years.

Position of the General Practitioners Society of Australia on fraud and overservicing

But one doctors' group which was actively antagonistic to the government was the General Practitioners Society of Australia. It was resolutely opposed to Medibank and had no intention of making conciliatory gestures on how to make the system work. This minority group, with a membership of two thousand, left reasonable argument and professionalism for their counterparts in the AMA and through the organ of their journal, *Australian GP*, proceeded to be defiant, provocative and subversive. The journal instructed their readers on "How to Rob Medibank Blind" being "A Guide to the Maximisation of Profit in a Minimum of Time before the Honey-pot is Emptied" (*Australian GP* January 1976: 5). It outlined strategies for fraud and overservicing: strategies that were currently being used by doctors. The article is structured as a dialogue between two doctors where one encourages the other to maximise profits through fraud and overservicing. Suggested ideas were the cutting down of the time for consultations from twelve minutes to five, claiming a service was an extended consultation when in fact it was a short one or taking a brisk walk through a nursing home with about one hundred patients and making claims for attendance for all the patients. By practicing these and other scams "a doctor could make a quarter of a million dollars a year". The additional advantage to this arrangement was there was little chance of being caught. Medibank

investigators were reliant on patients for evidence and the relationship of doctor and patient was such that most patients would not violate it by informing (JCPA 1982 Report 203: 244).

The patients aren't going to tell on you and anyway they don't even know the difference between one item number and the next. And they won't remember, anyway, when they're asked any questions years later if there's an enquiry (*Australian GP*, January 1976: 6).

Cornfield had remarked that "about the only way these rip-offs can be prevented is through the vigilance of patients" (Cornfield 1976: 7). The article in *Australian GP* left no doubt as to the ineffectiveness of this as a primary regulatory strategy. Nonetheless Health Minister Ralph Hunt persisted:

The Bill permits practitioners who direct bill to charge the patient an amount in addition to the benefit payable by Medibank provided that the total charge does not exceed the scheduled fee for the service. This should provide the patient with an opportunity to scrutinise and query accounts (CPD HR 99, 20 May 1976, 2352).

This left surveillance of doctors in the hands of the patients. It marked

The passing virtually of a way of life.... A physician was one of the few people one could confide in sure he had nothing but the best interests of the patient at heart... The majority of doctors believe in the sacred doctor-patient trust, a bond that traditionally and historically transcended all other interests (Wohl 1984: 96)

Health Insurance Commission

The Report of the Health Insurance Planning Committee to the Minister for Social Security (1973) mentioned that the claims processing system of the new program would provide administrators of Medibank with “information about what is happening in the health care system on a much greater scale and more detail than ever before. One aspect of the analysis will be the regular review of doctor’s service and billing patterns” (Report HIPC 1973: 19). The Health Insurance Commission was the administrator of the program but as of July 1975 it did not have a unit to deal with ‘abuse’ against Medibank. It was not until later in the year that such a unit, named the Claims Review and Investigation Branch, was established (Penkethman 1977: 8).

However, the focus of the Health Insurance Commission in its early months was not on the checking of claims but on the efficient payment of claims. In its early days being able to make payments at all was the achievement. The volume of claims was much higher than anticipated (Russell 1995: 38), the staff were untrained and the computer technology primitive by current standards. The implementation of the program was so rushed that it hadn’t been able to be tested before it was started. And all the while Medibank was under attack, much of it politically motivated (Scotton *pers. comm.* 1996). It was a situation that was encapsulated in journalist Peter Samuel’s begrudging compliment on the HIC’s performance, “That Medibank is working at all goes some way to

discrediting critics... and for the moment people can gasp in awe at the sheer scale of the operation" (Samuel 1975: 14).

As a statutory body, the HIC was not bound by the usual public service recruitment constraints (Russell 1995: 24). This was as well for between 25 September 1974 and 1 July 1975 staff increased from twenty-two to three thousand five hundred (Scotton & Macdonald 1993: 197). Getting Medibank working placed staff under heavy workloads. "We literally worked from dawn till midnight all the time; it just went on and on and on" explained John Evered, Assistant General Manager, Processing and Control. "We didn't mind doing it nor were people particularly worried whether we were paid to do it or whether they weren't; it was a matter of pride. We knew we could do something that had never been done before" (Russell 1995: 30). Richard Scotton commented "The climate of urgency was such that no one concerned themselves with trivialities. Already there was an esprit de corps and a sense of mission" (Scotton & Macdonald 1993: 200) - an "esprit de corps", said Medibank's first medical director, Dr. Ken Doust, "that was hard to imagine occurring in the public service" (Doust *pers. comm.* 2002).

Staff needed to implement the Medibank program by the deadline of 1st July 1975 but were hampered by computer problems. The result was an ever-increasing backlog of claims and a looming public relations disaster so it was

decided to bypass the usual claims assessment process. “There was a clear choice between the possibility of letting a small number go through that might have been unpaid or allowing the vast numbers of claims to go unpaid and the whole program come to a grinding halt” (Scotton *pers. comm.* 1996). So it was decided to process 500,000 claims in one day. The philosophy behind this action was that the efficient payment of claims would be the basis of the success of Medibank (Scotton & Macdonald 1993: 214). Roy Harvey, statistician and head of the actuarial and statistics branch of Medibank, recollected that this short cutting of the system continued for six to eight months to ensure that all doctors were paid and to minimise the political damage to Medibank, which was itself “a fairly political program” (Harvey PAC, vol. 5, 1982: 2261).

However, the tension between the fast payment of claims and the scrutiny of claims needing payment and aberrant claims being severely dealt with was not to be that easily resolved and was an on-going issue. Reginald Penkethman, manager of the Claims, Review and Investigations Unit, was sure of where he saw the balance lying. He explained to a seminar organised by the Australian Institute of Criminology in 1977 that the activities of the unit and its state branches were ancillary to the insurance function of the organisation. He argued that, “The Commission is not in being to prosecute doctors, or anyone else for that matter. The function of the Commission is to provide a service” (Penkethman 1977: 18).

The judgment that the success of Medibank was to be based on its efficiency was underlined by the findings of The Royal Commission on Australian Government Administration, which released its report in 1976. It noted that the “delay in the receipt of cheques” was one of the universal complaints of the public about public administration (RCAGA Report 1976: 128). Nonetheless, Scotton remarked that the throughput of claims without checking, “was not an action that would have survived too close a public scrutiny, and was performed in great secrecy.” Scotton remarked that, “It was with some sense of relief that only one journalist gave a hint of these troubles, and his report was not taken up by the media” (Scotton & Macdonald 1993: 231).

This journalist was Peter Samuel of *The Bulletin* magazine who issued a wide-ranging critique of Medibank. Samuel argued that “Medibank is certainly not the smooth flowing, efficient looking operation it was cracked up to be... Medibank is as slow if not slower than the private funds...through July Medibank was in serious trouble...for several weeks the processing of claims could not keep up with lodgments in NSW and a stockpile grew” (Samuel 1975: 16). “There are now three quarters of a million claims in the stockpile” (Samuel 1975: 19). Samuel’s concerns were the cost of Medibank and the problem of abuse of the system. “Payouts were to be \$840 million a year” and total administrative costs of over \$49 million (Samuel 1975: 14). In terms of federal

government spending it was just exceeded by education and defence. (Samuel 1975: 19). His assessment of the financial vulnerability in the system was based on the direction of present trends. He judged that there would be an enormous expansion of pathology and radiology but that the greatest scope for abuse would come from direct billing. This had been problematic under the pensioner medical scheme but there would be greater “scope for expansion of such rackets” under Medibank (Samuel 1975: 19). In opposition to this point of view was that of Bill Hayden, Minister for Social Security, who judged bulk billing as a tool for greater efficiency,

If there were total abolition of bulk billing I would reckon that the cost in increased administrative charges would be between \$12m and possibly \$14m a year. Additional staff of between 450 and 500 would be required by the Health Insurance Commission...the most distressing part is that efficiency would go down (CPD HR 31 March 1977: 802).

Samuel continued

Medibank officials say...they will work harder on crackdowns once they have the basic systems working better. They may need to modify their systems to stop some abuses, and there will be a continuing minor war between officialdom and people finding ways of milking the huge handout animal rather too hard (Samuel 1975: 19).

The complaints from the media mounted over the coming months and years.

Setting up a system

Around the end of 1974 Brian Hull of the Australian Federal Police contacted John Evered, the assistant General Manager, Claims and Processing. Hull's concern was that considering the amounts of money that the HIC was going to be handling they are going to be highly vulnerable to fraud. From these discussions came the proposal to form two units, one for claims review and investigations and the other, the office of medical director (Evered *pers. comm.* 2001). Penkethman mentioned that the "early emphasis, through necessity, was concentrated on alleged ad hoc breaches of the Act" (Penkethman 1977: 8). The leads for investigations came from complaints from patients, the examination of claims documents, the examination of processing system reports and the analysis of statistical data relative to doctor profiles. The role of the Medical Director was to deal with complicated assessments, to give medical advice to assessors and those working in the claims review and investigation sections and to liaise with professional bodies (Penkethman 1977: 9; *HIC Second Annual Report* 1977: 28). One limitation was the small number of staff assigned to the units, "four or five in the States and in Canberra three or four investigators and a few analysts to assist them" (Evered *pers. comm.* 2001). Ken Doust had been promised counsellors but, "when I got the job I was advised that we would have a central medical director and two or three counsellors in each state. In the time I was there we had Dick Smibert in Victoria and Peter Gunton in New South Wales and that was it" (Doust *pers. comm.* 2002).

Bluff and other compliance strategies

Investigations were conducted using very rudimentary material (Evered *pers. comm.* 2001). Doust explained his method, “What I used to do was look at the profiles on the computer paper – I would get a stack, three feet deep a day of computer paper with hundreds of annotations on each page. If I saw anything that stuck out, that looked different then I’d look at it. But we were not computerised to know exactly what was going on” (Doust *pers. comm.* 2002). If Doust believed there was a problem he would ring up the doctor and without any legal basis ask for the money back, “and very often he would get it. It was all bluff” (Evered *pers. comm.* 2001). Roy Harvey concurred: “People had been doing very simple reviews using all sorts of bluffs and things like that to try and tell doctors we are watching what you are doing” (Harvey *pers. comm.* 1995). Evered’s philosophy was to foster the bluff approach in the section so that doctors would be edged towards more ethical practice. Doust’s comment on this irregular regulatory approach was,

In those days it was a bit like a cowboy run activity in so far as we would put a proposition to a doctor that things weren’t running according to Hoyle and we’d ask for the money back or else we would threaten with prosecution...I’ve told people that if you continue to submit claims of this nature I’ll put an investigating officer outside your surgery and we’ll time every patient going in and out (Doust *pers. comm.* 2002).

A lot of enforcement was achieved through a carefully crafted letter and Doust’s interpersonal skills: it was a method that brought results and saved “a couple of hundred thousand a year” (Doust *pers. comm.* 2002).

First skirmishes in the 'minor war': Dr. Geoffrey Edelsten

It was with a limited budget, a small core of staff, and lack of legislative power that the HIC dealt with those testing the vulnerability of Medibank's financial system. Dr. Geoffrey Edelsten was testing the system from the beginning and became by the 1980s, a colourful local identity, promoter of the Sydney Swans and proponent of aberrant medical practice.

Evered remarked that Edelsten, "would try out an idea and if it was intercepted and cut him off at that point, he wouldn't debate the issue, he would move onto something else. He bought into a whole lot of fitness clinics, the John Valentine clinics. He was going to run those all round Australia. Ray Williams said to him if he did take it across Australia he would get some legal impediment to stop him from doing it. We headed him off and he didn't do it" (Evered *pers. comm.* 2001).

Prior to Medibank Edelsten was known to the medical funds through his ownership of a pathology company, Preventicare. Doust thought that while the principle of Preventicare was quite good, financial aspects of it were clearly unsatisfactory because they stimulated overservicing (Doust *pers. comm.* 2002). This was done through Edelsten's offer of inducements to general practitioners of computers and nursing staff. They were ordering thousands of dollars of pathology tests and the funds decided not to pay on the money owed for the pathology carried out.

Dr. Richard Klugman, raising the matter in parliament, said he was unsure of the legal position but in any event “just delaying payment can break those sorts of pathology laboratories” (CPD HR 99: 17 February 1977: 192). Preventicare did go bankrupt. It was perhaps for this reason that when the government-funded health insurance system was established Edelsten wanted to be sure that he would be paid. He sent a telegram to Ray Williams, the general manager of Medibank, saying, “direct billing a disaster stop need to be paid stop”. Evered commented, “the people who sent us those sort of ‘you’re not doing the right thing’ in the early days of the Medibank program as often as not turned out to be the ones we were investigating later on” (Evered *pers. comm.* 2001). To journalist Chris Masters, Edelsten was a pioneer of entrepreneurial medicine, an original thinker with enough good ideas to make any number of honest fortunes (Masters 1992: 125). But over the coming years Edelsten became involved in one scheme after another of doubtful legality.

The Royal Commission into Deep Sleep Therapy

One case that reached the attention of the Health Insurance Commission but appears was not dealt with was complaints from former patients of Chelmsford Private Hospital in Sydney. Between 1962 and 1979 twenty-four patients died there either during or after receiving Deep Sleep Therapy (Palmer & Short 2000: 51). As a result of years of activism and media agitation a royal commission was established to investigate these deaths.

But in terms of medical fraud the complainants referred to the practice by three doctors at the hospital, Doctors Bailey, Herron and Gardiner, of performing Electro-Convulsive Therapy on patients without the benefit of an anaesthetic for this procedure⁴. In the 1960s an anaesthetic injection was a usual and accepted part of ECT treatment (RCDST 1990 vol. 6, ch. 7: 206). The doctors submitted claims to the HIC between July 1975 and October 1978 for both procedures, the ECT and an anaesthetic injection. In this fashion the doctors were defrauding their patients, the Commonwealth and by inference the private health funds (RCDST 1990 vol. 6, ch. 7: 210). By the time Commissioner, Mr Justice Slattery, was making his recommendations Dr. Bailey had died so the Commissioner referred the matter to the Commonwealth Director of Public Prosecutions to take disciplinary action against Doctors Herron and Gardiner in respect to their defrauding of Medibank (RCDST 1990 vol. 6, ch. 7: 212).

A second outcome of the Chelmsford Royal Commission was the establishment in New South Wales of a complaints unit in the NSW Department of Health (RCDST 1990 vol. 13, ch. 16: 215), which later became the Health Care Complaints Commission. The unit was set up in response to the problem of over charging and over servicing by some medical practitioners for claims from third party payment funds. The Health Minister, Laurence Brereton, saw it as appropriate for the State government to take a role in this matter, as it was the body responsible for controlling services as distinct from paying for them. He also believed this action was necessary as the Federal Government had been so inefficient in this area. Errant doctors would be brought before the Medical

⁴ Caroline Hayes drew my attention to this failure of the HIC to take action.

Registration Board, disciplined, and if necessary deregistered (Bornhurst *The Australian*, 23 September 1982: 3).

Brereton did not set down any guidelines and it was left to Phillipa Smith, the new manager of the Complaints Unit to establish what powers the State government might have in an area that was the responsibility of the Commonwealth government (Thomas 2002: 248). When Brereton ceased to be Minister for Health in February 1984, Smith decided it was more expedient to refer cases of fraud and overservicing to the Commonwealth Department of Health and the Health Insurance Commission (Thomas 2002: 251-252), and expand the Unit's terms of reference "to look at broader issues of quality of care, matters of administration and matters of policy" (RCDST 1990 vol. 8, ch. 9: 279; Thomas 2002: 250).

Blue-collar crime discovers medical fraud

Doust found that with the introduction of Medibank and the introduction of bulk billing, there was a broad opportunity for fraud and overservicing to occur, which didn't exist previously. In addition the fraud potential of Medibank was being realised by people other than doctors. Ken Doust found from his experience that "the expression of criminality is in direct relationship with opportunity" (Doust *pers. comm.* 2002), an insight mirrored in criminological research (Grabosky, Smith, Dempsey 2001: 2).

Inside the Health Insurance Commission some lower ranking members of staff with links to professional criminal gangs became involved in what was known as the “Kalamazoo scam”. This scam involved ‘identity fraud’ and the printing of their own stationery. They made counterfeit copies of a popular accounting system used in the professions called Kalamazoo. False identities were constructed by taking the names of suitable patients from the telephone book and these were put on counterfeit doctors’ accounts. Kalamazoo receipts were printed and handed over at Medibank offices. The maximum amount that could be claimed on any one day was ninety-nine dollars so these false accounts were passed over and they received that amount for each false account. This scam came undone when investigators made inquiries of a particular patient’s husband and she replied that “my husband has been dead for two years” and it was noticed that the serrations on the Kalamazoo receipts were slightly different to the original (Doust *pers. comm.* 2002). As Doust recalled

They kept on going like this for ages and they were working gradually from Victoria up to New South Wales and into Queensland...They were a fairly tough mob of people and we had witnesses that were threatened. One had a broken leg. They were not nice people. One had been associated with the ‘toe cutter’ gang.⁵

Information surfaced that Medibank fraud was known in the jails and that “if you went to a certain address at Kings Cross in Sydney they would give you

⁵ The ‘toe-cutter’ gang refers to the Mayne Nickless heist of April 1976. Between \$3 and \$12 million of bookmakers’ holdings were stolen from the Victoria Club, Melbourne, after the money had been delivered to the club by Mayne Nickless security guards. Bolt-cutters were used to open cashboxes. Three men were charged with the robbery but none were convicted. [<http://www.vicclub.com.au/vcgbrcnts.htm>].

this kit. And the kit had all the instructions in it, and you paid for that and then you could make a profit on it, if you used it (Doust *pers. comm.* 2002).

Inadequacies of the Legal System

At a criminology seminar held at the University of Sydney in 1975 the Federal Attorney-General, Kep Enderby, spoke on white-collar and its elusive features. It is “less obvious to the public. The traditional features of a crime where the victim appears in the witness box are missing. The complaint may be brought by a journalist, or often by a politician. It is harder to detect. Much less attention is therefore given to it by our law enforcement authorities and our courts” (Enderby 1975: 2-3). Legal academic Karen Wheelwright agreed that fraud cases generally are “of great complexity and the legal system within which those responsible for tackling fraud must work is both antiquated and inefficient” (Wheelwright 1994: 107). This new area of law and its enforcement was grafted onto a legal system designed to contain blue-collar crime. One example of its impediments to investigative efforts was a Statute of Limitations that applied to prosecutions (Penkethman 1977: 17). This meant that a case had to be launched within twelve months of the criminal occurrence in question. Ken Doust outlined the everyday impracticalities of trying to work within this tight time frame,

It might take three or four months for the matter to become apparent and then for the Medibank staff to investigate it, refer the matter to the Department of Health for approval, to be passed to the Commonwealth authorities for prosecution. The Australian Federal Police then look at this to make a recommendation to the prosecuting authorities – you are looking at a couple of years at least.... (Doust *pers. comm.* 2002).

In the financial year 1977/78 the number of statute-barred cases had reached eighteen but the situation was eased with the revocation of the Statute by an amendment to the Health Insurance Act in June 1978 (HIC Fourth Annual Report 1979: 7).

The Law of Evidence

Hindering investigative efforts were either the lack of suitable witnesses in some cases or in regard to pathology patients not being aware of what services were provided (Penkethman 1977: 14). There was also the evidentiary nature of the law. In this area of white-collar crime where each 'crime' may be financially insignificant but where the crime has been committed many times it was difficult to be dealt with by the court system. Penkethman explained,

It is usual to prove charges by calling patient witnesses; each witness may give evidence regarding one or more charges. The problem of presenting a case involving perhaps hundreds of patient witnesses is daunting to all concerned, the Commission, the Police, the Court authorities, Prosecutor and Defence Counsel and perhaps most importantly, the presiding Stipendiary Magistrate.

This point may be illustrated by the fact that a recent prosecution for offences under the Act was the longest running matter ever decided by summary jurisdiction in that State's history (Penkethman 1977: 12).

Roy Harvey recalled that as a statistician working for Medibank he visited several provincial health organisations in Canada in 1975. The information compiled during this visit formed the basis for his report on proposed legislation for a Medical Services Committee of Inquiry. A working group had

been formed consisting of officers from the Department of Health, including John Kelly and Harvey from the Health Insurance Commission, and they drafted the guidelines for this legislation for the Attorney-General's Department. They discovered that a curious feature of the Australian legal system, in contrast to its Canadian counterpart, was that there had been a court decision relating to the now defunct Pensioner Medical Service that would be a barrier to successful prosecutions for cases of medical fraud and overservicing under Medibank. The ruling of the court was that

every count of fraud had to be 'proved' and that proving ten cases and producing statistical evidence that there may have been a hundred more was not admissible. The Canadian systems were generally different as they had accepted systems of 'proof' established by the doctor organisations who ran the medical insurance programs before the introduction of Provincial Medibank type organisations. These doctor run organisations did accept evidence of 'patterns of practice' when determining overservicing and fraud (Harvey *pers. comm.* 2004).

This legal ruling was to hamper prosecutory effectiveness not only under Medibank but also under Medicare.

Harvey, in evidence before the Joint Public Accounts Committee Inquiry into Medical Fraud and Overservicing, explained the difficulties faced by the Commission over the problem of the law of evidence. When it is prosecuting fraud it has the resources to present to the court perhaps fifteen to thirty cases but if the same pattern of fraud was repeated one thousand times the court remained blind to this. The problem of not being able to present generalised

evidence had meant that the penalties had been too lenient (JCPA vol.6 1982: 2279).

Dr. Shik Aun Low

Dr. Shik Aun Low, of Malaysian origin and living in Perth, was a general practitioner specialising in acupuncture. In August 1978, he was the first doctor to receive a custodial sentence for defrauding Medibank and this case illustrated a number of problems including that of the evidentiary nature of the law. He was convicted of fraud in 1978 on the first of ten charges of a group of 149 charges. The reasoning was that ten charges was the most that a jury could be reasonably asked to consider at any one trial. The remaining 139 were to be left until the outcome of the first trial was known. Following Dr. Low's conviction on the ten charges, involving a sum of \$172.50 and prior to his sentencing upon those charges, Dr. Low voluntarily repaid an amount of \$2381.25 in respect of the total number of charges. However, the Deputy Crown Solicitor in Perth was considering action to recover other amounts over and above the amount Low had repaid (CPD HR vol. 121, 1981: 698). Judge Gunning of the District Court said that Low had on many occasions "charged for two professional services where one charge might not have been warranted". The judge continued, "the whole system of Medibank would not function if doctors operated dishonestly" (Hall 1979: 60). He was given a three-year sentence but was released from jail after serving a nine-month non-parole period (Drewe 1981: 34). Low was struck off the medical register, but in February 1980, he was reinstated. He resumed his practice in April of that year.

He discovered four months later that his practice patterns were again the subject of investigative efforts by the Department of Health. On 22 October he was arrested and released on \$60,000 bail. On 28 October he was in court on three charges of making false statements (Drewe 27 January 1981: 22). He committed suicide on 30th October 1980 (Death certificate). Sabrina Low, the widow of the deceased, referred the matter to the Commonwealth Ombudsman in January 1981 (Drewe 1 June 1982: 30).

Robert Drewe's series of four articles in *The Bulletin* magazine on Dr. Shik Aun Low took a position that supported Dr. Low and was antagonistic to the government. Drewe was more hostile than other Australian journalists in his coverage of fraud and overservicing. Drewe would not accept that Low had financially abused both Medibank and the health funds and was convinced that the 'persecution' of Low was racially based and that the Department of Health had hounded the doctor to his death for a paltry sum of two hundred dollars, whereas the total amount involved was \$120,000 (JCPA vol. 5, 1982: 2022). A Baptist minister, the Reverend Ian Bland, patient and friend of Dr. Low, described the case as a very Perth affair. "There is a conservatism present in Western Australia which makes this kind of event more possible than in other places. The word victimise is appropriate. I have no doubt that the cause of his suicide was that he couldn't handle the pressure he was under from the system...This bureaucratic control of our freedoms is terrifying" (Drewe 81: 37).

Drewe's interview with an unidentified Perth barrister reiterated similar themes. This barrister was adamant

This is a very Western Australian case. In no other State has a doctor been treated like this. An underlying explanation for what happened to Dr. Low was his race. Look he was the first doctor to be charged, the first to have a jury trial and the first to be imprisoned. It was a piddling sum of money...It is hard for Asians to do what the authorities want – and if they don't they'll be out to get them. To the end Dr. Low found it hard to make that adjustment – and he was hounded to death (Drewe 20 January 1981: 38).

In the light of the Ombudsman's investigations the Department felt constrained from issuing a public statement until the inquiry was completed (JCPA vol. 5 1982: 2024). Drewe continued his defence of the innocence of Shik Aun Low in the face of Health Minister Michael Mackellar's exposition in parliament of the Department of Health's position. Mackellar argued that Drewe had ignored pertinent details, distorted the facts and overall the facts did not support Drewe's interpretation of the case. "The trial judge in 1978 said that Dr. Low 'initiated a deliberate and systematic practice designed to defraud the authority Medibank, and indeed carried it out'" (CPD HR 121, 1981: 698). Mackellar continued, "The Government's view ...is that medical practitioners who set out to deliberately defraud the medical benefits systems by claiming for services they did not provide are to be prosecuted without hesitation and to the full extent of the law" (CPD HR 121, 1981: 698).

But the government did hesitate in the face of Drewe's repetition of the 'injustice' of the government's regulatory behaviour in the Low case over four articles (Drewe *The Bulletin* 20 January 1981: 33-40; 27 January 1981: 22-23; 10 March 1981: 22-27; 1 June 1982: 30), a cover story on the police seizures of doctors' files (17 March 1981: 56-61) and an article on "doctors' resent unwarranted examinations" (24 March 1981: 117). John Deeble recalled that Malcolm Fraser had passed some legislation that would automatically disqualify any doctor, guilty of fraud against the health insurance system, from receiving any further benefits from Medibank.

It was a substitute for having to prove anything. There was a belief that people who were defrauding, were defrauding in a large way, and therefore they should be penalised but we couldn't quantify it and the answer of the Fraser government was automatic disqualification (Deeble *pers. comm.* 2000).

In the face of Drewe's articles on the doctor who defrauded Medibank of \$200, suffered imprisonment and committed suicide, the government backed down and rescinded its proposed legislation. The automatic disqualification of doctors from Medibank was judged to be politically unsustainable. "So it was back to square one. Very small penalties" (Deeble *pers. comm.* 2000).

While Deeble saw this as an example of an un-cooperative media thwarting effective legislative initiatives, Ken Doust judged system failure from another perspective. As Medical Director of Medibank he was well acquainted with the case. He said of Low "he was a man unprepared to accept advice...and that it

was the fault of the Medical Board that this thing occurred". If he had been deregistered for a longer period Low "wouldn't have been left in a position where once again the opportunity for criminality presented itself" (Doust *pers. comm.* 2002).

Different perspectives on measures to contain fraud and overservicing

Reg Penkethman, the Manager of the Claims and Review Unit for Medibank, presented the public face of the HIC at the seminar organised by the Australian Institute of Criminology in 1977. He judged that "while there are enquiries continuing into a number of other doctors the seven doctors prosecuted represent a very small proportion of an honourable profession" (Penkethman 1977: 18). This was a sober, factual and detailed account of procedures in place and legislative changes to be introduced with little suggestion of the extent of the underlying problems. His was the voice of the institutional 'insider' with official expert knowledge offering reassurance that medical deviance was contained, controlled and addressed.

Statistician Roy Harvey, who had worked for Medibank until 1979, in evidence before the Joint Public Accounts Committee into Medical Fraud and Overservicing, recalled that there was recognition by staff in the HIC that there was a substantial problem, without knowing the dimension of it, in financial terms. "You would literally go down to the pub with officers in the Department and say, 'some things we are seeing are outrageous'" (JCPA vol. 6, 1982: 2246). Harvey said that management was aware of the problem from about three

months after Medibank started. Detection was by the crudest of all measures, just to look at gross fees or gross benefits paid to individual doctors. "Some of the frauds were so crude – billing thirty hours a day – you just need the item number and you can add up the number of items. Could this man have rendered fifty 45 minute consultations in a day? No" (JCPA vol. 6, 1982: 2261). "Even using relatively poor quality data you could identify gross forms of overservicing and fraud". This is adequate as long as "what happens after, namely, that the law is appropriate and that prosecutions can fact be effectively carried out" (JCPA vol. 6, 1982: 2277). Harvey saw that although the Commission was using horse and buggy regulatory strategies, those defrauding the system were using horse and buggy methods to do it. "Quite honestly I do not know whether the methods of fraud and overservicing ... are sophisticated. It seems to me that there have been so few successful prosecutions no one would have been deterred from using the old tried and proven methods" (JCPA vol. 6, 982: 2261).

Another expert, speaking as one outside the HIC, presented a case that the regulatory system was flawed at its most basic level. In 1981 at a seminar, this time organised by the Institute of Criminology at the University of Sydney, Professor Lou Opit of Monash University brought academic authority and expert knowledge to the debate. He argued that procedural propriety would only be achieved when the practice of overservicing was defined as fraud. He delivered a strongly worded paper "Medical Overservicing as a Criminal

Activity” condemning the practice of overservicing. Such practice was fraud, he argued, but the legal proof that a medical service was “unnecessary” is almost impossible to obtain (Opit 1981: 41). In this area of “professional discretionary decision making” (Crichton 1990: 108) in which this fraud flourishes, “we have no idea of the scale of the fraud and, indeed, it is part of the fraud that we cannot easily find out” (Opit 1981: 43-44).

At the same conference the problem was discussed of the difficulties of prosecuting a multiplicity of fraud cases involving small amounts of money and where this same offence is committed many times in succession. Offences committed in this fashion could bring returns from small amounts up to millions of dollars. R. J. Findlay, Assistant Director-General of Health, said his Department would not lay more than fifty charges against one practitioner (Findlay 1981: 31). In response, Judge Staunton, Chief Justice of the New South Wales District Court cited a case that had come to his attention, where sixteen charges were laid so that by the end “everybody was finding the whole matter a bit tiresome”. In his opinion “the Commonwealth should provide the courts, facilities and the support necessary to police this very expensive system” (Staunton 1981: 65).

Attacking this problem from another position were officers of the Department of Health and the Attorney-General’s Department. Their recommendations were published in a joint discussion paper in October 1981. They argued that

the judicial system could not handle such a multitude of small charges and was never designed for the task. It is a case of “nineteenth century legal processes being unable to cope with twentieth century circumstances” (JCPA Report 203: 252). As the law stood evidence is restricted to specific charges and generalised evidence is not admissible before the courts. (JCPA Report 203: 246). The paper recommended that consideration be given to the use of generalised evidence of the extent of the fraud to be put to the court following conviction but prior to sentencing (JCPA Report 203: 246).

It was against a background of growing disquiet over the difficulties of administering the *Health Insurance Act* that the detailed accounts of these failures from two whistleblowers, Joe Shaw and John Kelly, galvanised support for reform. It was their actions supplemented by the disclosures of unauthorised leakers, media agitation, support from the AMA, and parliamentary interest in the topic that led to the establishment of the public accounts inquiry into medical fraud and overservicing. This was to be the longest running public accounts committee inquiry in the history of the Committee.

Conclusion

The Health Insurance Commission was able to make some inroads into controlling abuse of Medibank but evidence mounted that the structures set in place to deal with it were inadequate at both the legislative and administrative levels. The years 1975 to 1981 were marked by a slow drift towards crisis.

Evered remarked that the move of the investigative function to the Department of Health was when “things really started to go wrong” (Evered *pers. comm.* 2001). In fact, the move added new dimensions to problems already in motion.

Chapter 5

Whistleblowing: knowledge without power

Knowledge will forever govern ignorance: and a people who mean to be their own governors, must arm themselves with the power which knowledge gives.

Letter to William T. Barry, Lieutenant Governor of Kentucky, from James Madison, President of the United States August 4, 1822
James Madison, *Writings*: 1999: 790.

Dramatis Personae - 1982

Parliament

Malcolm Fraser	Prime Minister till March 1983
Michael Mackellar	Minister for Health to April 1982
Jim Carlton	Minister for Health – May 1982 to March 1983
Dr. Neal Blewett	Shadow Minister for Health

Joint Committee of Public Accounts

David Connolly	Chairman of the Joint Committee of Public Accounts
Michael Talberg	Secretary of the Committee
Katherine Beauchamp	Researcher for Committee – February 1982 to October 1982. Journalist; active in public advocacy; member of the Rupert Public Interest Movement; involved in the campaign for Freedom of Information legislation.
Michael Boyle	Seconded to the Committee on an executive development program from the Australian Security Intelligence Organisation

Health Insurance Commission

Ray Williams	General Manager, Medibank
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John Evered	Assistant General Manager, Audit, Planning and Control Division, Medibank. In 1996 he was appointed Managing Director of the Health Insurance Commission.
Joe Shaw	First fraud investigator, Medibank
Roy Harvey	1974 -1979 Statistician, head of the Actuarial and Statistics Branch of Medibank

Commonwealth Department of Health

Dr. Gwyn Howells	Director-General, Cth Department of Health
Charles Nettle	A/Director-General, Cth Department of Health
Dr. Cyril Evans	Deputy Director, Cth Department of Health
Matt Carroll	Deputy Director, Cth Department of Health
Dr. Ronald Webb	Director, Cth Department of Health (Vic.)
Dr. Charles Selby Smith	First Assistant Director-General, Medical Benefits Division, Cth Department of Health. Currently, Professor Department of Management, Faculty of Economics, Monash University.
Dr. Charles Eccles Smith	Medical Counsellor, Cth Department of Health (Vic)
Lawrie Willett	Director-General Cth Department of Health from Jan. 1983
John Kelly	Director, Development Section, Operations branch, Cth Department of Health
Chris Haviland	Union official, Australian Clerical Officers Association; Investigator, Fraud and Overservicing Section, Cth Department of Health (NSW). In the 1990s he was elected to the Federal House of

Representatives (ALP) and was a member of the joint parliamentary committee of public accounts.

Australian Medical Association

Dr. Lionel Wilson	President of the AMA
Dr. Lindsay Thompson	Deputy president of the AMA
Dr. George Repin	Secretary General of the AMA

Journalists

Michael Smith	Investigative journalist – <i>The Age</i> Insight team 1982
Michelle Grattan	Columnist - <i>The Age</i> newspaper
Mark Metherell	Medical roundsman - <i>The Age</i> newspaper
Shane O'Connor	Journalist – <i>The Sunday Mail</i>
David Hickie	Journalist- <i>The National Times</i>

Introduction

The architects of Medibank had given consideration to the integrity of the program believing that the mounting evidence of substantial fraud and abuse of the system would trigger legislative, administrative and law enforcement reform. The unspoken assumption was that reform would be management driven. This was not to be the case until the 1990s. In the early 1980s some of those in the middle ranks of the public sector, working on the frontline of the fight against fraud and overservicing - the fraud investigators, counsellors and statisticians - were pushed, by the logic of inadequate controls over fraud and abuse, to take action to force change. They took the message of the failure of the regulatory system to the media, to activate public demand for reform.

Some became whistleblowers, here defined as people

motivated by notions of public interest who initiates of her or his own free will, an open disclosure about significant wrongdoing directly perceived in a particular occupational role, to a person or agency capable of investigating the complaint and facilitating the correction of wrongdoing (Senate Select Committee on Public Interest Whistleblowing 1994: 7-8; De Maria 1999: 24-25).

Others became 'leakers', defined in this instance, as those who disclose unauthorised, confidential information to the press, that has not been processed by official channels and where there is an undertaking by the journalist that the identity of the source will not be revealed (Sigal 1973: 184; Bok 1982: 216-218; Ericson 1989: 135; Tiffen 1989: 96-97; Thompson 1995: 144). Like whistleblowers, they disclose information in the public interest, but without the protection afforded by holding a position of high status and power. Leakers operate within a work culture of the routine secrecy of information and if caught leaking may well expect demotion or dismissal from their employment or legal penalties. If their leaked information leads to a parliamentary inquiry and they are called to give evidence before the inquiry, their identity is revealed and their position is not unlike that of a whistleblower, and they can suffer retribution in the workplace for their disclosures.

Blowing the whistle and leaking of confidential information to the media are beset by a number of difficulties. They relate to the nature of bureaucracies, the

relative powerlessness of information holders in the middle ranks of the public sector, and the secrecy provisions of the Acts.

Bureaucracies

Bureaucracies are designed to discharge official business with efficiency, and discretion (Weber 1946: 214). Their norms are rationality, legalistic objectivity, disinterestedness, fair treatment under the law, and standardized procedures (Jackall 1988: 11; Weinstein 1979: ix-x). Bureaucracies are hierarchical and under this authoritarian structure (Weber 1946: 197; Weinstein 1979: 58; Gitlin 1980: 256; McMillan 1986: 193; Alford 2001: 101; Martin 2002: 2), the public servant must “execute conscientiously the order of his superior officers, exactly as if the order agreed with his own conviction. This holds even if the order appears wrong to him” (Weber 1946: 95). Max Weber’s defence of this practice was that without this “self-denial...the whole apparatus would fall to pieces” (Weber 1946: 95).

Other sociologists have been sceptical of the argument of the negative social impact of an independent moral judgement. Zygmunt Bauman argued that bureaucracy was a “morality eroding machine” (Bauman 1989: 199), citing as evidence the Jewish Holocaust, where the bureaucracy could efficiently eliminate a government’s “unwanted population”, leaving those blinded by obedience to authority as its immoral accomplices. Adding weight to this side

of the debate are the psychological experiments conducted by Stanley Milgram, who demonstrated the ease with which authority ensures compliance to its demands, even when its injunctions are cruel, unnecessary and unenforceable (Milgram 1974: xii).

An authoritarian and hierarchical structure means that these holders of insider knowledge, in the middle ranks of the public sector, lack sufficient seniority to align their knowledge to the power to promote organisational change. An elite of senior managers exercises control and any opposition can be interpreted as a threat to loyalty, order, and effective governance (Bok 1982: 215). In this way bureaucracies resemble authoritarian systems of government, rather than the democratic political system in which they are located. Yet this location within a democratic political system has a bearing on whistleblowing. If the political system is authoritarian then whistleblowing has less prospect of success than under liberal democracy.

Whistleblowers often fall into the trap of misunderstanding the nature of bureaucracy. They report on institutional malfeasance believing they live in a democracy (De Maria 1999: 15), with the ancillary expectation of response and reform. However, the success of any direct challenge to authority is limited, but has a greater chance for success when whistleblowers acquire the appropriate skills to reposition their strategies for reform (Martin 1999: 7-8). Such an

approach is used by those who leak information to journalists and become their unauthorised, unofficial, confidential sources. They are on safer ground. It is more difficult for senior managers to locate this anonymous, oppositional source: to isolate, discredit and marginalise it (Bowman 1984: 35).

Whistleblowers pay a high personal price for their challenge to the bureaucracy. A hostile management retaliates with an attack on the motives, credibility and working conditions of the whistleblowers (Weinstein 1979: 108; Martin 2002: 6). It means a change of their status within the organisation, from trusted employee to distrusted whistleblower: from team player to malcontent. Generally whistleblowers do not anticipate this fall from grace (Weinstein 1979: 58), for they are often the institution's most faithful servants, dedicated to reform of the organisation, not to its destruction (Milgram 1974: 163; Weinstein 1979: 28).

The ethical dimension

The philosophy of action guiding whistleblowers and leakers is a disposition to stand fast to personal integrity in the face of the moral compromises and expediency of organisational life (Jackall 1988: 111-112). Organisations, for their part, value team players, that is, those who stick to their assigned positions (Jackall 1988: 52-54), and are alert to the social relationships binding together the organisation (Jackall 1988: 56).

Colliding here are two different systems of moral values: those external and those internal to the organisation. Those external to the organisation, that is, those of the Church, the home or the sports field, can be a liability unless they fit into the organisational ethos (Jackall 1988: 105). Within the organisation a whistleblower's moral vision can interfere with his ability to "read the drift of social situations" and such a person can be disruptive of organisational life (Alford 2001: 113). Destructive individual morality may result in the breakdown of hierarchy (Alford 2001: 128) and loss of control of organisational boundaries (Ericson 1989: 379 - 381; Alford 2001: 99,129). This idea is expressed by Bauman when he said "every organisation is dedicated to the destruction of its members' individuality, defined as the ability to think seriously about what one is doing" (Alford 2001: 116). It is a philosophy given voice by Martin Luther King Jr. when he said, "our lives begin to end the day we become silent about things that matter" (cited in Time magazine 30 December 2002: 54).

Speaking out

If the profile of the whistleblower and the leaker is one "who is fervently in belief of the truth, a truth that he sees is part of his life's mission" (Leaker *pers. comm.* 1998), and that the lack of transparency of bureaucracies undermines trust and deprives others of the power to take action based on accurate understanding of what is happening (Simons 2002), then support for this moral

vision could come from the media (Jackall 1988: 105; Glazer & Glazer 1989: 167; Lennane 1995: 3). Its work practice is conventionally based on the ideals of objectivity, balance (Tuchman 1972; Ericson 1996: 213) and the separation of fact from value (Schudson 1978: 5; Gitlin 1980: 268), but standing in juxtaposition is a competing tradition. It is that strand of journalism, which gives primacy to values, and its practitioners are those engaged in interpretive or investigative journalism (Carey 1974: 232; Schudson 1978: 187; Miraldi 1990; Protess *et al* 1991: 54, 254; McKnight 2001: 50). Here moral disengagement and moral custodianship are joined together in a paradoxical relationship (Ettema & Glasser 1998: 185). Here the moral order is articulated (Ettema & Glasser 1998: 62) and the public's right to know finds expression (Carey 1974: 232).

This partnership between journalists and their unauthorised, confidential sources can be effective in challenging excessive bureaucratic secrecy (Ericson 1989: 22). It invites more rigorous examination of policy proposals, resulting in their modification or rejection, dispelling the illusion that governments have complete control over public policy (Leaker *pers. comm.* 1998). A new policy agenda then can be formulated which is morally informed and developed in a way that is contrary to the original intentions of officials and policy makers (Ettema & Glasser 1998: 190).

Open government and the Australian media

The tradition of investigative journalism flourished in the decades of the 1960s, 70s and 80s: a period of social reform and cultural and political change (Glazer & Glazer 1989: 24; Schultz 1998: 20; McKnight 1999: 156). One expression of this was a movement away from the secretive government of Prime Minister Robert Menzies and his predecessors, and a movement towards open government (Terrill 2000: 1, 52-53). Secrecy had meant that parliament was not well informed about the activities of its own government departments, annual reports were not regularly presented to parliament, and there was opposition to the proposal for public servants to appear before parliamentary committees (Terrill 2000: 1, 52-53). In the spirit of open government, Gough Whitlam established a Royal Commission on Australian Government Administration, under the chairmanship of H. C. Coombs (RCAGA), whose report acknowledged community demands for greater access to political decision-making (Terrill 2000: 61). Open government meant, to Prime Minister Malcolm Fraser, a politically well-informed electorate, with unhindered access to information, through a free and effective press (White & Kemp 1986: 167-168). He went so far as to suggest that in exceptional circumstances public servants could leak information to the press if they had knowledge of illegal activities by a government or prime minister (Bowman 1980: 35).

Investigative journalism

Paralleling this interest in the workings of government were demands for a *Freedom of Information Act*, especially by groups like the Rupert Public Interest Movement (Terrill 2000: 194-5), and the media busily documenting the failures of executive accountability. Investigative journalism by the 1980s was in its prime (Schultz 1998: 20, 195; McKnight 1999: 155). It had the resources, the editorial and legal support to tackle larger and more complex issues than in routine news production, and a readership eager to be engaged with these revelations (Schultz 1998: 183, 192). Illustrating this change of media direction, McKnight observed,

In the popular press of earlier decades the target of these exposes was as likely to be an individual quack doctor, whereas in the 1970s and 1980s it was more likely to be a Health Minister or an entire health system (McKnight 1999: 155).

Investigative journalism came to be judged to be so politically effective that one set of commentators concluded,

Investigative journalism is to democracy what predators are to the balance of nature, a corrective force, vigorous in attack and addicted to blood (Fisse & Braithwaite 1983: 254).

While such a description overstates media power, later analysts still afforded it an elevated place in the political landscape. Ericson argued, “at the level of organisations, publicity is an increasingly important component of achieving

compliance to laws and regulations” (Ericson 1996: 221). Establishing the place of journalism within the public sphere was an Australian publication on government accountability. After listing the arms of government that performed this role, it added, “an independent mass media provided an additional guarantee of, and spur to, public accountability” (Accountability in the Commonwealth Public Sector 1993: 3).

The first whistleblower – “this muddy booted wallopper”

The first to provide the media with copy on medical fraud and overservicing was Joe Shaw. He was Medibank’s first fraud investigator and its first whistleblower on medical fraud and overservicing.

Like Ken Doust, Shaw found evidence of criminal fraud, particularly the fraudulent use of doctor’s provider numbers to obtain Medibank benefits. Surveillance of doctors brought to light some interesting cases. There was the doctor who had settled into a comfortable routine of visiting his elderly patients on a daily basis when they were not in need of medical care and then billing.

Most of these patients were capable of visiting a surgery but none of the patients complained of receiving home visits, in fact, they loved it because the doctor came at the same time every day of the week and they didn’t have to go into town (Shaw *pers comm.* 2002).

Also doing home visits was a doctor attending to the needs of the town’s Aboriginal community. Many of these patients were alcoholics who lived by a

riverbank. He held all their pension cards and he would give them \$2 a day and they would get drunk and come back the next day to sign a Medibank form and then he would visit them on the riverbank for “home visits”. This doctor ran a private hospital at Warmuran and when the patients started to dry out he employed them as gardeners, carpenters and painters for his private hospital while still controlling their pension card (Shaw *pers comm.* 2002).

Particularly frustrating was the case of the doctor at Gin-Gin in Queensland who would go to the local hospital every morning and who in the space of thirty minutes would visit its forty or so patients and “there was a medical charge for everyone, every morning. Following on from that he had lunch with his mother every single day of the week and charged a long hospital consultation with his mother!” This doctor was not stopped or prosecuted and according to Shaw the doctor claimed he was not overservicing (Shaw *pers comm.* 2002).

Shaw had difficulties in gaining the co-operation of the AMA and the law enforcement agencies, the Australian Federal Police, the Deputy Crown Solicitor’s Office, and the Office of the Director of Public Prosecutions. The AMA adopted a “hands off our doctors approach”. The AFP was under-staffed and investigations into medical fraud were labour intensive: to bring one doctor to court required several hundred pages of evidence, plus two Commonwealth police working full-time for six weeks (O’Connor 1978: 1). The Deputy Crown

Solicitor Office failed its duty in the case of a doctor who was on three thousand separate charges and offered to repay \$200,000. The Crown Solicitor rejected this offer and the doctor appeared on only one charge. The Magistrate gave the doctor “the benefit of the doubt in relation to the interpretation of the Medical Benefits Schedule” and dismissed the charge (Shaw letter to Public Accounts Committee 30 September 1982). This spirit of unco-operativeness also applied to the Office of the Director of Public Prosecutions (Shaw *pers. comm.* 2002).

In addition to this lack of co-operation, some doctors could stand their ground and defy any attempts at policing. One doctor complained directly to Medibank about Shaw’s investigative efforts. She self-righteously dismissed him as “this muddy booted wallop”. She then detailed her objections to his intrusiveness in investigating her pattern of overservicing of Aboriginal communities (Shaw *pers. comm.* 2002).

A realisation that the main problems of overservicing, incorrect itemisation, exaggeration of services, and unnecessary home visits were not going to be addressed by the inadequate legal and administrative remedies convinced Shaw that he needed to adopt another approach. He calculated the amount of money lost through fraud and overservicing by comparing the Australia system of medical benefits payments with Medicare and Medicaid in the United States. An American government inquiry had estimated that leakage was one fifth of the total health benefits budget, so Shaw guessed that the figure in Australia

could be one sixth of the Medibank budget, being \$100 million (JCPA 1982, vol 1: 538). He compiled a seventy-page report detailing his concerns, and arranged to discuss the material with his senior officers in Canberra in May 1978 (NAA: A983/1, 1982/9/203).

Shaw's intention was to garner support, commitment and resources for fraud and abuse control efforts from Medibank's senior officers. His superiors in Medibank head office were sympathetic to Shaw's predicament, but General Manager Ray Williams and Assistant General Manager John Evered were unresponsive to the report. Evered annotated the margins with comments like "you believe these people are guilty but if you can't prove they're guilty then they are not guilty until they are proven guilty" (Evered *pers. comm.* 2001). He was told that in order for his report to be read by the Department of Health, it had to be reduced to two pages. Shaw was not aware that this was a normal bureaucratic procedure. As far as he was concerned, it was the volume of the cases that he had encountered and replicated in his report that supported his argument for the inadequacies of controls over medical fraud and overservicing. Williams met with him privately and Shaw was in tears as he explained the difficulties of maintaining a law enforcement presence in this area. Shaw was judged to be "a nice enough guy" but one who saw things in "black and white". Detracting from his case was his emotionality and anger. Evered said, "he was not wrong to get angry about it. He was wrong to get so obsessed about it" (Evered *pers. comm.* 2001).

In the presentation of his case, Shaw had unwittingly made procedural errors and broken a number of behavioural codes pertaining to large organizations, due to a lack of understanding of the higher administrative culture (Martin 1999: 7-8). Delegitimising his argument was his display of emotion (Jackall 1988: 49). His strong convictions, for all their sincerity, were judged to be irrational and lacked the credibility that a neutral presentation would have provided. Shaw had also erred on the timing of his report. He had delivered it in the early months of 1978 and management was preoccupied with another issue, the organisation's survival.

Shaw had gone to Canberra to win support for improved regulatory structures to fight fraud and overservicing. He left disillusioned, not having won a commitment to organisational change. He judged himself to be

Totally naïve. I had no idea of the ramifications of politics or anything else. I just naturally thought that if I exposed it, that some action would be taken and it just shows how naïve and foolish my thoughts were because I actually did believe something would happen and I just lost all faith and all confidence in the system (Shaw *pers. comm.* 2002).

Shaw was dejected but not defeated. He resigned his position with Medibank and some months later, armed with his report, contacted the local Brisbane newspaper, the *Courier Mail*. A journalist was dispatched to cover the story and this time Shaw did get a hearing. "Multi-Million \$ Fraud in Bulk-Billing" was the headline in the page one story in *The Sunday Mail* (O'Connor 1978).

While Shaw's performance to his superiors was judged to be inept, his actions served him well in one sense: his message was now in the public arena, where it had another life. Two days later, in Federal Parliament, Senator Mal Colston asked that Shaw's report be tabled in the Senate. It was refused. Senator Margaret Guilfoyle was "satisfied that any appropriate action warranted by the report has been taken" (JCPA Report 203: 204). She did not specify what this appropriate action was.

Four years later, committee members of the Joint Committee of Public Accounts Inquiry into Medical Fraud and Overservicing, and journalists covering the story, recognized the value of Shaw's report. It was on the public record that, as early as 1978, the HIC had a report suggesting that fraud and overservicing could be in the order of \$100m (Kelly, *SMH* 17 September 1982: 7). This made it difficult for senior management in the Department of Health to deny knowledge of the problem (JCPA Vol. 1: 333; Vol. 2: 538; Vol. 8: 3130). A journalist with *The Age*, Michelle Grattan, said, "although the Health Department questioned his methodology, his conclusion was in line with later departmental estimates" (Grattan, *The Age* 20 September 1982: 9). The *Sydney Morning Herald's* Jenni Hewett commented on the lack of a departmental response to the report.

No one took it seriously. The officer's report was dismissed as overzealous, his comments too personalised, his figures unreliable

because they were rough and based on American experience. The report disappeared into a drawer. The officer resigned. No alarm bells rang (*SMH* 13 October 1982: 7).

As a whistleblower, Shaw fared better than most. Medibank was a young organisation with a strong spirit of co-operation. Shaw was not treated badly by management; he was simply not listened to. Shaw was fortunate in having blown the whistle in a young organisation, where the managing director was of a kindly, not vindictive disposition, and in making the prudent decision to resign and pursue another career. Those who have blown the whistle in an older organisation and continued their employment with this institution tend to endure the customary workplace reprisals dealt to whistleblowers, that is, to suffer for their principled stand with overwork or being assigned meaningless work, reprimands, punitive transfers, demotion, social ostracism, and abuse from work colleagues (Weinstein 1978: 108-125; Glazer & Glazer 1989; Ericson 1989: 218; Miceli & Near 1992; Lennane 1993: 669; de Maria & Jan 1996; Dempster 1997; de Maria 1999; Martin 1999; Alford 2001: 18-19). It is, as Hallie argues, the usual “institutional cruelty...grinding its victims with a large apparatus of catch-words and justifications” (Hallie 1969: 63).

Reasons for Shaw's success

The relative success of Shaw's disclosures was due to a number of factors. The times favoured closer public scrutiny of government administration, the issue was on the media agenda, the media itself was affording space to investigative

journalism, and the AMA, for the brief period of the presidency of Dr. Lionel Wilson, supported tighter controls over fraud and overservicing.

In addition to these factors, the Minister for Health, Michael Mackellar, was aware of some of the problems. He was concerned that the Australian Federal Police gave few resources to this area of law enforcement and he feared priorities in this area would be further reduced (JCPA Report 203: 68). The Minister for Administrative Services, Kevin Newman, responded to Mackellar's letter of 13 May 1981, by saying that medical fraud was indeed a low priority for the AFP, as it involved small monetary amounts and police resources needed to be directed to the traditional areas of policing, that is drug trafficking, terrorism and organised crime (Newman 1981 *see Appendix*). Despite Mackellar's request, additional resources were not provided (JCPA Report 203: 68-69). Newman argued that investigations could be more effectively performed by the department with administrative control of this function (Newman 1981 *see Appendix*; CPD, HR Vol. 30 9 December 1982: 3287). This was an idea whose time did not come until the 1990s.

It was to be one newspaper article which acted as the catalyst for a parliamentary inquiry into medical fraud. It was entitled a "Patients' Guide to Medical Rip-Offs" that appeared in *The National Times* in May 1981. The journalist, David Hickie, argued that "a small but increasing number of doctors are engaging in unethical practices for financial gain; indeed the situation has become so blatant that many doctors are now openly discussing the currently

fashionable rackets” (Hickie, *The National Times*, 17 to 23 May: 12 and 14).

Michael MacKellar called for a departmental briefing.

John Kelly, the second whistleblower

The person chosen to devise an estimate of the revenue lost through fraud and overservicing was John Kelly, Director of the Operations Branch, of the Department of Health, and he became the second person to blow the whistle on the financial abuse of medical benefits. He had done the development work for a statistical system, that he termed the Fraud and Overservicing Detection System (FODS), to measure the extent of abuse of medical benefits. His estimate of the amount lost through leakage from the system was the same as that calculated by Shaw: \$100 million (O’Connor 1978: 1). John Kelly wrote the departmental briefing. The acting head of the Department of Health, Charles Nettle, reviewed the document on 25 May 1981, before it was sent to the Minister and deleted seven paragraphs from it. One of the deleted paragraphs confirmed the newspaper account,

Unfortunately, the tenor of the article is correct, particularly in respect of the medical benefits scheme...The Department is quite concerned at the current level of exploitation and more particularly at the potential for that exploitation to increase (JCPA Report 203 1982: 211).

Kelly, on this basis of his experience with the Department of Health, calculated that if the estimate of \$100 million were included in the brief, then it would be deleted by senior management, so what he did was hide the estimate in the complicated statistical appendix in an attachment to the brief. He judged that Charles Nettle, the acting Director-General of the Department of Health, would

overlook it. Kelly's assessment was correct. All the paragraphs of the brief were deleted, but the attachment stayed (JCPA, 27 October 1982: 3142). John Kelly, in blowing the whistle, had used an unusual strategy. He released information that the department would rather not be disclosed, but by including it as an appendix to a departmental briefing he did it in a fashion which was procedurally proper. The estimate of \$100 million for fraud and overservicing was forwarded to the Minister. This figure came as a surprise to Mackellar, for on first taking up his portfolio, had been informed that the estimate was in the order of \$15 million per annum (*The Australian*, 12 November 1982: 2). This revised figure was then sent to the AMA who accepted the figure of \$100m as the amount lost through fraud and overservicing.

Fuelling Kelly's resolve for Ministerial action was his indignation at the department's lack of support for fraud control initiatives, but of particular concern was a cavalier attitude to fraud control by the responsible staff in the state offices of the Department of Health. Kelly recalled that the Victorian office was particularly bad, with investigative officers in near open rebellion against their medically qualified managers. They objected to doctors being "tipped off" about prospective investigations, with the early warning enabling them to cover their tracks. One example of the maladministration in the Victorian office was a cheque for sixty thousand dollars that was sent to a doctor for invoices which had not been countersigned by patients. Although there were a few occasions when patients were unable to sign invoices, all the invoices in this "batch" were

unsigned. The officer responsible for the processing and payment of these claims had refused to pay this claim, but the State Director had ordered that payment be allowed. Kelly reported his findings to his superiors in Canberra, but no action was taken (Kelly *Statement*1995).

As disheartening as this situation was, Kelly pushed ahead with his plans for regulatory reform. In October 1981, he co-authored a Discussion Paper, in conjunction with the Attorney-General's Department (JCPA Report 203: 236-254). He also wrote the specifications and the Cabinet submissions for new legislation (JCPA Vol. 2, 27 July 1982: 720 and 802). It imposed sanctions on doctors found guilty of two or more fraud charges, and these doctors were to be denied access to medical benefits for three years (CPD, HR Vol. 129, 23 September 1982: 1793). The legislation was put into effect on 27 May 1982 (JCPA Vol. 2, 27 July: 739).

The Australian Medical Association

John Kelly, and the Department of Health's Medical Director, Dr. Pip Ivis, started lobbying the AMA, to win agreement from its Federal Council as to the size of the estimate of monies lost through fraud and overservicing. In the period, 1979 to 1982, Dr. Lionel Wilson was President of the AMA, and had been a long-term advocate of government intervention to deal with the problem of overservicing. Kelly's calculation of the magnitude of the problem, struck a responsive chord with Wilson, and he supported the estimate.

Wilson had been pressuring the government since the beginning of his presidency for more effective methods to be implemented to deal with overservicing, meaning that improvements needed to be made to the Medical Services Committees of Inquiry. In 1979 he complained that the Committees had so far dealt with only six cases and had forty-eight cases pending, and this was only a fraction of the total profession of 24,000 doctors (AMA *Annual Report* 1979: 10). In June of 1979, the Federal Council of the AMA requested the Minister for Health to establish a joint AMA and Commonwealth working party to enquire into “the framework of reference, administrative structure and mode of operation of the Committees” (AMA *Annual Report* 1979: 9). In the following year the AMA made a number of recommendations to government asking that,

Cases of alleged overservicing to be judged on the pattern of services, rather than on an examination of whether each and every service provided was necessary...Better data collection to be instituted and more counselors appointed (AMA *Annual Report* 1980: 8).

In 1982, Wilson writing in the *Medical Journal of Australia* expressed his dissatisfaction with the government’s tardy response to the AMA’s recommendations. He did not believe that the government would rise from its inertia to address the problem until a public issue was created.

Wilson made a public statement in February 1982, agreeing with the government’s estimate of \$100 million lost in fraud and overservicing. In so doing, he accepted that many of his colleagues were in denial over the problem

(AMA *Annual Report* 1982: 1). He argued that unless the issue was dealt with then the current system of health insurance “would not survive indefinitely under the burden of the current abuse. It is not a question of adopting a high moral tone but of wishing to survive” (Wilson AMA *Annual Report* 1982: 7).

Many in the Association were against this decision. Wilson’s vice-president at the time was Dr. Lindsay Thompson, who said he would not have acted as Wilson had, for the decision was “unpopular with some, with many of the people in the profession” (Thompson *pers. comm.* 2002). The Secretary-General of the AMA, Dr. George Repin, recalled that “Lionel really put his neck on the block.....I disagreed strongly with him in accepting the figure for which there was no real proof”. Repin argued away the estimate in the following terms:

To call it fraud was quite inappropriate. It was not fraud. And the judgement of whether it is inappropriate servicing or not is still very much dependent on people’s looking at the nature of the servicing and why it was rendered (Repin *pers. comm.* 2002).

Despite dissension within the Association, the government agreed to a parliamentary inquiry into medical fraud and overservicing, but it is unlikely that such an inquiry would have proceeded had it not had the support of the AMA’s president.

Australian media interest in medical fraud

Media interest was now heightened by the knowledge that an estimate for fraud and overservicing had been agreed upon by the key stakeholders, the

Department of Health, the AMA and the Royal Colleges of General Practitioners (RACGP), Surgeons (RACS), Obstetricians and Gynaecologists (RACOG), and Pathology (RCPA).

The Age, *The Australian*, *The Canberra Times*, *The Courier-Mail*, *The National Times*, *The Sydney Morning Herald*, and, to a lesser extent, *The Bulletin* magazine had all followed the medical fraud issue with a dogged interest from 1976 onwards. In the period 1976 to 1981 there were approximately twenty newspaper articles on medical fraud and overservicing. In February of 1982, the figure was in excess of fifty items in newspapers, radio and television, and by the end of that year there were over two hundred items (Appendix A, B). This interest in medical fraud and overservicing was framed by media attention being given to widespread corruption and inertia in a number of government departments. This gave rise to the Woodward Royal Commission into the meat substitution racket, the Asia dairy inquiry, the Nugan Hand inquiry and most damaging of all the Costigan Royal Commission.

By the end of 1982, journalists were drawing comparisons between the findings of the Costigan Royal Commission and fraud against medical benefits (Smith *The Age* 13 September 1982: 1; Forell *The Age* 15 September 1982: 15; Editorial *The Age* 16 September 1982: 13; Editorial *SMH*: 17 September 1982: 6). “The Fraser government”, argued Paul Kelly of the *Sydney Morning Herald*, “is now being overtaken by medifraud revelations which, in terms of revenue lost and

government incompetence, equals if it does not exceed that of the tax evasion issue" (Kelly *SMH*: 17 September 1982: 7).

The Joint Public Accounts Committee

The Joint Public Accounts Committee decided that the matters raised in the media coverage were such as to warrant an inquiry into abuse of the Medical Benefits Schedule by medical practitioners.

Following widespread reports in the media in February 1982 of abuse by doctors of the Medical Benefits Schedule, the Committee sought detailed briefing from the Commonwealth Department of Health on mechanisms for the detection and apprehension of offending doctors and information on problems associated with this area (JCPA Report 203, 1982: 1).

In addition to this media agitation, other major considerations were problems in the Victorian branch of the Department of Health and a damning Auditor-General's Report. There is no mention made here of the role of the Auditor-General's Office in recommending that the PAC should investigate this area. In an interview I conducted with a former officer of the Australian Security Intelligence Organisation, Michael Boyle, he disclosed that he had had dealings with the Auditor-General's office in 1981 and this department was raising strong concerns about the extent of medical fraud and overservicing. The Auditor-General's office had a close liaison with the PAC inquiry and it was on their advice that the PAC held an inquiry into medifraud (*pers. comm.* 2003). One journalist also noted that the Committee's decision to proceed with the inquiry was also influenced by its earlier success in examining overpayments to

chemists, under the Pharmaceutical Benefits Scheme (Snow, *AFR* 15 April 1982: 5). The Auditor-General's Audit Report of March 1982 expanded on the problems of regulatory failure raised by John Kelly. It noticed that there was inadequate co-ordination between the automated data processing system and other systems and controls (Audit Report 1982: 82). It noted that

In one medical benefits organisation alone in a six-month period in 1981 there were over 200,000 cases of invalid provider numbers on which Commonwealth Medical Benefits had been paid. The non-acceptance of such items for investigatory statistics purposes casts doubt on the validity of the records, which among other things, form the basis of medical counselling for overservicing (Audit Report 1982: 77).

The Report concluded that there were serious defects in the systems for payments of medical benefits (Audit Report 1982: 82). The Committee's terms of reference indicated areas warranting attention. These included the evidentiary nature of the law and the subsequent difficulties in gaining prosecutions. The work of policing medical fraud and overservicing was dependent on co-operation from the Australian Federal Police and the Office of the Director of Public Prosecutions, and this did not appear to be operating effectively (*AMA Gazette* July 1982: 15). The inability of the relevant government departments to regulate fraudulent practice pointed to underlying structural problems that needed to be addressed. In addition, the Chairman of the Committee, David Connolly, had received leaked information that indicated that either the Victorian division of the Department of Health, or individual staff members of that office, had facilitated criminal fraud by some doctors

(JCPA *Report 203*, 1982: 48). Connolly subpoenaed forty-one files from the Department of Health's Melbourne office relating to his matter. On hearing of the Chairman's action in obtaining the files, the Committee urged a formal inquiry (Beauchamp 1985: 42), which was announced on 25 May 1982 (JCPA *Report 203*, 1982: 1). Its aims were to indicate areas needing immediate attention and to offer a number of options for legal and administrative changes (JCPA *Report 212* 1983: 11).

Public Accounts Committee Inquiry into Medical Fraud and Overservicing

It would seem that the Committee was prepared to deal with the issue with some degree of resolution. It employed a freelance journalist from February 1982 to interview whistleblowers on the medical fraud issue and prepare questions for the Committee. The researcher, Katherine Beauchamp, had links to *The Age* and *The Canberra Times* newspapers and was a key member of the Rupert Public Interest Movement. She was diligent and committed to the task. She used the techniques of investigative journalism to establish networks of informants across the police, staff from the Health Insurance Commission and the state offices of the Department of Health. She was encouraged by the numbers of officials willing to provide information to the Committee and rewarded by the number with high standing prepared to come forward. It was some of these contacts who reported that Medibank offices were being broken into and people under investigation were removing their files so they would not come under examination by the FODS system (Beauchamp *pers. comm.* 1995).

In due course¹ the Secretariat gave her office to Michael Boyle, of ASIO who had been assigned to the JCPA on an executive development program. Beauchamp was concerned as she knew he worked for ASIO because “in Rupert it was part of our job to know who was who” and her office included two telephones, one known in the Secretariat to be a hotline for confidential whistleblowers. She alleged that after his appointment, medical fraud files began to go missing and locked filing cabinets were found forced open (Beauchamp 1985: 43).

Boyle’s account differed. In his time with the JCPA he was occupied with preparing a background study for another JCPA investigation, the Tobruk inquiry, rather than the one pertaining to medical fraud. However, his memories of staff conversations regarding Ms Beauchamp was of a feeling that her methods of investigating the Department of Health and its Director-General, Dr. Gwyn Howells, could embarrass the Committee. “I formed an impression that no-one knew what to do about this. Staff gave the impression that they were becoming concerned about the direction that she was going”. He added,

the Public Accounts Committee is a standing committee of the parliament. Its inquiries must be overt, transparent and its information on evidence public, except in unusual circumstances. Therefore it is not part of the Committee’s function, let alone the staff function, to carry out what could

¹ Beauchamp said it was May and Boyle that it was August of 1982.

be regarded as clandestine or covert investigations (Boyle *pers. comm.* 2003).

These attitudinal differences over the function of the JCPA in public sector accountability is well played out in this confrontation between Boyle and Beauchamp. At stake here were different understandings of the Committee's role as an arm of regulatory compliance. The public record of the Committee's findings would enhance the constitutional values of transparency and accountability but could place at risk others such as legality (defined in its broader, ethical sense) and procedural fairness (Yeung 2002: 53). If the JCPA was to be at all effective then Beauchamp's approach was not unreasonable. There was also a case to be made for Boyle's reproach over the use of unsourced leaked information. However, this information provided the background for lines of questioning for the Committee and there were plenty who were prepared to give information on-the-record to the inquiry.

By September of 1982 Beauchamp was invited by the Secretariat to find other employment. Three years later Beauchamp wrote an article for the Rupert Public Interest Movement magazine *Matilda* that described her period of employment with the JCPA and her understanding that Boyle worked for ASIO and her suspicion that he was spying on her activities (Beauchamp 1985: 42). Boyle was effectively 'outed' by Beauchamp and he considered taking an action

for defamation, but the magazine closed down shortly afterwards (Boyle *pers. comm.* 2003).

Lest it be thought that whistleblowers would have a safe space to air their grievances in a committee of inquiry, Senator Gareth Evans, writing in 1982, sounded a timely warning. On the one hand, parliamentary committees of inquiry were in a position to force accountability on the most recalcitrant ministers and senior managers (Evans 1982: 83). On the other, senior managers could intimidate and deter witnesses from the lower ranks of the organisation from writing submissions to the committee or blowing the whistle (Evans 1982: 90).

What distinguished this from previous parliamentary inquiries was the number of people who, in the face of intimidation, were still willing to give evidence. Reflecting on his reasons for this disclosure, John Kelly thought a public inquiry would give the Department of Health sufficient resources to improve the system (Kelly *pers. comm.* 1995). Commenting more generally on the motives of the whistleblowers, he said,

I suppose we would all have been quiet if there had been a commitment to cover-up and to change but there was no such real commitment. They just wanted to cover it up...It was the troops versus the Senior Executive Service (Kelly *pers. comm.* 1996).

John Kelly estimated that at least ten other officers gave information to the Committee (Kelly *pers. comm.* 1995). Commenting on this willingness to make

disclosures in the public interest, one witness to the inquiry, Professor Lou Opit said,

It should be publicly acknowledged how important it was that people spoke out... without them there would have been no inquiry. That the whole thing happened was a bit of fluke, some people, not at all senior, stuck their necks out (Beauchamp 1984: 24).

John Kelly

Where previously Kelly had been circumspect in his handling of confidential information, he was now outspoken before the Committee. Kelly argued that severe restraints on resources hampered the effectiveness of his section. The problem of overservicing needed to be dealt with and monies needed to be allocated for more staff and their training (JCPA Vol. 2, 27 July 1982: 721). Of particular concern was that some of his current staff feared losing their positions (JCPA Vol. 2: 727). The Department's most senior officers were sceptical that the abuse of medical benefits was fraud and overservicing was a problem and had made no effort to request additional staff. The lack of staff was making Kelly's work particularly difficult. Senator Georges observed, "Kelly's job at the present time is impossible and has been impossible for some time" (JCPA Vol. 2, 27 July 1982: 741).

When Dr. Gwyn Howells prevaricated on Committee questions on the department's lack of written briefings given to Michael MacKellar, in his first seventeen months as Minister for Health, Kelly contradicted Howells and said that a briefing for the Minister had been prepared, but had been cut at a senior

departmental level (JCPA vol. 8 1982: 3126). Howells, in a comment that expressed his indifference to the question of ministerial briefings said, “There is no officer still preparing the monthly reports [for the Minister], to the best of my knowledge. If there is I will transfer him to somewhere more useful” (JCPA vol. 8, 27 October 1982: 3158). Senator Georges supported John Kelly’s analysis of the problem, as it was articulated in the deleted paragraphs of the brief, and said it was in line with the conclusions being reached by the Committee (JCPA Vol. 8: 3144).

In reference to the apparent criminality evident in the Victorian branch of the Department of Health, both Dr. Gwyn Howells (JCPA vol. 8, 27 October 1982: 3192 and 3192) and the Divisional head, Dr. Chris Selby Smith, denied any evidence of criminality. John Kelly was asked his opinion on this allegation, and he replied,

To me corruption involves not doing one’s duty or being swayed by position, advantage or whatever, not necessarily money. In that context I have to take the opinion that there is corruption in the Department of Health (JCPA vol. 8, 27 October 1982: 3197).

In saying this Kelly had given the sort of answer neither Howells nor Selby Smith would have wanted to hear, nor would they have gained much pleasure by its reproduction, the next morning, on the front page of the newspapers *The Sydney Morning Herald* (Hewett 28 October 1982: 1), *The Age* (Davis & Gordon 28 October 1982: 1) and *The Canberra Times* (28 October 1982: 1).

Roy Harvey

Roy Harvey was a former head of the data management operations section of the Health Insurance Commission, and at the time of the inquiry, was a part-time advisor to the Committee and a Research Fellow at the Australian National University (JCPA Report 203 1982: 141). He saw the area of greatest need in the fight against fraud and overservicing as the necessity for administrative changes in the Department of Health. He believed that unless the management structure was improved all other reforms would be of little benefit (JCPA vol. 6: 14 September 1982: 2088). In his written submission to the Committee Harvey said,

The Department has demonstrated a capacity for identifying obstacles that stop it achieving its objectives and has demonstrated an incapacity for acting to remove these obstacles (JCPA vol. 6: 14 September 1982: 2088).

The Department, Harvey said, had demonstrated little sense of urgency in regard to the situation. There was a lack of basic data and insufficient provision for analysis of available information and this meant that there were few prosecutions.

Staff from the Department of Health in Western Australia

Despite the lacklustre performance of most of the state branches of the Department of Health those in New South Wales and Western Australian were able to make inroads in the fight against fraud and overservicing (CPD HR Vol. 130 9 December 1982: 3286). Four staff members from the Department of Health

in Western Australia appeared 'in camera' before the Committee, in the hope that their experience and ideas could help improve "this slow moving, cumbersome sort of system" (JCPA, 6 August 1982, vol. 9: 3454). They were Dr. William Wilmot, director of the Commonwealth Department of Health in Western Australia, Rodney Adams, Assistant Director, Health Benefits and Services Branch, Alan Hodder, Senior Investigator, Claims, Review and Investigation and Dr. William Smart, Medical Counsellor for Western Australia. Dr. Wilmot's concerns were focused on the failure by the Department of Health to deal adequately with overservicing. Many doctors, he argued, were so locked into overservicing that their medical practices would fail without this source of revenue (JCPA, 6 August 1982, vol. 9: 3454). The mechanism to deal with this, the Medical Services Committees of Inquiry, in Western Australia were, in his opinion, a waste of time (JCPA, 6 August 1982, vol. 9: 3449).

In regard to the legal issues, Alan Hodder argued that having to deal with the Australian Federal Police only increased the inefficiencies in an already inefficient system (JCPA, 6 August 1982, vol. 9: 3412-3415), and he recommended dispensing with the AFP altogether (JCPA, 6 August 1982, vol. 9: 3441).

On the problem of the evidentiary nature of the law, Mr. Justice Toose raised the possibility of "using devices such as those contained in the *Customs Act*, of averments against people and deeming them to be proved, thus putting the

onus on the accused" (JCPA, 6 August 1982, vol. 9: 3456). This was the first time that this idea was presented, but those before the Committee were not versed in this aspect of the law and offered no comment. Alan Hodder suggested that the court hearings should be away from the usual courts. He suggested that they be heard by a judge sitting alone in a federal Court. In other types of court hearings the evidence was too complex for the jury to understand. If the matter goes before a magistrate then penalties do not match the crime (JCPA, 6 August 1982, vol. 9: 3456).

Joe Shaw and Garry Patterson

Two witnesses who didn't appear before the Committee were Joe Shaw and Garry Patterson. Shaw made a request to appear before the inquiry but it was declined (NAA: A983/1, 1982/903). Garry Patterson was executive officer in charge of investigations in the medical fraud and overservicing area of the NSW office of the Commonwealth Department of Health. Patterson was successful in gaining prosecutions against doctors for fraud in NSW. In mid 1981 Patterson was given the task of training investigators in the other states. It was then that he came across problems in the Victorian division. The Director of Health in Victoria was not assisting investigations, in fact, he was tipping off doctors under investigation. Patterson also uncovered corruption among Australian Federal Police at Sydney's Redfern office and the fraud of Commonwealth benefits in Sydney nursing homes (Beauchamp 1985: 44; Patterson *pers. comm.* 1995).

Patterson was due to appear as a witness before the Committee on 4 August 1982. He was threatened with losing his position if he was critical of the Department of Health or the NSW Division of the Federal Police, before the Committee. He had also received death threats. Even with this level of stress he was not permitted to appear before the inquiry 'in camera' (Beauchamp 1984: 28; Patterson *pers. comm.* 1995). He suffered a heart attack the day before he was due to give evidence to the PAC (Beauchamp 1984: 28; Haviland ACAO Report 1984; Patterson *pers. comm.* 1995; JCPA, vol. 3: 4th August 1982: 906), and left the Department of Health on an invalid pension (JCPA, vol. 10: 2 April 1984: 3796).

Dr. Charles Eccles Smith

Dr. Charles Eccles Smith was a medical counsellor, working in the Victorian office of the Commonwealth Department of Health. The Director of the Victorian branch, Dr. Ronald Webb, tried to discourage Eccles Smith from writing a submission to the Committee on the grounds that he would be contravening Section 130 of the *Health Insurance Act*, that in any case the department would be putting in a submission and that the Director General wanted uniformity of Departmental opinion and no dissenting judgment (JCPA vol. 9, 1982: 3372). No invitation was extended to Charles Eccles Smith to submit material for the Department's submission (JCPA vol. 9, 1982: 3373).

Eccles Smith proceeded to write his own detailed critique of the Victorian division of the Department of Health's Claims and Review section. The section, he argued, was poorly organised and a lot of the review work was done on an

ad hoc basis (Eccles Smith *PAC Submission* 1982: 36). It was understaffed and the existing staff were frustrated and discontented (Eccles Smith *PAC Submission* 1982: 24). It was common to find widespread abuse of itemization by the medical profession (Eccles Smith *PAC Submission* 1982: 27). One example of this was contained in a letter of complaint sent to the Minister for Health from the controversial public figure, Dr. Bertram Wainer, who objected to an investigation conducted by Charles Eccles Smith into Wainer's misitemisation of ultrasound procedures (*see Attachment*). Wainer claimed that he should have been given a clear warning that he was abusing the system, when in fact it was Wainer's responsibility to ensure that he was billing correctly (Eccles Smith *PAC Submission* 1982: 33).

Some of the legal problems included the long delays from the time the Australian Federal Police received a file to it proceeding to the Deputy Crown Solicitor's office and even longer delays for it to proceed to prosecution (Eccles Smith *PAC Submission* 1982: 26). The Committee asked him if he thought there was deliberate collusion between the Director-General of Health and the Superintendent of the Australian Federal Police to frustrate the prosecutory process. He said this was not the case rather these needless delays were a symptom of "the lethargy of the public service" (JCPA vol. 9, 1982: 3392). In his judgment the punitive effect of prosecution was totally ineffective (Eccles Smith *PAC Submission* 1982: 31). Like Dr. Ken Doust he was perplexed by the lack of any legal basis for the recovery of monies taken through fraud and

overservicing, with the doctors being aware of this deficiency (JCPA vol. 9 1982: 3351 and 3355).

The leaker

On the first day of the Committee's hearings it was announced that there would be no discussion of forty-one files (JCPA vol. 1, 1 July 1982: 303) that were seized by the Australian Federal Police from the Victorian branch of the Commonwealth Department of Health, following an anonymous complaint that a staff member of the department had been taking kickbacks. The Chairman of the Committee, David Connolly, said that the Committee would not be questioning the Department on the files as the citing of names of doctors could prejudice police investigation or the trials of those mentioned in the files (JCPA vol. 1, 1 July 1982: 303).

When the Committee did question members of the Victorian branch of the Federal Department of Health, indeed there was no mention of the files, but lacking as well were any probing questions of the Department relating to its conduct of investigations. It was noticed that procedures were run on an *ad hoc* basis (JCPA Vol. 4. 5 August 1982: 1355), there was a breakdown in the communications between the counsellors and the investigators (JCPA vol. 4. 5 August 1982: 1391) and that a low priority was given to the process of recoveries through the Claims, Review and Investigations Section (JCPA vol. 4. 5 August 1982: 1371). Added to this, the Chairman had difficulty in getting

clear answers on resource allocation from the Director of the State branch, Dr.

Ron Webb

When I ask you specific questions about your degree of determination as the senior officer of the Department in this State as to how of you utilise resources, I have frankly not received any response from you that makes much sense to me (JCPA vol. 4. 5 August 1982: 1399).

Someone frustrated with the inability of the Committee to deal with the entrenched problems of the Victorian branch took it upon themselves to leak the police report of the files to *The Age* newspaper. On the 11 September *The Age* newspaper's investigative unit, the Insight team, reported on the medifraud issue. The story entitled 'Medifraud Cover-Up Suspected' was a significant intervention into the political debate. The most serious problem uncovered by the Federal Police was that senior officers checking doctors for overservicing or fraud had failed to refer to the Federal Police cases where there was evidence of fraud (Smith *The Age* 11 September 1982: 1). On 13 September *The Age* followed this with "Medifraud: A Tale of Political Failure", which was compiled from "leaked government documents, reports that are on the public record, other reports with more limited circulation including attachments to Cabinet submissions and from interviews with Health Department personnel". It noted that staff investigating fraud and overservicing had fallen between 1978 and 1982 and that there had been a failure by the government and the bureaucracy to support the computer system, which analysed claims, the Fraud and Overservicing Detection System (FODS) (Smith *The Age* 13 September 1982: 1 & 3).

The leak of the Victorian files put pressure on the government to complete an interim report earlier than expected (*SMH* 13 September 1982: 3; *The Age* 14 September 1982: 1). A task force, headed by an officer from the Department of Prime Minister and Cabinet, was brought in so the report could meet the new deadline (*SMH* 18 September 1982: 3).

Recommendations of the Joint Committee of Public Accounts - 1982

By December of 1982 the interim findings of the Committee were published as the 203rd Report of the Joint Committee of Public Accounts. Its forty-five recommendations vindicated the principled stand taken by the Committee's whistleblowers and leakers.

Among the Committee's main recommendations were that the senior management structure should be reviewed, and that lines of responsibility be clearly delineated. Adequate management information systems should be introduced and additional resources be allocated for the detection and prosecution of those suspected of fraud and overservicing (*JCPA Report 203*, 1982: 6). Additional staff should be allocated to the development of Fraud and Overservicing Detection System (FODS) and staff should be given adequate training. There should be an integrated investigation section. The Medical Services Committees of Inquiry should be abolished and replaced with Medical Benefits Tribunals in each state (*JCPA Report 203*, 1982: 12). The Committee recommended that new legislation be proposed that automatically disqualified

doctors from medical benefits who were found guilty of overservicing, so as to bring it into line with the penalty currently applying to doctors who committed fraud (JCPA *Report 203*, 1982: 13). It also recommended that final year medical students be given compulsory training in medical ethics, health economics and the law associated with medical practice (JCPA *Report 203*, 1982: 13).

Progress Report 203 noted that, in regard to the problems in the Victorian office, departmental officers had sought to minimise any action that would be taken against doctors suspected of abusing the medical benefit scheme, and had used counselling sessions as an early warning mechanism to doctors that they were under investigation. It found that many of the cases were not referred to the Australian Federal Police, even where it was apparent that the Department of Health believed that criminal offences had been committed (JCPA *Report 203*, 1982: 48). Of the forty-one files, two police officers assigned to the case found evidence in thirteen cases of a Department of Health officer condoning matters, which on investigation may have revealed offences of a criminal nature. The Committee recommended that investigations should be pursued in respect of possible breaches of *The Public Service Act* and *The Crimes Act* (JCPA *Report 203*, 1982: 7). The Committee was alert to the discrepancy between the findings of these two police officers and the position taken by the Director-General of Health and the Deputy Commissioner of the AFP, who said there was no evidence that any officer of the Department of Health had committed any criminal offence (JCPA *Report 203*, 1982: 50-51).

The Finance Minute, Report 212, published in November 1983, brought to light that the Director-General of Health, Gwyn Howells, had asked the AFP to examine not only the thirteen files that were of interest to the Committee, but all the files held in the Victorian branch of the Department of Health relating to fraud and overservicing, and all the files in the Central Offices of the Department: a total of 1,600 files. In the face of this unnecessary procedure, the Acting Commissioner of Police requested further clarification from the Chairman of the Committee to determine the extent of the inquiries (JCPA *Report 212*, 1983: 24). The outcome was that no evidence of misconduct, as defined under the Public Service Act, was uncovered. In regard to any breaches of the *Crimes Act*, the matter was left with the Australian Federal Police (JCPA *Report 212*, 1983: 23).

Consequences – for politics and the media

1982 was a year of increasing weaknesses for the Fraser administration. It was the seventh year of the coalition government: a government whose authority was diminished by a progression of political scandals (Gratten *The Age* 13 September 1982: 13; Hewett *SMH* 13 October 1982: 7). A weakened government provided an opportunity for the Opposition to add its weight to demands for administrative reform. In federal parliament, the Shadow Minister for Health Dr. Neal Blewett's expertise in health policy was evident, as he delivered a critique of the Liberal government's management of fraud and overservicing (CPD HR 129, 1982: 1793; *The Australian* 24 September 1982: 4; *The Canberra*

Times 24 September 1982: 10). He saw responsibility lying with the Department of Health and the relevant Health Ministers. The Department of Health was encumbered with “a rather aging elite”, out of touch with modern technology as an essential tool in regulatory management. Needed was a “sense of overall cohesion and direction” and immediate action to curb the apparent abuses against medical benefits (CPD HR 129, 1982: 1795).

Newspaper columnists expanded on the criticisms outlined by Neal Blewett in Federal Parliament. They condemned the performance of the bureaucracies in controlling fraud and overservicing. Michelle Grattan, of *The Age* newspaper, wrote that senior management of the Department of Health, in their statements before the public accounts committee, revealed their lack of interest and understanding of this regulatory function. The area was inadequately staffed. There was a lack of direction from the Central offices to the States, in how they should handle fraud and overservicing, and hence, large discrepancies in the competency of the various State branches in their handling of the issue. But not only were there deficiencies in the performance of the Department of Health: the Crown Solicitor’s Office and the Australian Federal Police were also inefficient and under-resourced (Grattan *The Age* 20 September 1982: 9). Paul Kelly in *The Sydney Morning Herald* commented “huge revenue has been lost during the entire period of the Fraser government as bureaucrats failed to make a concerted effort to plug the holes and ministers failed to assert such a policy priority” (Kelly, *SMH* 7 September 1982: 7).

If it could be said that there were any beneficiaries in the conflict between parliament and the executive and between senior and middle management of the Department of Health, then it was the Labor Party and the media. The conflict ensured that health policy was before the public eye, in the year leading up to the 1983 federal election: an election that brought Labor to power and the reinstatement of universal health insurance. Neal Blewett, reviewing these events, said

No area of Australian social policy has been more considered, debated and fought over in the last decade than health insurance. That battle continued unabated through 1982 and was one of the clearest areas of delineation between the parties during the election campaign (Address, Sydney University 22 July 1983. Cited in Sax 1984: 74-175).

Michael Smith, an investigative journalist with *The Age* newspaper's Insight team during this period, speaking on behalf of his newspaper said, "Medifraud was a great issue for the paper. *The Age* had been vigorously following white-collar crime in all areas and was active in following the health debate". The accusation that the press was deliberately undermining the Fraser government was one he denied, but he acknowledged

this is a common belief, but a misconception. Any government in decay will do things that deserve kicks. The whistleblowers and leakers get more aggressive in the face of a weakened government. They now have the opportunity to do something that will be effective and make a difference. So it is not so much the journalists doing the kicking as the sources (Smith *pers. comm.* 2000).

Consequences – senior management of the Department of Health

The ranks of senior management of the Department of Health thinned in the period 1982 to 1983. Charles Nettle, Deputy Director-General of Health, retired during 1982. The Director-General of Health, Dr Gwyn Howells, took the option of early retirement and left the Department by the end of the same year (*The Age*, 15 November 1982: 3; *Australian Financial Review* 16 November 1982: 3). Matt Carroll, Deputy Director General, retired in 1983 (*Annual Report Department of Health* 1983-84: 153). Dr. Ronald Webb, Director of Health, Victoria, retired at age 58 in 1983 (*Annual Report, Department of Health* 1983-84: 53). There had been a perception that the permanent head was seen as being too closely aligned to his own profession, a profession that the department was meant to be regulating. In a change not warmly welcomed by Dr. Gwyn Howells (Howells 1990: Oral TRC 25/4, NLA: 6), the new departmental head was drawn from the ranks of the senior public service. The appointment broke the tradition of the Department of Health being headed by a medical practitioner (Ormonde *The Age*, 24 November 1982: 5; Waterford *The Canberra Times*, 24 November 1982: 31) and marked the first step in the de-professionalisation of the Department of Health (Howells 1990: Oral TRC 25/4, NLA: 6).

Chris Selby Smith, who at the time of the PAC inquiry was First Assistant, Director-General of the Medical Benefits Division of the Commonwealth Department of Health, believed that the PAC inquiry, allied with continuous media reportage, had a dampening effect on staff morale and on staff

recruitment in the Health Ministry. He speculated that talented people would have been deterred from pursuing a career in this agency if it involved a risk to their career prospects. It was a situation where a job well done will not necessarily be defended. And a poor job will certainly be exposed (Selby Smith *pers. comm.* 1996).

Consequences – whistleblowers

The ranks of the whistleblowers also thinned, but more slowly. John Kelly, Garry Patterson and Dr. Charles Eccles Smith were among the casualties of this protracted bureaucratic war. Senator Georges was well aware of the vulnerable position that John Kelly had placed himself in by his disclosures and said “any sort of recrimination which may be directed to him would certainly be taken very seriously by the Committee” (JCPA vol. 8 1982: 3145). Notwithstanding this injunction, John Evered recalled that Gwyn Howells hated Kelly for the impact that his actions would have on the Department, and the Department in its turn reciprocated with harsh treatment of Kelly (Evered *pers. comm.* 2001). His work colleagues regarded him with animosity and disdain. He was excluded from departmental programs requiring his expertise. Kelly was promoted from Class 10 to Class 11 in the surveillance branch at the behest of the Lawrie Willett, Director-General of the Department of Health. This was to ensure that charges of victimization could not be laid against the department (JCPA Vol. 10, 2 April 1984: 3796). However, Kelly lost a key promotion, lost the appeal and was unsuccessful in his application for a position in another government department.

It was, he said, a process of “day-by-day harassment, day-by-day fighting”, where “everything was a struggle” (Kelly *pers. comm.* 1995). After two years he resigned (Beauchamp 1984: 27; Kelly *pers. comm.* 1995). George Repin, who was convinced that Kelly was unable to translate the statistical evidence of overservicing to the real world of medicine, where there were often feasible explanations for aberrant practice, said with satisfaction “we finally got rid of Kelly” (Repin *pers. comm.* 2002).

Roy Harvey felt that Kelly could have survived had he not taken on Gwyn Howells, “a very authoritarian man”, and challenged him in front of a committee of politicians (Harvey *pers. comm.* 1995). Whether Kelly’s survival was possible is a matter for conjecture. But Harvey’s own position was secure. He had left the Health Insurance Commission some years earlier, and in blowing the whistle, had done so from a safer vantage point.

For Kelly it was difficult to achieve closure on blowing the whistle: the harassment against him continued after his resignation. Kelly’s superior officer had been Chris Selby Smith, then First Assistant Director-General, Medical Benefits Division in the Department of Health. In the 1990s, Selby Smith, now with a professorial appointment at Monash University, wrote two articles “Public Service Ethics in Conflict Situations – Public Servants, Ministers, Parliament and the Public” (1991) and in conjunction with Professor David Corbett, “Parliamentary Committees, Public Servants and Due Process” (1995), in the *Australian Journal of Public Administration*. Here he attempted to

demonstrate that he had been defamed by Kelly's corruption allegation (JCPA vol. 8, 27 October 1982: 3197), and had sought legal advice for a defamation action (Selby Smith 1991: 11).

Dr. Charles Eccles Smith, a medical counsellor working in the Victorian office of the Commonwealth Department of Health, also was harassed. There were death threats made to Eccles Smith and his family by people associated with the Tasmanian branch of the AMA. Dr. Howells' reaction to a report on these incidents was to throw the information in the waste paper basket. The Committee was not impressed (JCPA vol. 9 1982: 3376).

Eccles Smith was fortunate in that his personal circumstances differed from the other whistleblowers and so the outcomes were different. He was two and a half years from retirement and said he would be standing by his strongly held views. Workplace retaliation was something he both anticipated and could manage. "I am not a young career officer. There is already a chill wind blowing around and I can weather that" (JCPA vol. 9 1982: 3529-3530).

Official views on whistleblowing

From time to time senior officials have offered their suggestions to public servants for dealing with institutional malfeasance. The Coombs Royal Commission recommended,

Giving weight to the judgment of peers, in counselling, in ...obtaining advice from appropriate, independent, senior statutory office-holders in central agencies (RCAGA Report 1976: 25)

One set of guidelines on ethics from the perspective of public sector management was sympathetic to the ethical conflicts faced by public servants, but suggested that blowing the whistle was neither “a correct nor prudent course of action” (O’Faircheallaigh, Wanna & Weller 1999: 242). The authors went further than the Coombs Royal Commission by suggesting that these whistleblowers might use the threat of covert action to release unauthorised information to the media,

One might involve the sharing the information with peers and close supervisors on a confidential basis, followed by a joint approach a senior official or minister, as appropriate, bringing the matter to their attention and pointing out that a damaging leak is likely to occur at some stage unless appropriate remedial action is taken (O’Faircheallaigh, Wanna & Weller 1999: 242).

Those who have studied the sociology of whistleblowing would not regard this advice as presenting a correct or prudent course of action (Lennane 1996; de Maria 1999; Martin 1999: 48–49). The use of official channels leaves informants unsupported and unprotected. Taking priority over the valid claims of complainants is the need for officials to protect hierarchy and authority (Martin 1999: 52).

Lawrie Willett became the Director-General of Health following the early retirement of Dr. Gwyn Howells in November 1982. In September of 1984 he

issued a memorandum to all staff cautioning against the disclosure of official information, whether by leaking or whistleblowing. These disclosures are, he said,

Damaging to the public interest because they may provide an incomplete, and sometimes distorted and misleading view of a problem or situation. They may also detract from the willingness of individuals or outside bodies to provide the Government with essential information and they may be wasteful in terms of the time, and public funds, that may have to be extended in attempting to clarify a situation which has been incompletely exposed (see Appendix).

In 1991 Willett was appointed General Manager of the Health Insurance Commission. In response to a request from the Select Committee on Public Interest Whistleblowing in 1994, for a submission on whistleblowing, he wrote, “the public interest is served sufficiently by the process of scrutiny and review to which the Commission [HIC] is already subject”. But if a new person or body were to be considered to protect whistleblowers then,

There is much to be said for disclosures being made to a Parliamentary Commissioner so that any investigations of disclosures and the protection of any witnesses might properly fall within the ambit of Parliamentary privilege (Willett *‘In the Public Interest’ Submission 1994: 6 & 8*).

Willett found, on assuming the Managing Directorship of the HIC in 1991, that the organisation had not been managing fraud and overservicing. He was concerned that the issue “could go bang in the night”, that the media, with its unexpected and unpredictable demands for accountability, could revisit this politically contentious issue. In order to protect the organisation from the

prying eyes of journalists and parliament, he believed that fraud and overservicing had to be reviewed every four to five years, with effective systems securely in place (Willett *pers. comm.* 2002). John Evered recalled that when Willett became a commissioner he was instrumental in setting up a sub-committee of the Board, the Fraud and Services Audit Committee, to ensure that the Board was overseeing this area. On becoming managing director Willett commissioned an independent review of the area by consultant, Harvey Bates. As Evered explained

The reason he wanted an independent review was to assure himself that the function would stand up to public scrutiny. And he wouldn't find that he had a repeat of what had happened to him as head of the Department of Health, where he was caught up in machinations because the function wasn't seen as operating as well as it should be. He wanted to be certain that this function worked and worked well, because he knew that it was always going to be vulnerable to public criticism (Evered *pers. comm.* 2001).

In this fashion, journalists had ensured "media justice" by forcing public authorities to take control action (Ericson *pers. comm.* 1999). By the 1990s the whistleblowers were silenced, but reform was now management driven

Chapter 6

Medicare and medical militancy: 1983 to 1985

Health is a bottomless pit. Health ministers should get up and say if people want modern medicine they are going to have to pay for it and they are going to have to pay dearly for it. We could spend the whole of our GNP on health and we would probably improve health care by about 10 per cent.

Dr. Dermer Smith, *Joint Committee on Public Accounts*, 23 October 1985, Vol. 16: 6136

Introduction

In 1982, the contours of medical politics were shaped by whistleblowers, the media and parliamentarians in their campaign to restrict the financial abuse of medical benefits. The subject of this chapter concerns the years that immediately followed when the fraud and overservicing issue spread to other theatres of medical politics, and became more complex and divisive. From a single issue which was the preoccupation of a parliamentary committee it developed into a protracted public dispute between the federal government, the New South Wales and Australian Capital Territory governments, the federal

AMA and the New South Wales branch, the specialist medical colleges, and the Public Medical Officers' Association of New South Wales (Gray 1990: 228).

The Federal Labor government, in an attempt to control the alleged overservicing in pathology and radiology in public hospitals, introduced a controversial amendment to the *Health Insurance Act*. The amendment, known as Section 17, had the acceptable aim of attempting to ensure accountability in health expenditures, by the unacceptable method of requiring doctors working in public hospitals to sign contracts so their patients could receive medical benefits. This measure would mean that doctors would no longer be private contractors but salaried employees of the state (Penington June 1984: 3). The New South Wales Labor government, with a convincing electoral win behind it, supported the federal government by way of complementary legislation. This was the introduction of Section 42 to the *Public Hospitals Act*, which was aimed at increasing government control over public hospitals (Daniel 1990: 109). Medical practitioners were incensed. Politically active doctors mobilised to defend the profession and were joined on the battle lines by colleagues many of whom had no previous interest in medical politics (Penington September 1984: 7).

What had started as a perception of overservicing of diagnostic services in public hospitals led to the implementation of inappropriate legislation by the government and protracted industrial action by doctors. The hostilities ended in defeat for both governments on this issue and a moderation of regulatory

regimes to effectively deal with fraud and overservicing. It meant that key recommendations of the Joint Committee of Public Accounts Report 203 on fraud and overservicing were not implemented. This was a triumph for *Realpolitik* over the findings of the independent arm of government, the parliamentary accounts committee, whose work was now irrelevant. It meant that with the spiraling cost of the health insurance system federal cabinet considered cutting the Medicare rebate, but had become uninterested in dealing with a principal cause of cost over-runs, the financial burden of the abuse of medical benefits (Oakes *The Bulletin* 5 March 1985: 35). These events were situated in the specificities of the economic conditions of the 1980s, a change of government at the federal level in 1983 and subsequently new directions in Commonwealth and state health policies.

Australia's deteriorating economic position

The continuance of the long post war boom provided a favourable economic environment for the implementation of Whitlam's social reforms. However, by 1974 inflation had reached 14 per cent (Keating 1987: 178-179; Costa and Duffy 1993: 127), and in the following year, Treasurer Bill Hayden's budget was one that acknowledged the need for economic restraint. Malcolm Fraser took advantage of Labor's economic policy weakness to promote the coalition party's claims for superior economic management to his electoral advantage. However after Fraser's first term of office, he too lost the battle for fiscal austerity. By his last term of office, real spending increased, the deficit grew to \$9.6 billion (Walsh 1995: 37; Henderson 2003: 43) and against a background of

international stagflation, an under-performing domestic economy and drought came the recession of 1982 (P. Keating 1987: 180).

Paul Keating, Treasurer in the Hawke government, believed that the Fraser government had been over reliant on the resources boom as a way to cushion the effects of a world economic downturn. The trade union movement, encouraged by the prospect of an economic revival, pressed its demands for wage increases. In 1981 the average wage increase was fourteen per cent and in 1982 it was thirteen per cent. This resulted in double-digit inflation, high interest rates and a widening current account deficit. The consequence of this was that gross foreign debt climbed from eleven to twenty one per cent of Gross National Product in the period June 1981 to June 1983 (Walsh 1995: 54-55). The onward march of inflation met the disapproval of the government's economic advisors who warned of its dangers to the economy throughout the 1980s (M. Keating 1993: 27).

Robert James Hawke brought the Labor party to electoral victory in March 1983. The economic lessons learnt during the Whitlam and Fraser years informed Labor's thinking and framed the life of federal Labor governments for the next thirteen years. The goal was the transformation of Australia's economic base to avert a fiscal crisis (Kelly 2001: 148; Moore 2003: 113-114). This was to be achieved through budgetary restraint to prevent a deficit blow out (Hawke 1994: 174) and the restoration of the private sector as the engine of recovery (P.

Keating 1987: 183). Hawke defined his administration by the values of sound economic management and economic growth (McMullin 1991: 412; Hawke 1994: 169). These were not the values of a one-term government but a program requiring the expansiveness of time and a long period of governance (Kelly 2001: 150).

Neoliberalism

However, many in the Labor Party were uneasy that its traditional values of the public ownership of banks, industry protection, state intervention, equity and social justice were being moved sideways by the new economic ideology, neoliberalism. Now Labor's values included deregulation of the Australian dollar, deregulation of the financial markets, privatization, micro-economic reform, tariff reductions, and changed work practices (Pusey 1991: 135; Costa & Duffy: 1993: 19; Walsh 1993: 285). But not everything was left to the market; the hand of government intervention was still visible. There was the retention of minimum wages, industry awards, centralised wage fixing (Watson 2002: 88), and the introduction of a range of social policies. National health insurance was restored in the form of Medicare; there were improved social security provisions, a doubling of funds for public housing and the creation of a Community Employment Programme (P. Keating 1987: 182). This was to support those in need at a time when permanence of employment was no longer the norm (Kelly 2001: 89). It was neoliberalism with a soft edge. These policies were not without their critics. Many within the Labor Party were hostile. It brought caucus to the verge of revolt (Blewett 2003: 77), but Keating

defended these policies on the grounds that Labor had not lost its way, rather from 1983, had found a 'third way', long before its articulation by Anthony Giddens and Tony Blair (Kelly 2001: 88; Moore 2003: 114). He argued

These reforms...do not represent a grafting of conservative thinking onto Labor administration. Rather...they contribute to the capacity of the economy to support the social reform programme (P. Keating 1987: 185).

From another quarter, Health Minister, Dr. Neal Blewett was aware that the maintenance of Keynesian economic philosophy in the form of publicly funded health insurance would draw antagonism from two of the central agencies, Finance and Treasury. As he explained

both Finance and Treasury disliked Medicare because it ran against the prevailing orthodoxies of the time, which was that government should be getting out of these activities rather than getting into them (Blewett *pers. comm.* 2002).

In a world of new economic thinking, social programs like Medicare were accommodated in a program going in the other direction (McKnight *pers. comm.* 2003).

In the Hawke government Federal Cabinet's most important committee was the Expenditure Review Committee (Willis 2003: 144). It assessed government resource allocation, and was in Blewett's estimation giving closer scrutiny every year to the health budget than all the other portfolios combined (Blewett *pers. comm.* 2002). Notwithstanding the pressures from this Committee and Treasury

to make savings in the Health area, Paul Keating and Finance Minister Peter Walsh supported the Medicare program. Keating favoured it for political reasons and Walsh for financial ones. Walsh was convinced that in terms of saving money for the community as a whole not just for government, Medicare was the most effective way to run health policy (Walsh 1995: 139-140; Blewett *pers. comm.* 2002). An expensive social welfare program like Medicare needed the combined political support of Hawke, Keating, Walsh and Blewett in ERC meetings as well as the articulation of imaginative ideas for trimming its costs. It was judged that there were savings to be made from the enforcement of rules regarding overservicing. Blewett's officials and Finance officials would confer on the savings that could be achieved from the effective policing of this abuse of medical benefits and estimate what was a reasonable amount and agree on it (Blewett *pers. comm.* 2002). If there were any savings here they were negligible. Overall this was a peculiar arrangement considering that the Medical Services Committee of Inquiry that investigated overservicing was so ineffective that the Public Accounts Committee recommended on more than one occasion that it be replaced. Walsh was not convinced and called them soft options. More success was achieved with other measures like the reductions in radiology and pathology fees in the light of technological change, eliminating the subsidy to private hospitals and the financial restraints imposed on the State public hospital system by the 2nd Medicare Agreement of 1988 (Blewett *pers. comm.* 2002). Running counter to these avenues for possible savings were two in-built

features of the health industry, health care inflation and moral hazard, a problem inherent in insurance.

Health care inflation and moral hazard

The health care industry provides a service, which has inflationary components built into it (Zubkoff 1976: 1-4). This type of inflation means the share of Gross National Product devoted to the costs of health care grows steadily with the passing years, a problem common to most Western countries (Richardson & Wallace 1989: 2)¹. Factors driving health care inflation are the success of medicine in achieving positive health outcomes; this success generates increasing demand, which in turn drives advances in the medical sciences and innovation in costly medical technology. The market for health services is expanded by universal health insurance, which provides the largest possible pool of consumers able to avail themselves of medical care. Additional inflationary pressures come from medical practitioners who over order diagnostic services in an effort to protect themselves from litigation, to reduce diagnostic uncertainty or to personally profit by providing services that are not necessary for the care of patients. However, the abuse of medical benefits through fraud and overservicing is an under recognised factor of health care inflation due to the paucity of data on fraud loss rates (Sparrow 2000: ix).

¹ The annual growth of total health spending after inflation was 5.4 per cent between 1997-98 and 2001-02 (*The Australian* 3 November 2003: 19).

The continuing growth in the demand and supply of health services is a fundamental weakness of health insurance. The quantity of services demanded and supplied is not kept in check by price mechanisms. This moral hazard gave politicians and health policy advisors pause for reflection, but its importance was diminished in the context of other political objectives. Peter Walsh and Neal Blewett were aware of the steady rise in medical services per capita (Blewett 1999: 40). Walsh argued that moral hazard was inescapable and “a function of insurance itself, unaffected by its private or public nature” (Walsh 1995: 140).

Labor’s health policy

In formulating its health policy in 1982 the political instincts of Labor were for the return to the financial simplicity and social equity of universal health insurance. It was a policy that enjoyed reverential status within the Party (Duckett 2003: 216) with few diminishing it with the label ‘middle class welfare’². It was a policy in tune with Labor policy and electoral sentiment and it carried the Hawke government into political office (Sax 1984: 175; Crichton 1990: 110; Palmer & Short 2000: 72).

² An exception was Bill Hayden who described it as “medical-class welfare reform and it favoured the medical profession” (Hayden 1996: 213).

Medicare replaced the health system of the Fraser government, whereby according to figures from the Australian Bureau of Statistics, nearly two million Australians were uninsured (CPD HR 132: 399), of whom one million were eligible for free care in the state hospital system and the rest paid for their own medical care as best they could. For the poor and the struggling Medicare offered a better option. For a family just above the income limits paying 7.2% of its total income for basic health cover there was now a one per cent levy on personal income tax (CPD HR 132: 400). The Liberal Shadow Minister for Health, Jim Carlton, protested that the cost of Labor's proposal would be \$1.7 billion per annum and that the current scheme with all its deficiencies could be remedied by simple legislation and some minor adjustments (CPD HR 14 September 1983: 735-737).

But Labor had taken a risk. Medibank had substantially contributed to the deficit in the Whitlam years and so carried a political vulnerability to be exploited by the opposition. But with a name change to Medicare, an alignment to the Prices and Income Accord and an agreement from the unions to exercise wage restraint Medicare was now linked to both social reform and sound economic strategy (CPD HR 132, 1983: 398; Palmer & Short 2000: 71-72). Policy weakness was now policy strength.

Medicare was also linked to improved strategies to manage fraud and overservicing. Neal Blewett outlined the design of the new system in federal parliament, in September 1983. It included amendments and regulations to the *Health Insurance Act of 1973*. He said there would be a single fund, the Health Insurance Commission, to administer Medicare and it would be in a position to accumulate accurate data on doctors' services (CPD HR 132, 1983: 409). Supporting this argument, Labor parliamentarian Roz Kelly said that the new Medicare arrangements would go hand in hand with the recommendations of the Public Accounts Committee, recommendations, which she believed the government would follow up (CPD HR 132 1983: 769).

What Medicare offered

Medicare was introduced in the context of an economy in transition: one positioned towards free market economics and globalisation; where markets would reward those in innovative sectors of the economy, where many would be left behind and the differences between the rich and poor would widen. Medicare would help bridge this gap. "It's a policy for everyone" said Paul Keating, evaluating Medicare's achievement as part of Labor's program for social equity (Kelly 2001: 89). In accordance with this ideal, the Labor Party's Medicare Advisory Committee developed firm proposals for the introduction

of Medicare (Sax 1990: 74), which were accepted by the government. They included a single public insurance fund that paid 85 per cent of doctors' bills, provided free accommodation in public hospitals and free hospital treatment for Australian citizens (CPD HR 132, 1983: 401). It meant the end of the means test for hospital usage and the end of a complex system of funding.

In order to compensate hospitals for revenue lost from private patients who now elected to be public patients the federal government provided block grants to the States (*Medical Practice* March 1983: 6; Sax 1984: 167, 176; Crichton 1990: 112). These grants gave the Commonwealth greater control over State health expenditures. Anne Crichton described it as "coercive federalism", a strategy which, aided by the support of Labor governments in four states and specific Medicare legislation, was intended to direct the hospital system towards greater cost efficiency and effectiveness (Crichton 1990: 112). What Medicare offered the federal government was greater control over the state hospital system and the medical profession.

The Medicare Advisory Committee had wanted to avoid the experiences of 1974 when salaried radiologists and pathologists left the public hospitals because they did not have rights of private practice. Medicare provided for medical benefits to be paid for diagnostic services for private patients in public hospitals. However, with pathology use increasing at the rate of ten per cent

per annum (Deeble 1991: 11), and public hospitals providing 41 per cent of pathology services, they felt that some control was required, and this was to be achieved through amendments to Section 17 of the *Health Insurance Act 1973* (McKay 1986: 221).

This was in line with the recommendations of four inquiries at Commonwealth and State level that had argued for more effective controls of such payments for services to private patients. When Blewett announced amendments to the *Health Insurance Act* he was acting in accordance with these recommendations (Penington June 1984: 1-3). This was a position in line with a Commonwealth Department of Health submission to the Penington inquiry, which argued that in regard to public hospitals there was “a potential for fraud and overservicing exists because of the lack of adequate administrative controls and peer review processes” (*Medical Practice* June 1984: 11). Bernard McKay, Director-General of the Department of Health, before the Public Accounts Committee, illustrated the savings that could be achieved in pathology costs in public hospitals. He knew of one medical superintendent who found when examining pathology costs that

one practice in his hospital actually had full blood count daily on patients, rather than taking a full blood count on the first day in hospital and then doing a haemoglobin for subsequent days...They reversed that practice and saved the hospital \$60,000 a year (JCPA vol. 15 27 March 1985: 5870).

What appeared to be reasonable and considered advice from different quarters was not however supported by the findings of an independent government inquiry into this issue under the chairmanship of David Penington, Dean of the Faculty of Medicine of Melbourne University (*AMA Annual Report* 1984: 8). The inquiry found management information systems were not in place to calculate the figures on the utilisation of diagnostic services in public hospitals. The inquiry took the view that these services were increasing at a slower rate than the private sector (Penington September 1984: 52).

The lack of information on how public hospital money was spent provided the Hawke government with major policy problems, but it has been an on-going feature of the Australian health system. John Deeble commented in 1991,

Some data could with difficulty be obtained about public sector activities from the records of hospital laboratories and other public authorities, but they would be scanty and are rarely compiled on a regular basis (Deeble 1991: 40).

In 2003 *The Australian* newspaper reported

Information technology in most public hospitals is woefully inadequate ...Perhaps the one issue that unites the health industry is the need for improved liaison between state and federal governments and greater transparency revealing where the dollars are spent (Pirani *The Australian* 8 September 2003: 12).

George Palmer and Stephanie Short too had observed shortfalls in data collection by the states and were of the opinion that the states were fearful that the Commonwealth would use such data to their detriment in the negotiations over federal funding to the state governments (Palmer & Short 2000: 312).

The Section 17 proposals were based on a number of premises that were not supported by the findings of the Penington inquiry. These were that health costs in public hospitals were rising in the area of pathology, radiology, computerized tomography, radiotherapy and nuclear medicine; that diagnostic specialists were charging private patients more than the scheduled fee; that visiting medical officers fees were excessive and that these doctors were not making an adequate contribution to the cost of the facilities they were using in public hospitals (CPD HR 139, 11 October 1984: 2162).

To correct these perceived problems, Section 17 proposed that the Minister would be able to control by Regulation and by Guidelines private practice in public hospitals, but these proposals offered no right of appeal through parliamentary scrutiny or through the Administrative Appeals Tribunal (Penington June 1984: 4). All accounts were to be raised by the hospital on behalf of the doctor, and this would make the doctor an employee of the state. There would be a national scale of charges for the use of hospital facilities. All hospital specialists would be subject to uniform income limits for providing

such services. Payment of specified diagnostic services would be subject to a contract between the hospital and the doctor rendering the service (CPD HR 132, 1983: 405). The legislation required States Governments to exclude doctors from public hospitals if they did not sign the contracts. (*Medical Practice* March 1984: 7). This threat of a lockout, observed Dr. Bruce Herriot, Medical Secretary of the NSW branch of the AMA, was not imposed on any other professional association or union and placed the Labor Government in an extraordinary position (*Medical Practice* July 1984: 6).

The AMA was totally opposed to these amendments to Section 17 of the legislation (*Medical Practice* March 1984: 7). Neal Blewett was totally opposed to changing the guidelines on the rights of private practice in public hospitals and he reiterated,

We plan to contain costs by reducing incentives for overservicing, particularly in high technology areas, so that neither the public hospitals nor the Medicare system can be exploited (*Medical Practice* March 1984: 7).

Blewett, while hoping for the smooth introduction of Medicare (McKay 1984: 223) was faced instead with the strident opposition of the medical profession to his proposals. This prompted one journalist to ask Blewett after his speech at the National Press Club, on the eve of the introduction of Medicare on 1 February 1984, to defend his policy on hospital contracts. He admitted that they were not necessary to the operation of Medicare and that he had been accused

of being unnecessarily provocative on the issue (Blewett 1984: 4). Surveying the situation in later years he admitted that the insertion of *Section 17* into the Health Insurance Act was a mistake as was the belief by the government that there would be no confrontation with the medical profession over Medicare. Blewett judged “I think possibly if there had been no *Section 17* there would have been a lot of guerrilla warfare, but there would not have been a major battle” (Blewett *pers. comm.* 2002).

Background to the response from the medical profession

The battle lines were already drawn. Medical specialists had been restive since the introduction of Medibank in 1975 (Sax 1990: 76). Prior to this time visiting medical officers freely gave their services to public patients in an honorary capacity and their income came from treating private patients in private and public hospitals. Only pensioners and low-income earners were eligible for free care. With the introduction of Medibank these honorary staff were now paid on a part-time salaried (“sessional”) basis and private patients paid their fees directly to their specialist. Part of the problem for doctors was that their earnings per hour under the sessional payments arrangements were substantially less than the amounts they would receive from fee-for-service treatment of private patients.

Under Medicare specialists working in public hospitals foresaw a loss of income, a loss of status and a measured advance towards nationalisation of the profession. Support for their predicament came from Jim Carlton, shadow Minister for Health when he argued in parliament that Medicare was “a major act of nationalisation ... [and] threatens the future of private medical practice by shackling doctors to a direct government payment system” (CPD HR 132, 14 September 1983: 732). Concurrence with this view came from an editorial in *The Canberra Times*,

The Government's tactic as it now stands amounts to de-facto nationalisation of the health sector, in much the same way as education has been nationalised...understandably doctors are resisting the proposal that they should become more dependent on the Government for their incomes (CT 13 March 1984).

Specialists accurately gauged that their remuneration would be further reduced under Medicare, due to the abolition of the means test, and hence the contraction of private practice in these hospitals. In particular the amendment to Section 17 of the *Health Insurance Act* and new state legislation provided a focus for long standing concerns of doctors in New South Wales. The *Private Health Establishments Act 1982* prevented the opening of new private hospitals, closing off the possibility of employment for many specialists in these hospitals (Daniel 1990: 108). In NSW twenty per cent of all hospital beds were in private hospitals. In other states the figure was as high as seventy per cent (*The Bulletin*

19 June 1984: 27). In 1982-82 private patients filled 46% of all beds in public hospitals and in 1984-85, the figure had dropped to 29% (Palmer & Short 2000: 70-71). The Commonwealth's block grants to the states did not compensate for this financial loss, for these grants were still substantially less than the amounts they would receive from fee-for-service treatment of private patients. Here was further scope for declining medical incomes leaving rancorous specialists in New South Wales ready for industrial action.

With the introduction of Medicare many people dropped private health insurance knowing that they could receive free care in the hospital system. Doctors were left wondering why unnecessary burdens were being placed on the welfare system and on an under-resourced hospital system at a time of economic recession (Thompson 1985). They were disquieted over the provision of social welfare to those who could afford private health insurance. Dr. Brian Morgan former Vice-President of the Australasian College of Surgeons commented,

When surgeons saw affluent patients seeking public hospital treatment and competing with pensioners and the poor for services, they became uncomfortable and uneasy about the future (Morgan 2000: 36).

The abolition of the means test effectively meant a redistribution of national income in favour of those in the community living in comfortable

circumstances, and in the eyes of the medical profession this did not fit the definition of social equity. The Labor Party had a different vision. Those to the right of the political spectrum saw social equity in terms of private sector delivery, those on the left saw it in terms of public sector delivery, and underlying this tension were differing notions of the rightful place of government in service provision. In effect, the term social equity had slipped into the political discourse in the guise of neutrality, but was clothed in ideological values (Sax 1984: 189).

Labor's health policy also had a detrimental impact on doctors' status and influence within hospitals. Before the introduction of Medibank, when visiting medical officers treated their public patients in an honorary capacity these doctors enjoyed a special relationship with hospital management. The honorary staff rather than professional administrators largely directed hospital policy. This changed with the acceptance of sessional payments and the Boards of Management of hospitals now treating these doctors as employees and they were excluded from playing a central role in policy-making (Penington June 1984: 6; Marshall 2000: 37).

Response from the AMA

The president of the Australian Medical Association in the period 1983 to 1986, Dr. Lindsay Thompson, had wanted to avoid confrontation with the new

federal Government over Medicare (*AMA Annual Report* 1983: 9). The AMA accepted in principle a health insurance scheme with universal cover, but judged that it would offer no greater equity, efficiency or cost effectiveness than its predecessors (*Medical Practice* May 1983: 13; Repin 1984: 31). By August 1983 the Federal Council of the AMA was in receipt of the government's proposals on hospital contracts, and expressed strong opposition to the government's proposals. Diagnostic specialists were aware that "the arrangements may prove to be the thin edge of the wedge for all specialist medical staff practice in public hospitals" (*Medical Practice* September 1983: 12).

The concern was such that the federal council of the AMA resolved as a matter of urgency to form a working party to examine the proposals (*Medical Practice* September 1983: 12). The AMA hoped that the legislation could be amended in the Senate (CPD S 1983: 910) but the Government did not support the amendments to the Bill (*Medical Practice* November 1983: 14; Repin 1984: 32).

Discussion between the government and the medical profession continued during the later months of 1983 and into January and February 1984. In January 1984, the President of the AMA, Dr. Lindsay Thompson, expressed his frustration that the Association's negotiations were not producing concessions from the government (*Medical Practice* February 1984: 13) and he said that doctors in most states would not sign the proposed new contracts. Despite the

setting up of the Penington Inquiry ongoing negotiations between the AMA and the government were unproductive and during March doctors engaged in one-day stoppages (Daniel 1990: 107).

The New South Wales doctors' dispute

Medical specialists working in public hospitals in New South Wales were aggravated by interventions into medical practice by both the Commonwealth and the NSW state government. The Health Minister in NSW, Laurie Brereton enacted Section 42 of the *New South Wales Public Hospitals Act 1929*, which was gazetted in March 1984, and gave the Minister power to regulate how doctors would work in public hospitals, establish regulations determining the appointment, regulation and government of doctors and make regulations covering the visiting practitioners conduct at work and elsewhere (McKay 1986: 222; Daniel 1990: 110).

The significant shift of patients from private to Medicare patient status in public hospitals had increased unpaid honorary work and reduced the number of private patients for which Medicare benefits were payable. Orthopaedic surgeons and plastic surgeons were particularly affected. They relied on accident work and they saw the number of private patients drop by 90 per cent (Rice *SMH* 12 June 1984: 1). In April visiting medical practitioners attached to public hospitals in New South Wales went on a seven-day strike (Daniel 1990:

110). However, specialists found they needed to combine strike action with more extreme forms of public protest to make any political impact. The industrial strategy chosen was to undertake mass resignations from the public hospital system. In May 1984, orthopaedic surgeons relinquished their positions and were later joined by plastic surgeons, neurological surgeons and anaesthetists (Daniel 1990: 116). The politicians responded but not in the way the doctors expected. In June 1984 the Wran government declared null and void the notices of resignation already given and disqualified doctors who resigned subsequently from holding any public appointment for a period of seven years (McKay 1986: 224; Sax 1990: 76). Columnist, Peter Bowers in *The Sydney Morning Herald* commented,

Mr. Wran was driven by a belief that he had to break the surgeons before they broke the concept of Medicare...He calculated that if there was to be a bloodbath over Medicare, better that it be contained in NSW and at the beginning of his four year term than it spreading to other states, inevitably involving the Hawke government in the run-up to the Federal election (Bowers 16 June 1984: 13).

The AMA responded with industrial action, which on 27 June saw 5000 full-time, visiting and resident doctors on strike. On the following day Wran announced the repeal of the seven-year-ban (Green & Castaldi 1985: 63). However, Wran's provocative action had united the profession and the number of resignations increased (*SMH* 25 June 1984), and by February 1985 it exceeded 1,500 (*Medical Practice* January/February 1985: 6-7; Pensabene 1986: 67).

Frustration with these circumstances and with the moderate leadership of the AMA led to the formation of a militant group of doctors, the Council of Procedural Specialists, in October 1984 (Daniel 1990: 137). Led by Doctors Bruce Shepherd and Michael Aroney, the demands of this group of influential doctors (Palmer & Short 2000: 70) included the means testing of public patients, the delivery of honorary services only to those who met the means test, fee for service for all other patients with charges to be determined by the doctor, the removal of Section 17 from the *Health Insurance Act* and the abolition of government controls over private hospitals. These specialists were uncompromising. They had little patience, in their dealings with the government, with the protocol of conciliation and negotiation used by their moderate colleagues in the AMA (Daniel 1990: 141). Their campaign of mass resignations from the public hospital system reinforced their message to the government that their approach to industrial relations would be as belligerent as that used by their principal adversaries Neville Wran and Neal Blewett.

The Penington Inquiry

The progress report of the Penington inquiry of June 1984 sought to be a moderating influence in a conflict where the stakes were rising and opportunities for consensus and concession were falling (Penington, *SMH* 12 November 1984: 1). It outlined a case for the legitimacy of the concerns of both

the government and the profession, where the underlying problem was a misunderstanding of intention.

Either side has been speaking a language of its own, misinterpreted by the other as control for the sake of control on the one hand or independence and protection of earnings as ends in themselves on the other (Penington, June 1984: 7).

Yet the report could find little evidence of overservicing in hospitals. The government, it found, was busy addressing a problem that didn't exist and not dealing with the one that was a major burden on the health budget – the overuse of pathology services in the private sector (Penington *et al* June 1984; *Medical Practice* August 1984: 9). The final report noted that the Department of Health had based its evidence on services in the country at large and there was no specific information on utilisation of services within public hospitals (Penington September 1984: 6). The report found no evidence of charging above the scheduled fee (Penington September 1984: 49) and no evidence of excessive incomes gained by doctors working in public hospitals (Penington September 1984: 13-14).

This report, along with its critique of the government's action, died with its tabling on the last parliamentary sitting day before the 1984 federal election and with fifteen minutes for debate (CPD HR 139, 11 October 1984: 2159-2164; Carlton 1985: 14). This was enough time for the Shadow Minister for Health Jim

Carlton to outline a case for the dismissal of the Minister for Health, Neal Blewett for his “declared war on the medical profession without evidence or cause” (CPD HR 139: 2164).

Professor Penington continued to be outspoken. In delivering the Lambie-Dew Oration at Sydney University in 1987, he reiterated, “the [Section 17] proposals were ill-conceived, and manifestly inappropriate” (Penington 1987: 6). The result, argued Penington, was that the profession no longer saw a need to make concessions to the government, strike action continued and the settlement that was finally achieved, after Prime Ministerial invention, meant the near abandonment of all controls on fraud and overservicing in the private sector (Penington 1987: 6). He argued for “Medicare to be overhauled as it was a blank cheque for overservicing”. Medicare had controls for fraud and overservicing on paper but they were not being implemented. The situation was such that “it would be hard to introduce effective controls...given the entrenchment of the present uncontrolled system” (CT 30 November 1985: 1).

The Federal Election November 1984

The Penington Report was not successful as a tool in the conciliation process and the conflict was now intense and protracted (Backhouse 1994: 158). The chairman of the Australian Association of Surgeons, Dr. Michael Aroney, said the NSW surgeons’ dispute would continue despite the findings of the Report

(*SMH* 12 October 1984: 1). In November 1984 the AMA resolved there should be an escalation in industrial action (McKay 1986: 229).

There are conflicting reports from two of the major players in the dispute. Neal Blewett recalled that the fact that there was a major strike in the NSW hospital systems was an advantage to Labor in the period preceding the federal election of December 1984. Blewett and Hawke believed that a short-term fight with the doctors would not be detrimental to the party's interests (Blewett *pers. comm.* 2002; Blewett 1999: 319). This meant that Blewett was under no pressure to resolve the conflict with the medical profession.

I think that there was a generally shared view in the cabinet that a conflict with a group or a union, which represented well-paid workers, was not going to be something that would be bad for the government (Blewett *pers. comm.* 1984).

On the other hand Bernard McKay, Director-General of the Commonwealth Department of Health, also a participant in the dispute, said that with the impending Federal election the Commonwealth and the NSW government re-entered the dispute reluctantly recognizing the real possibility of it spreading to the other states (McKay 1986: 225). Despite these differing accounts no final settlement of the doctors' dispute was reached at this time, but steps were made towards reconciliation between the government and the profession. One area

where it was thought that friction could be reduced was that of fraud and overservicing: the government's solution was to try to kill it as an issue.

Four Corners

This was easier as the issue of fraud and overservicing had become muted in the media by the federal government's attempts under Section 17 to control the profession, the NSW government's attempts to induce doctors into a salaried medical service, the NSW hospital system in crisis and the large scale mobilisation of the profession in defence of its highest aspirations.

Media interest in fraud and overservicing was muted but not silent. Chris Masters of ABC-TV's investigative current affairs unit *Four Corners* had made a program 'What the Doctor Ordered' broadcast in July 1984 on the structural forces allowing abuse of medical benefits to flourish. It was in the making of this program that Masters found, in the career and lifestyle of medical entrepreneur Dr. Geoffrey Edelsten, the subject of his second story on fraud and overservicing. (Masters 1991: 112). Entitled 'Branded' it profiled the pioneer of corporate medicine, a doctor who had built up his medical practice on a peculiar mixture of innovative business ideas, hard work, poor taste and deviant behaviour. Masters calculated that

Edelsten was rorting the system. The number of operations being performed made it clear there was not enough time in the day for the busy doctor to be doing them all himself. As I observed myself, while Edelsten began the operation, it was often completed by a nurse (Masters 1992: 118).

His assessment that Edelsten was abusing the medical benefits system was confirmed by leaked documents supplied by unofficial confidential sources in the Department of Health³. It demonstrated that in addition to the delegation of medical procedures to his nurse Edelsten was charging Medicare in excess of the scheduled fee for his services (Masters 1992: 128, 137).

It made compelling television. It concerned Edelsten's inept tattoo removing procedures, his overservicing, over charging, kickbacks for diagnostic referrals and employment of hitman Christopher Dale Flannery to threaten a former patient (Masters 1992: 128). "It was about allegations of medical malpractice and a dubious practice that was costing the Commonwealth a fortune"⁴ (Masters 1992: 139).

In 'Branded' the routine dullness of white-collar crime was injected with the dramatic features of its blue collar variant. Medical fraud and overservicing

³ Included in the appendix is a profile of the activities of Edelsten from the Department of Health.

⁴ Press accounts estimated that Edelsten's annual income from medical benefits was \$2.4 million, (Smark & Harris *SMH* 29 April 1985: 1) but the Department of Health's computer practice profiles indicated that the figure was closer to \$4.8 million (Beauchamp *Matilda* September 1985: 28).

now had a colourful figure to capture public attention⁵ (Tiffen 1999: 66). In this fashion insurance fraud was rendered less complicated and less abstract: this was criminal activity as it was commonly understood.

For his efforts Masters too was threatened by Edelsten's underworld associates, and Edelsten complained to the Australian Federal Police that Master's was the recipient of unauthorised confidential information. The police acted and seized his diary and notebooks in their attempt to trace the source of the leak from the Department of Health (Ryan *NT* 24-30 May 1985: 4; Masters 1992: 138 -139). Edelsten for his part had instituted legal proceedings to stop the broadcast of the program but was unsuccessful in a permanent injunction. Edelsten was right to be concerned about the program's repercussions. He was under investigation by the National Crimes Authority; he was a subject of inquiry by the Costigan Royal Commission; and he was an associate of underworld figure Abe Saffron. Since 1976 fifteen investigation and prosecution files had been opened on him by four agencies, yet much of this data had been allowed to date. (Beauchamp 1985: 27). This publicity was the cue for effective prosecutory activity. In due course he received a custodial sentence, was struck off the NSW and Victorian medical registers for professional misconduct, and was

⁵ Rodney Tiffen in *Scandals: Media, Politics & Corruption in Contemporary Australia*, argued that medical fraud and overservicing failed as a media scandal because it lacked a colourful identity. Edelsten fulfilled this function and the issue was a scandal and is still a scandal.

prosecuted for tax evasion (Cameron *SMH* 19 May 1987: 4; *SMH* 16 December 1987: 8; Masters 1992: 141; Videnieks *The Australian* 1 August 2001: 4).

'Branded' was broadcast on 3 November 1984. The program gave Australia one more larger-than-life criminal character to define its cultural identity. However, the program made no impact on the agreement being reached between the AMA and the government. Three weeks later negotiations between the two parties resulted in the modification of procedures for the investigation into fraud and overservicing and the softening of its penalties.

The Government backs down on fraud and overservicing

In 1984 the official estimate of fraud and overservicing from the Department of Health was \$130 million annually (JCPA vol. 15, 27 March 1985: 5811), a figure based on the increase in the schedule fee cost of medical benefits since 1982 and on calculations derived from the Department of Health's computerised Fraud and Overservicing Detection System (FODS). This statistical system generated profiles of an individual doctor's service patterns for comparison with their peers. Investigative activity focused on those profiles that fell in the highest percentile from the norm. However FODS was oriented towards general practitioner analysis and required further work to be effective in specialist analysis. This meant that there were no estimates available for fraud and overservicing in relation to pathology, the area known to Departmental officials

as the site of the largest abuses against medical benefits, and where the extent of the leakage was “unknown and virtually inestimable” (ACOA submission November 1984: 20). Tracking fraud by pathology companies was difficult because some aspects were like big business with legal technicalities and complex company structures designed to disguise deviant practice (*Medical Practice* September 1984: 14).

Both the Department of Health and the AMA in 1984 considered the figure of \$130 million to be inaccurate. The Department of Health regarded the figure as an underestimation of the level of fraud and overservicing, the AMA considered it a gross overestimation. Where Lionel Wilson was ready to accept the figure of \$100 million as a fair estimate of the extent of fraud and overservicing, this was not the position taken by his successor Lindsay Thompson and Secretary-General of the AMA, George Repin (Thompson *pers. comm.* 2002; Repin *pers. comm.* 2002). Now the AMA would not lend its support to a co-operative joint venture with the Department of Health to deal with the issue. The AMA now questioned the extent of fraud and overservicing, the usefulness of the FODS system and measures to control aberrant practice (*AMA Annual Report* 1984: 12). Their stance was that judged by the relatively small number of prosecutions for fraud and overservicing, that it was problem of minor significance (*Medical Practice* July 1984: 11; JCPA vol. 15: 5812).

It was in this climate of discontent (*AMA Annual Report* 1984: 12) that the signs emerged that the government was planning a discrete disengagement from effective measures to deal with fraud and overservicing. This was signalled by criticisms of the Surveillance and Investigation Division of the Department of Health from the Public Accounts Committee; from the Auditor-General's Office, from a commissioned report from auditors and management consultants, Price Waterhouse and Associates, and from discussions held at a summit meeting of representatives of the federal government, the AMA, the Commonwealth Department of Health and other stakeholders. These reports failed to present a convincing case for the government's back down on measures to deal with fraud and overservicing.

The Chairman of the Public Accounts Committee, ALP Senator George Georges, remarked to the Committee that he had received reports that the Department of Health was using intrusive police monitoring techniques in investigations of doctors and patients (JCPA vol. 14, 4 October 1984: 5605). This he regarded as an invasion of privacy both of the doctor and the patient. This indicated to him that while the Committee had been set up in response to an urgent requirement that something be done about the extent of fraud and overservicing, strong enforcement measures were no longer appropriate.

It is my concern that there may have been an overreaction in the Department of Health in setting up the Surveillance and Investigation Branch and that because of the urgency of the matter, techniques were

being accepted that normally would not be tolerated (JCPA vol. 14, 4 October 1984, 5605)

John McCauley, First Assistant Director-General, Surveillance and Investigation Division, Department of Health, in defending these methods argued that the procedures used had been agreed between Health, AFP and the Director of Public Prosecutions. He recalled that there had been a small number of complaints but upon investigation they could not be substantiated (JCPA vol. 14, 4 October 1984, 5608-5609). Senator Georges remonstrated that doctors should not be subject to the normal police investigation process. Ron Hackett, Director of Investigation Resources, responded that these investigations were no different "from the police processing the investigation of any other criminal offence" (JCPA vol. 14, 4 October 1984, 5614). Hackett also added that in fact they had very little surveillance equipment. He argued that one of the reasons for undertaking surveillance was to have an independent record of a doctor's movements rather than relying on the memories of the elderly nursing home patient. Senator Georges was not to be placated. He was less than impressed with a practice whereby departmental officers of intimidating physical stature could be interviewing the elderly. Georges was of the opinion that those whom he called the "tall, big and fairly wide in shoulder" might frighten the sick, frail and infirm (JCPA vol. 14, 4 October 1984, 5615). Hackett's response was that the number of elderly witnesses was no greater than in any other police investigation.

In spite of the insubstantiality of Senator Georges' criticisms the issue continued to have a life of its own. *The Age* newspaper using the *Freedom of Information Act* found that medical fraud investigators were using cameras, binoculars, portable radios and three car pursuit teams in their surveillance of difficult medical fraud cases (Metherell *The Age* 3 November 1984: 1). Dr. Shilkin, President of the Western Australian branch of the AMA, argued that the use of surveillance techniques by investigators was an attack on civil liberties of medical practitioners. AMA President, Dr. Thompson, believed that the Health Department had grossly over-reacted to medical fraud and overservicing, with the result that some doctors in order to avoid being charged with overservicing would provide less than adequate care for their patients (*Medical Practice*, December 1984: 9). In response the Director-General of Health, Bernard McKay, ordered his investigators to cease using cameras for their investigations (*The Age* 8 November 1984: 1). He was aware that many AMA members were convinced that the government was out to get them and that

by signing claim forms they were committing themselves to being exposed. So there was within the profession sympathy for doctors who were being, if not prosecuted for overservicing, then being examined for overservicing. So they didn't have a lot of sympathy for us (McKay *pers. comm.* 2002).

The Auditor-General's report of September 1984 took a different line. It focused its criticisms on the Fraud and Overservicing System (FODS). It found that its reports were often of limited usefulness for identifying instances of fraud and overservicing (Audit 1984: 69); there was an absence of a comprehensive management information systems to monitor FODS; there were delays in implementing advanced training programs; there was a lack of evidence that the most significant overservicing was given the highest priority; that the backlog of cases to be heard before the Medical Services Committees of Inquiry was such that they would not be all dealt with for another thirteen years, and it was unlikely that the Division would be able to achieve its program objectives (Audit 1984: 68).

Building on these criticisms was a report by George Field of Price Waterhouse Associates in December 1984. It argued that FODS was unwieldy, inefficient and inaccurate and "had been used without imagination, doing some disservice to the Department's relationship with the medical profession" (Field 1984: i). The report argued against the use of peer group analysis and against the analysis of patterns of practice over a period of time. The report recommended that FODS be dismantled and the Surveillance and Investigation Division be transferred to the Health Insurance Commission. This would allow the Department of Health to retain cordial relations with the medical profession while passing the unpopular policing function to the Health Insurance

Commission (Field 1984: 41). This report vindicated the AMA. It provided external validation to its criticisms of the statistical system that had “besmirched the good name of the profession for more than three years” (AMA *Annual Report* 1985: 11).

Defending effective measures to deal with fraud and overservicing

Chris Haviland, union representative and staff member of the Surveillance and Investigation Division’s NSW regional office, critiqued the Auditor-General’s report in his submission to the Public Accounts Committee on behalf of Administrative and Clerical Officers’ Association (ACOA submission to the PAC November 1984: 15-18). The union argued that the Audit had been undertaken in the first few months of a new \$8 million five year plan to control fraud and overservicing, and it was too early to be able to judge the program’s effectiveness. The Auditor-Generals’ report made reference to the lack of progress in FODS development when staff involved in the FODS program could not be developing it as they were engaged in preparing and conducting training courses in each state. ACOA argued that there appeared to be an overall lack of appreciation by both counsellors and management of the potential and capacity of FODS in the identification of excessive servicing through statistical indications. The submission argued that the government needed to support the Department of Health by providing the staffing and

technical resources as well as the legislative and regulatory power to effectively combat overservicing and fraud.

Also defending the performance of the Surveillance and Investigation Division were staff members Alan Mackay, Bill Taylor and John McCauley. They argued that the Field Report was inaccurate and its criticisms contrived. The statement that the Department's attitude had contributed to the rift between the medical profession and the Department ignored major issues that had brought the government and the profession into conflict. They argued that the Health Insurance Commission would not be able to handle the fraud and overservicing function if it only focused on the hundred worst offenders and without reference to peer group analysis (*see appendix*).

Katherine Beauchamp of the Rupert Public Interest Movement, which was a subject of interest to ASIO, continued to be outspoken about abuse of the medical benefits system after her dismissal from her research position with the Joint Committee of Public Accounts inquiry into medical fraud and overservicing. In the journal *Matilda* she reported that

A review by senior management of policy for handling big pathology fraud made negligible progress while the FODS computer showed ripoffs escalating...Doctors learned new tricks from their FODS scan profiles and, hearing of the bunglings and the blunders by untrained staff under

pressure to produce miracles, they safely exploited the system even more (Beauchamp 1985: 45).

The Summit

Despite these arguments in defence of the Fraud and Surveillance Division from Department of Health staff members, the public sector union and the Rupert Public Interest Movement, efforts to moderate measures to deal with fraud and overservicing continued. In order to deal with what Mr. Bernard McKay, Director-General of the Department of Health, regarded as the AMA's 'paranoia' over the question of overservicing (Oakes *ST* 18 November 1984: 44), he organised a summit meeting for 26 and 27 November 1984, in the week leading up to the federal election. The summit brought to the discussion table McKay, the Health Minister, Neal Blewett, and representatives of the AMA, the Health Insurance Commission, the Australian Federal Police, the Office of the Director of Public Prosecutions, the federal Attorney-General's Department and the Department of Prime Minister and Cabinet (*Medical Practice* December 1984: 7; Green, *CT* 30 November 1984: 13).

A further two-day summit meeting was organised for January 1985 and the outcome was that the Department of Health agreed to modify its investigative procedures, and doctors and their patients would no longer be photographed. In addition Blewett agreed that the incoming Labor government would give consideration to a review of the penalty and disqualification provisions of the

Medicare legislation, that penalties should distinguish between intentional fraud and technical breaches of the law, that there should be consultation on ways to deal with allegations of overservicing and that counsellors' interviews with doctors should be privileged, so that doctors' statements could not be used as evidence against them (Green CT 30 November 1984: 13).

Journalist Laurie Oakes had suspected that the purpose of the meeting was to make preparations for the government to take a more lenient attitude towards overservicing (Oakes ST 18 November 1984: 44). Louise Dodson of the *Australian Financial Review* was convinced that the measures were designed to placate the profession on the eve of the federal election (AFR 28 November 1984: 28). These preliminary negotiations formed part of the basis for the settlement the NSW doctors' dispute in April 1985 that was formalised in the *Health Legislation Amendment Bill* of October 1985 (AMA Annual Report 1985: 11).

The Great Negotiators

The late months of 1984 had seen tentative steps by the government towards a rapprochement with the medical profession, but progress towards the final settlement of the doctors' dispute in April 1985 was frustrated by the obstructionist tactics of both NSW Premier Neville Wran, and the radical faction of the specialist groups. Sidestepping these impediments was Prime Minister Bob Hawke, who was keen to broker a resolution of the conflict with

the medical profession. His preference was to avoid negotiations with the recalcitrant specialists and deal directly with Dr. George Repin, Secretary General of the AMA, the one whom he judged as the real intelligence behind the Association. In Neal Blewett's estimation Hawke and Repin were both

superb at the task of reconciling opposing positions and coming out with something they could both live with. In Repin's case, it was a great negotiator meeting another great negotiator: in a way admiring each other's skill (Blewett *pers. comm.* 2002).

The agreement that was reached was that negotiated between the government and the AMA, those whom the government regarded as "reasonable people who understood what democratic politics was about" (Blewett *pers. comm.* 2002). They were people who were adroit at playing their winning hand in this extended game of medical politics.

The Terms of the Settlement of the Doctors' Strike

The agreement between the government and the medical profession was announced in April 1985. It gave a \$16 million a year pay increase for doctors working in public hospitals; doctors were given a choice between employment based on pay for service or sessional payments for treating public patients; there would be additional funding of \$150 million for teaching hospitals for facilities and new equipment; the repeal of all amendments to Section 17 of the *Health Insurance Act*; the withdrawal of the Commonwealth from the regulation

of private hospitals; and an improved health insurance package designed to increase the number of privately insured patients going into public hospitals (Grattan, Metherell, *The Age* 3 April 1985: 1; Rice, *The Australian* 3 April 1985: 1; Malone *The Canberra Times*, 3 April 1985: 1; Buckley, Harris *SMH* 3 April 1985: 1).

Media reaction

While Hawke described it as an honourable settlement (*Medical Practice* April 1985: 6), Blewett understood it as “an abject surrender” (Blewett *pers. comm.* 2002). The newspapers showed no mercy. They judged the government’s capitulation to an interest group a humiliating backdown (*The AFR*, 4 April 1985: 12). An editorial in *The Australian* claimed that most people thought

Medicare a fairly simple method of health insurance. Instead it turned out to be a comprehensive program of health administration which, so the doctors rightly pointed out, ...reduced both their independence and their incomes (*The Australian* 4 April 1985: 10).

The *Sydney Morning Herald’s* editorial argued that the amendments to Section 17 were designed to address the problem of excessive use of services by controlling doctors’ fees and incomes. “Dr. Blewett both failed to define the problem and bungled the answer” (*SMH* 3 April 1985: 10). From Blewett’s ministerial office one staff member, writing for *The Bulletin* magazine, pointed

to the hidden complications of Medicare. The *Health Insurance Act* embodied its principles but entailed peripheral issues that needed to be addressed. They were embodied in the ill-fated Section 17 amendments, which the doctors rejected with exceptional professional cohesion.

By introducing Medicare at the beginning of an obviously secure tenure of government, Blewett believed that he could effectively 'snow' the medical profession and blunt any disputation...He is now in a severely weakened political position in the face of government concessions to the medical profession (Smith, *The Bulletin* 16 April 1985: 30).

But it was *The Australian* newspaper that understood that the government had offered one concession too many. It was one "with great symbolic value for doctors, for the Government agreed, as an added bonus, to scrap its computerised fraud and overservicing detection system" (Rice, *The Australian* 3 April 1985: 1). This was a concession of doubtful legitimacy. While the doctors' dispute had concerned government intervention into the public hospital sector, which was not needed, this concession concerned measures to address fraud and overservicing in the private sector, measures that were needed. AMA President Dr. Lindsay Thompson was alert to its significance.

Although overshadowed by the NSW hospitals dispute, the demise of the Federal Government's Fraud and Overservicing Detection System (FODS) was "a much more significant and less publicised event (*Medical Practice*, July 1985: 62).

As a profession,” said Dr. Thompson, “our interest is to see that the methods used to investigate fraud and prosecute irregular practices are kept to a minimum” (*Medical Practice*, July 1985: 62).

Government scraps FODS

Although Thompson was delighted at the demise of what he called this “inefficient bureaucratic monster” (*Medical Practice* April 1985: 9), Report 212 of the Joint Committee on Public Accounts had identified FODS as a key tool in a program to deal with abuse of the medical benefits system and urged its expansion.

The Committee believes that the development of the FOD system is of paramount importance to the success of the Department’s efforts to combat medical fraud and overservicing (JCPA Report 212, December 1983: 3).

Notwithstanding this recommendation the government announced in March 1985 that it would scrap its own computer analysis system.

But it went further, it meant that all data used for the estimate of \$170 million lost to fraud and overservicing was to be destroyed. It was not sufficient to silence John Kelly, the whistleblower who had come forward with an estimate of the extent of the abuse of medical benefits, but the machinery that had supplied this estimate also had to be silenced. This information was disclosed in

an article Katherine Beauchamp co-wrote for *The Age* newspaper. In it Bernard McKay denied that there had been an official cover-up, but revealed that the computerised system that produced the estimate would be scrapped. Dr. Lindsay Thompson said that doctors would be pleased with this decision by the government, and added “The process could flag only abnormal practice patterns by doctors, but this did not mean the doctors had done anything wrong” (Beauchamp & Metherell *The Age* 21 March 1985: 1; Payne, *S-H* 24 March 1985: 24). A departmental officer presaged that the consequences of the decision to dismantle FODS would be disastrous.

The real effect will not be acknowledged for years, and someone will have to start all over again on the problem of fraud and overservicing (Beauchamp, Metherall *The Age* 21 March 1985: 1).

Transferring the Fraud and Overservicing Function to the HIC

In addition to the mothballing of the FOD system, Neal Blewett announced to the Public Accounts Committee on the 27 March 1985 that the surveillance and investigation function would be transferred from the Department of Health to the Health Insurance Commission. He explained that this was done so that all operational aspects of Medicare would be dealt with by one organisation and to enable the HIC to explore new methodologies for dealing with the abuse of medical benefits. Bernard McKay said this new arrangement would free the

Department of its policing function and allow it to focus on educating the profession on areas of its practice that were inefficient, wasteful or inappropriate (JCPA vol. 15, 27 March 1985: 5871-5876).

Bernard McKay argued before the Committee that it was his intention to move the department as a whole into the areas of policy and move out of operational activities (JCPA Vol. 15 27 March 1985: 5900). He recalled in later years that one of his early decisions in taking up his appointment to the Commonwealth Department of Health in 1984 to pass the investigative function to the Health Insurance Commission (McKay *pers. comm.* 2002).

Neal Blewett reflected that the HIC was not merely pleased with this arrangement.

They were a vehement pressure group to take over the fraud and overservicing function. They actually campaigned very strongly with me that that should be their responsibility. I was sympathetic simply because the Health Department had made such a mess of it (Blewett *pers. comm.* 2002).

Evered wrote to Blewett to persuade him of the merits of the HIC handling the function. He argued that there was little difference between the ways the two agencies would handle the function except on presentational grounds. Evered argued

We will separate fraud and overservicing. We will consult with the profession. We will not use the term overservicing. We will use unusual service practice as a way of describing it. We will not make assumptions that statistical data tell us that somebody is guilty (Evered *pers. comm.* 2002).

The General Manager of the HIC, Bob Wilcox, announced confidently that the HIC would be handling the regulatory function differently to the Department (JCPA vol. 15, 27 March 1985: 5886). He argued that quantifying the amounts lost to the abuse of medical benefits was an impossible task and one that the HIC would not undertake.

Whether you use 100 million or two hundred million dollars or something else it is more important to identify the controls that we have in place within the system and ensuring the proper payment of claims (JCPA vol. 15, 27 March 1985: 5881).

Bernard McKay added investigators will be “looking for fraud as it happens, rather than looking back into the past” (JCPA vol. 15, 27 March 1985: p. 5891). McKay and Wilcox discussed the fate of two hundred outstanding cases. McKay thought it possible that the HIC could handle the matters Wilcox thought it appropriate that the Department of Health deal with them. As events transpired shortly afterwards two fraud investigators in the NSW regional branch of the Department of Health were told to remove over one hundred and sixty boxes of active files on Dr. Geoffrey Edelsten. The specified destination was Waverley tip in Sydney’s Eastern suburbs (*pers. comm.*)

From the Public Accounts Committee no dissenting voices were raised, no alarm bells were ringing by this winding back of regulatory measures to deal with fraud and overservicing by the HIC. Journalist Laurie Oakes sounded a cautionary note. He wrote that Departmental staff employed in surveillance and investigation were strongly opposed to being relocated. Many of them saw this as further evidence of a lack of commitment by the government and the department to countering fraud and overservicing. Handing the function over to the HIC would violate basic accounting principles because it would involve payment and audit being done under the same management (Oakes *The Bulletin* 5 March 1985: 36).

Softening of the legislation on fraud and overservicing

Along with the transfer of the investigation and surveillance function to the HIC, the government also made legislative changes that softened the penalties for fraud and overservicing. These were introduced into parliament on 11 October 1985. Neal Blewett argued that the penalty and disqualification provisions of the *Health Insurance Act* were “unreasonably rigid and insensitive and, in some cases unnecessarily harsh”. It failed to discriminate between practitioners found guilty of medical benefits fraud through intent or through “reckless or gross careless conduct” (CPD HR 11 October 1985: 1884). This legislation was not written within the spirit of the interim report of the Public Accounts Committee of 1982. This had argued that doctors found to have

provided excessive services over a certain amount, or on two separate occasions “should be automatically disqualified for medical benefits purposes, in the same way that current legislation provides for automatic disqualification of doctors convicted of fraud” (JCPA Report 203: 133-134).

Under the old rule, medical practitioners who had two or more fraud offences proven against them were automatically disqualified from participation in Medicare for three years. Under the new rule a Medicare Participation Review Committee would determine the penalties. These would range from no penalty to counselling, reprimand or disqualification from participating in Medicare arrangements for up to five years (CPD HR 11 October 1985: 1885). In addition there was a right of appeal to the Administrative Appeals Tribunal.

The chairperson of the MPRC would be a person with legal qualifications but all other members would be members of the relevant professional association. This arrangement left it to members of the two professions to determine the penalty rather than it being determined by automatic legal provisions.

Bernard McKay before the Public Accounts Committee had declared that with the transfer of the investigative and surveillance function to the HIC “Certainly we are not going to give it to the HIC and forget about it” (JCPA vol. 15, 27 March 1985: 5880). In terms of a reform agenda the function was largely

forgotten until Lawrie Willett took over as managing director of the HIC in 1990.

Geoff Probyn⁶ was one of a number of fraud investigators who moved across to the HIC from the Department of Health and witnessed the transition of fraud functions to the new agency. Despite legislative changes aimed at softening the penalties for the abuse of medical benefits and the rhetoric from senior management that things would be different now, Probyn recounted that for the first eighteen months investigators were free to pursue their work with little managerial interference. Their positions were budgeted from Canberra but they were outposted to the states. They had a budget sufficient to purchase vehicles and surveillance equipment and because of the secrecy of their work few questions were asked about their work or their methods.

This changed after winning some successful cases and one in particular involving Dr. Ian McGoldrick, who was linked to Geoffrey Edelsten. The circumstances were that McGoldrick ran an abortion clinic in Melbourne, 'The Action Centre', that did not comply with the state *Crimes Act* which stipulated that women had to undergo a compulsory counselling session before the abortion took place. The usual procedure was that the abortion was performed on the spot, but one young teenager who presented herself to the clinic experienced severe post-operative complications. Her mother found out what

⁶ This interview was conducted in the Health Insurance Commission with the kind permission of Dr. Janet Mould, Managing director of the Program Review Division.

had happened and in her distress and fury went to the clinic and wrecked it. This mobilised the Victorian police who mounted a combined investigation with the HIC, with the approval of the Australian Federal Police. The dilemma facing investigators was how to contact similarly affected adolescents without notifying the parents. It was judged that parents would be contacted and as it happened both the girls and their parents co-operated and acted as witnesses. It would seem on the face of it that the case had reached a satisfactory conclusion except for the negative publicity that ensued. Melbourne radio personality Darren Hinch judged that these youngsters had been bullied by HIC investigators and was not inclined to look favourably on the HIC's policing efforts.

This new function of the HIC had been out of the mind of senior management but was now well within its sights. The result was that the investigative function was reviewed and transferred to the state branches. Probyn argued that this did not impede their work but it meant it changed its direction. Medical advisors now had a larger say in determining whether an investigation would take place and the emphasis was now on education and counselling (Probyn *pers. comm.* 2001). It would be more accurate to say that the fraud and overservicing function languished under the managing directorship of Bob Wilcox. Health Minister Neal Blewett was preoccupied with the HIV issue as was the media.

Blewett was a Minister with a demanding portfolio and a public health issue of considerable complexity to manage; the media had moved on to other health matters then dominating the news agenda and administrative and legislative reform for the regulation of the abuse of medical fraud lay forgotten until Lawrie Willett assumed the managing directorship of the HIC. He proposed and enforced radical change of the Commission's responsibilities for the regulation of fraud and overservicing. He demonstrated that when there is strong leadership in an organisation reform measures can succeed. Willett was in the eyes of a former medical director of the HIC, Dr. Peter Taylor, "extremely competent, knowledgeable and accomplished an enormous amount" (Taylor *pers. comm.* 2002).

Conclusion

Medicare was introduced in 1984 on the premise that under a system of universal public health insurance fraud and overservicing would be more effectively managed and controlled than under private health insurance. Dr. Neal Blewett had been poorly advised that opportunities existed for the abuse of medical benefits to occur in the public hospital system but when the evidence for such malfeasance could not be substantiated, the government was loath to resolve the ensuing conflict with the medical profession. That it allowed the conflict to continue for fifteen months and at the end softened the penalties for fraud and overservicing in the private sector, as part of a package for the doctors' return to work, raises questions as to the government's motives. The government had manufactured the crisis, and the doctors responded in kind,

but there is no evidence that the cause of the conflict was of real concern to the government. What the government's motives were in staging this conflict and then weakening regulatory measures on the abuse of medical benefits is hard to discern.

The issue of fraud and overservicing did not claim a significant level of interest by the Minister, the Managing Director Bob Wilcox, or the media in the five years following the conclusion of the JPCA's enquiry into the abuse of medical benefits. It was not until 1990, when Lawrie Willett assumed the managing directorship of the Commission, that legislative and administrative changes occurred. This was a CEO with a commitment to reform. In terms of public accountability in this area of medical politics the new element was decisive leadership coming from the top of the organisation.

Chapter 7

Policing pathology

When I get old...I will want the very best of everything that curative health services will and can provide. As far as I am concerned, money is no object, and rightly or wrongly, the system will ensure that it is not my money I am speaking of.

Dr. Barry Catchlove, (Chairman HIC 1998-99), 1982: 67–68.

The most lucrative area for fraud was in pathology: the simplest method of fraud was through the payment of inducements and kickbacks by pathology companies to general practitioners for referrals. For this reason the regulatory gaze focused on pathology under Medibank and Medicare, with the Joint Committee of Public Accounts giving particular attention to this area of health

expenditure during the years 1983 to 1985. Despite the recommendations of the Committee the problem continued unabated.

One example of this practice was a case that was brought to the attention of the Health Insurance Commission, where a Sydney company, Quinn Pathology Services, in 1991 offered a methodone clinic, The Kobi Clinic, trading as Goyave Holdings Pty Ltd., a written contract for a fifteen per cent commission on all pathology tests, the payment of the salary of a nurse on a full time basis, a clerk on a part-time basis and the provision of telephones (see *Appendix*). It is not known if this was a typical contract as a fifteen per cent split of medical benefits would seem to be lower than the normal rate. Evidence given at the Joint Committee of Public Accounts hearings into the pathology industry suggested that the fee sharing arrangement could be as high as forty per cent for the referring doctor with sixty per cent of the Medical Benefits Schedule for the pathologist (JCPA Report 236: 48). The Quinn contract, with its explicit illegal fee-splitting offer, would have been an indictable offence under the amendments made to the *Health Insurance Act* (1974).

Ralph Watzlaff, then Manager of Compliance, with the Health Insurance Commission, said in reference to this case that written contracts were unusual, and it was for this reason that the HIC was interested in this case. They intended to institute legal proceedings against Quinn Pathology Services. It was referred to the DPP but did not proceed to court. Anecdotal evidence suggested

that the DPP dropped the case because of intervention by the Attorney General. Watzlaff's interpretation was that the DPP would not initiate proceedings unless the case was able to meet three criteria. The first was whether the evidence was sufficient for a *prima facie* case, the second whether there was a likelihood of securing a conviction and the third whether a prosecution would be in the public interest (Director Of Public Prosecutions *Annual Report* 1985-86: 14).

In the face of the difficulties of pursuing the individual criminal offender a complementary approach to fraud control was implemented whereby there were across-the-board reductions in benefits to service providers. The belief was that a lower reimbursement rate for pathologists would also mean that inducements would be less likely to be offered to general practitioners. This seemingly efficient and impersonal method of cost control did not discriminate between pathologists who provided a high standard of service and who were honest and those who provided a poor standard of work and who were dishonest. Lower reimbursement rates for the honest left them disaffected by this injustice while stimulating those intent on criminal fraud into ever more imaginative ways of cheating the system. What was needed was an appreciation of the wide variety of the ways benefits for pathology under Medibank and Medicare were being defrauded and the need for adequate defences against it (Sparrow 2000: 254). This chapter charts the development of a diversity of regulatory approaches to pathology from the 1970s to the present.

In 1971/72 Commonwealth benefits for pathology services were \$18 million (Sax 1974: 4). Costs accelerated with the introduction of universal health insurance and in the six months from January to June 1975, medical benefits payments for pathology were \$21.3 million and in the same time span for following year expenditure was \$44.7 million (PSWP 1977: 4). Pathology use for many years rose at the twice the rate for other medical services (Deeble 1991: 6), and proved to be the fastest growing area of the health sector. The pace of expenditure continued its upward climb and by the end of 2002, annual expenditure had reached \$1.4 billion (*Medicare Statistics* 2003: 35).

It is a situation that has left health policy makers with a number of concerns: that spiralling costs have to be reconciled against a finite national budget; that publicly funded universal health insurance gives a restricted role to market forces to control supply and demand; that accountability to the public purse is difficult when regulatory measures to contain costs are inadequate both administratively and legally (Deeble 1991: 10; Wheelwright 1994: 92); and that too many tests are ordered, with too little regard for their necessity (Deeble 1991; Vining & Mara 1996). For this reason the pathology industry has been the subject of ongoing review by government agencies.

Recognition of the need for reform came in the early 1970s with the work of the Pathology Services Working Party, in the mid 1980s by the reports on

pathology by the Joint Committee of Public Accounts, in the 1990s came legislative reform with *The Health Legislation (Professional Services Review) Amendment Bill 1993*, and *The Health Legislation (Powers of Investigation) Act 1994* and over all this period there have been ongoing amendments to the *Health Insurance Act 1974*. Most recently these legislative adjustments have been scrutinised in the *Report of the Review of the Commonwealth Legislation for Pathology Arrangements under Medicare 2002*. Some have interpreted these efforts as insufficient to correct the abuse of medical benefits and to prevent the domination of the industry by a small number of large companies, whereas others have interpreted these measures as sufficient to make pathology the most regulated sector in the health industry (Review of Commonwealth legislation regarding pathology – submission by AAPP 2000).

Market forces

Individual malfeasance is one issue, but the larger context is that fraud and overservicing are a built-in feature of a system that combines universal health insurance with fee-for-service to provide public money to finance private health services. In the case of pathology more incentives for overservicing are offered than other branches of medicine. It is also an industry with high labour and capital costs. In order to maximise returns on the investment in automatic analysers, optimal use needs to be made of the technology, and for this reason, many laboratories offer medical practitioners multiple tests and other services

(Deeble & Lewis-Hughes 1991: 13). Thus on the supply side the pathology market offers services, not all of which are necessary; on the demand side, the market is artificially inflated through the mechanism of health insurance. The price mechanism does not exert downward pressure on consumption, as the two consumers, the patient and the doctor, are not influenced by considerations of affordability, and are usually unaware of the cost of tests. It is a case of the demand-supply model of the market system being out of equilibrium.

Failure of the consumer (patient) to make informed choices.

In a competitive market the consumer is sovereign, but in the transaction between patient, the doctor and the pathology laboratory, the consumer, who is the patient, has few rights. The patient is not empowered with the knowledge to know what tests are available, for what purpose, if they are necessary, nor how to interpret them. Few patients are aware that they can stipulate the pathology company where their tests will be conducted but this choice cannot be exercised as consumers have no way of finding out the rating given by the national testing authority to the quality assurance program of pathology laboratories. Yet it is the patient who is paying for the service, albeit through Medicare, supplemented by patient co-payments. In this transaction there is a second consumer: the medical practitioner. He or she orders the tests as a diagnostic tool and, legally, is the owner of the results (Deeble & Lewis-Hughes 1991: 12).

Failure of the consumer (medical practitioner) to make informed choices.

If the lot of the patient is to be a passive consumer of pathology testing, literature reviews indicate that this passivity extends to medical practitioners who forego opportunities to actively critique their own pathology ordering (Deeble & Lewis-Hughes 1991: 53; Vining & Mara 1996: 4). In its analysis of the pathology industry, the Joint Committee of Public Accounts noted in Report 236,

Many clinical medical practitioners appear to gradually lose touch with the minutiae of pathology as they work in general practice and the various clinical specialities. Some may rapidly lose competence in the ordering of pathology investigations and instead of ordering the most relevant and useful specific tests may order the most vaguely defined, non-specific or even the wrong tests (JCPA Report 236: xxvi).

Some years later John Deeble judged,

when directed to specific diagnostic problems or issues in treatment, tests are both clinically valuable and cost effective...[but] tests are often repeated unnecessarily, the results ignored or overlooked and the purposes for which they were ordered are not always clear (Deeble & Lewis-Hughes 1991: 53).

Part of the evidence for this assessment was demonstrated in the wide variations in the patterns of pathology ordering among practitioners (Deeble & Lewis-Hughes 1991: 75). The answer of this and other reports was that some solutions have proved effective in the short term, like educating doctors in the cost of tests, on the applicability of tests and with a clearer understanding of clinical guidelines (Deeble & Lewis-Hughes 1991: 26; Vining & Mara 1996: 4).

A report compiled for the General Practice Branch of the Commonwealth Department of Health in 1996 was critical of both general practitioners and the industry. There was selectivity in the services pathology companies were prepared to deliver. This means that there is a high standard in the areas of specimen collection and the return of pathology tests but a poor record in the clinical interpretation of results and communication with pathologists (Vining & Mara 1996: 4). The report also commented on the role of the market in promoting consumption. There is an “increased availability of services, driven by competitive pressures in the pathology industry and general practice and perverse incentives in both” (Vining & Mara 1996: 4). Competition was very much alive in the practice of the giving of kickbacks/inducements by pathology companies to referring doctors.

Inducements

Fuelling growth has been the practice of pathology companies to achieve increasing market share and dominance over their competitors through what are called kickbacks, inducements, secret commissions, or fee-splitting. These terms refer to offers of cash or other benefits made by pathology laboratories to attract pathology referrals from general practitioners or others requiring pathology. A loose regulatory framework has offered the pathology industry ready-made incentives for overservicing and such a structure, once established, has proved difficult to modify. It represents a breakdown of both the market model and the regulatory system.

If the pathology company is in a position to offer inducements it means that the fees paid to pathologists are too high or the work is not being performed to an adequate standard so as to ensure accuracy in the interpretation of results, or it might be that the work is not being performed at all. Inducements and discounts have a natural place within business practice but are at odds with the philosophy and ethics of medicine. Dr. Frederick Bryce Phillips, Vice-President of the AMA, in evidence before the Joint Committee of Public Accounts pointed out that the AMA code of conduct, like that of the International Code of Medical Ethics, stipulates that “a doctor should not associate himself with commerce in such a way as to let it influence or appear to influence his attitude towards the treatment of his patient” (JCPA 23 October 1985, vol. 16: 6099).

Early signs of the abuse of medical benefits

In the early 1970s, the Royal College of Pathologists of Australasia alerted the government to two issues of concern to the College, one financial and the other scientific. The first was that there was evidence within the industry that medical benefits were being abused and that the high demand for pathology services would place a heavy financial burden on the public purse. The second was if pathology services were to have diagnostic value to the referring physicians, then high standards of professional practice would have to be upheld within the industry. This, they understood, could be achieved through a process of accreditation (Sax 1974: 1). Sidney Sax explained that its aim was to ensure a high standard of pathology testing in the interests of patient care. Accredited pathology laboratories would ensure that their facilities employed qualified

staff, that there was an adequate level of test supervision, that work was completed to a satisfactory standard and that there would be a code of conduct for those providing the pathology service (Sax 1974: 6, 8).

In 1973, the Whitlam government's Health Insurance Planning Committee, comprising Medibank's co-author's John Deeble and Richard Scotton and senior staff of the Department of Social Security and the Department of Health, agreed with this assessment. To control costs, the Committee argued for a sustained level of government control over the industry, by the payment of pathology services through hospital funding arrangements. It recommended that no fee-for-service benefits be paid for pathology services provided by public hospitals and laboratories with salaried personnel. It argued that a system of accreditation for laboratories would ensure quality assurance in the performance of pathology services (*Report of the Health Insurance Planning Committee* 1973: 16).

The approach outlined by John Deeble's committee for strong government control of the industry was a model that had been successfully adopted by New Zealand, where a fully socialised medical scheme had been in place since the 1940s. Professor Herdson, President of the RCPA, argued its merits before the Joint Committee of Public Account's inquiry medical fraud and overservicing. Laboratory services, he said,

are practised either in hospital laboratories where, in general, the laboratory is run by medical pathologists with technical back-up, or they

are practised in a limited number of private laboratories...staffed only by medical pathologists (JCPA Vol. 13, 3 September 1984: 5130 – 5131).

Such a system argued Herdson has guaranteed that the New Zealand pathology industry has fewer problems than its counterpart in Australia.

The design for the scheme for universal health insurance in Australia was to include similar arrangements to those applying in New Zealand. There would be no fee-for-service benefits for pathology and radiology work performed in public hospitals, with all work provided at no charge to patients. In an interview with John Deeble he argued that the problem facing the Australian government was that by the early 1970s pathology was largely hospital based but some private pathology firms were already established. Doctors preferred the private practice model to continue, and in 1976, with the change to the Liberal Country Party coalition government, plans for the scheme were revoked. So private pathology was retained and the balance has been that 60 per cent of pathology services are performed in private laboratories and the remainder in public laboratories, mainly in hospitals (Deeble & Lewis-Hughes 1991: 11, 13; Deeble *pers. comm.* 2001).

In the following year, Sidney Sax, of the Hospitals and Health Services Commission, brought his recognised expertise to bear on the problems of the pathology industry. His report of the Interim Committee on Pathology Accreditation explored the options open to the Government in regard to

accreditation. It did not recommend that the profession control itself. This, it was argued, would mean that legislative power would have to be granted to the profession and Governments would have no involvement, a difficulty when they are the ones paying for the service¹ (Sax 1974: 17). The Commonwealth government was not in a position to take direct control over laboratories because it lacked such power under the Constitution. For this reason legislative police powers would lie with the States. It recommended that the most satisfactory arrangement would be for the profession, the State and Commonwealth governments to combine to institute a system of accreditation (Sax 1974: 18).

The focus of the document was pathology accreditation and it was not discursive in dealing with the abuses of medical benefits. However, Sax did draw attention to the anomalous situation whereby the current regulations hampered cost containment, by allowing legal fee splitting and encouraging overservicing.

There is no restriction on the qualifications of persons performing tests in the medical benefits schedule. By referring a patient to someone who is not a medical practitioner or to a registered company a practitioner can avoid the ethical restriction on fee splitting and derive a profit in direct proportion to the number of tests performed (Sax 1974: 7).

In what would appear to be a statement of fact, rather than a recommendation, he noted that, "in certain circumstances qualified persons other than medical

¹ On the other hand in 1989 the NSW Government gave legislative power to the dental profession to police its own members in regard to fraud and overservicing.

practitioners could be accredited to operate a laboratory” (Sax 1974: 15). This was an issue that had drawn comment from Mr. Justice Ludeke in his fees tribunal decision in 1973:

For all pathology services, other than simple tests of a side room nature, the evidence has led the Tribunal to conclude that these services should be provided by specialist pathologists (JCPA 23 October 1985, Vol. 16: 6121).

The Approved Pathology Practitioners Scheme

In order to address the problems of an industry becoming increasingly dysfunctional a Pathology Services Working Party was established in 1976. It published four papers between 1976 and 1978 that made recommendations for a series of changes in the government’s administration of medical benefits for pathology services. Whether by accident or design these changes exacerbated the problems. One of these was a scheme to regulate suppliers of pathology services. In an attempt to maintain high standards of proficiency in pathology testing and discourage the culture of kickbacks and inducements it proposed an Approved Provider Scheme. It separated out medical providers (Approved Pathology Practitioners, or APPs) from the laboratories where the work was performed (Approved Pathology Laboratories, or APLs) and the legal owners of the laboratories (Approved Pathology Authorities, or APAs) (Deeble and Lewis-Hughes 1991: 40). Providers of pathology services could gain approval on a yearly basis from the Minister to be an APP, along with the payment of a \$10 fee and signing an undertaking to abide by a code of conduct not to offer arrangements in regard to fee splitting or kickbacks. The working parties also

recommended a lowering of the scheduled fee to minimise the temptation by pathologists to offer inducements. The working party reasoned, “the new schedule of services and fee relativities should reduce the current excess profitability of some procedures, which have provided an opportunity for fee-splitting” (PSWP March 1977: 10-11). They recommended that adjustments be made to the scheduled fee levels with full payment for specialist pathologists in private practice and a payment of 75 percent of the schedule fee for specialist pathologists in hospitals, and for all other providers of pathology services.

The recommendations of the Pathology Services Working Party in July 1976 and introduced in August 1977 (PSWP 1978: 2) formalised existing arrangements and opened the way for the corporatisation of the industry. It meant that the values of business would take the ascendancy over the values and ethics of medicine. It was an invitation for anyone to become an Approved Pathology Authority. All manner of people accepted the invitation, including pathology couriers and others with no interest in pathology or patient care, but conscious of the profits to be made from the industry (JCPA Report 236: 100). A person could obtain APP status by making application to the Minister. Then he could then sub-contract work to another APP, a laboratory or some other establishment (JCPA Report 236: 47). Under the umbrella of these corporate structures fee-splitting was now legalised.

Pathology companies with structures for fee-splitting could maximise growth through acquiring an increasing share of the market. Smaller companies, with fewer legal resources, found that under amendments in 1977 to the *Health Insurance Act* (1973) if they offered inducements that it was now both illegal and an indictable offence. Further recommendations were made by the Pathology Services Working Party in 1978 to prohibit pathologists or laboratories making direct reimbursements to requesting practitioners. Nor would they be able to make offers for the payment of wages for staff, rental agreements at other than normal commercial rates or other direct or indirect considerations to encourage the rendering of pathology services (PSWP 1978: 4-5). The pathology industry was now split between those in a position to offer legal inducements, those who could offer only illegal inducements, and those who refused to offer any at all.

It was a felicitous arrangement for those whose goal was the corporatisation of the industry, for others whose goal was high quality assurance within pathology, it signalled the waning of professional standards. It would appear that the Government was supporting commercial imperatives, which were undermining best professional practice. The RCPA was stridently opposed to this scheme and the hostility continued. The College was aware

The present APP scheme has failed in that non-approved laboratories have been set up which can legally fee split with the ordering doctor. The test may be medically necessary but it is still an incentive to run a high level of testing rather than a low level (JCPA Report 236: 51).

None of these new regulations regarding eligibility criteria and accreditation had a chance of success without some system of enforcement to support them. If these recommendations of the Pathology Services Working Party were to be effective then there needed to be legal and administrative mechanisms to deal with it and an administrative apparatus within the HIC which was sufficiently well resourced to carry out this function. There needed to be regular audits to ensure compliance by participants (Wheelwright 1994: 101). There was no administrative structure put into place to ensure that these regulations and its ideals could be upheld. There was already within the industry a stratum of practitioners who regarded pathology principally as a means for the pursuit of profit and who were not bound by ethical considerations. This was all the more reason to ensure that regular checks were undertaken to control malpractice. The eligibility criteria for differential payments for the scheduled fee were problematic because without the scheme being monitored there was no compulsion for providers to assert that they were anything else but specialist pathologists and claim the full fee (Wheelwright 1994: 101-102).

Yet in terms of dealing with deviant behaviour what had been implemented was an insurance-based model of social control. The emphasis was on managing the behaviour of the whole population of service providers to minimise the likelihood of crime occurring rather than apprehending individuals involved in opportunistic crime. Although inducements had been

made an indictable offence, unless a legislative framework was developed and administrative resources directed to this end, then these measures served the purpose of giving authority and resolution to government reports, but were counterproductive in practice. In accordance with Foucault's schema, this is the shadow of the coercive state of the rule of sovereignty but what had solid form was the rule of government; the exercise of control over the population of medical practitioners, technicians and pathology companies by government. This is Foucault's de-centred state in action, where social control is exercised at a distance, where the financial losses from crime are modulated by their spread across the community, where there is a growing inertia in searching for and punishing the individual criminal offender (Reichman 1998: 58).

The Joint Committee of Public Accounts – Report 236 - Pathology

Measures aimed at social control presented a polished surface of public policy rationality but the cracks were appearing. Labor was returned to power in 1983 and it resumed the hearing of the JCPA into medical fraud and overservicing. It was the problems within the pathology industry that were the focus of the Committee's hearings in the years 1983 to 1985. It heard complaints from the major medical associations, senior bureaucrats, pathologists, pathology corporations and members of the public regarding the administration of the APP scheme, the Medical Benefits Schedule, the growth of entrepreneurial medicine (JCPA report 236: v) and the encouragement it gave to the unscrupulous for profit maximisation, illegal behaviour and poor standards of pathology testing. In order to deal with these issues the Committee compiled a

report specifically targeting the problems afflicting the pathology industry. It was a call for administrative and legislative reform, and the amendment of the *Health Insurance Act* so that its disqualification provisions would be used to deal with fraud and overservicing.

The JCPA's inquiry into fraud and overservicing was a forum for industry resentment with the APP arrangement. As one pathologist argued for the sum of \$10

Anybody at all can become an Approved Pathology Provider - anybody...This means that you are entitled not to do pathology but just to bill for it. The technician or company, or whoever owns the business charges the fee for doing that pathology. So in other words you have a fee-split straight away (JCPA Report 236: 39-40).

Apart from having a fee so low that it was held in derision by the industry and a membership that did not stipulate any knowledge of medicine, the Committee had other major problems with the APP scheme. The APP scheme was not enforced or reviewed by the Department of Health. Legal measures to deal with overservicing by the Medical Services Committee of Inquiry were ineffective. There was no laboratory accreditation attached to the scheme to ensure that standards of quality assurance were maintained. The words "for and on behalf of" in Section 16A of the *HIA* effectively meant that technicians could be paid the SP rate for pathology work in laboratories where there was little or no supervision by specialist pathologists. Non-pathologists owned all the commercial laboratories: commerce was moving

into medicine and with it a set of commercial values that were inimical to best professional practice. Automation meant fast test results and fast profits. The College of Pathologists grimly held to its ideal that pathology was not about speed and money but was a consultative service to general practitioners

in which the pathologist and the clinician work out the standard pattern of testing for ordinary problems together and also deal with more difficult problems in consultation whereas what is tending to happen is the ordering of vast number of tests without adequate attention to their significance or what people are trying to find out by means of them (JCPA Vol. 11 21 May 1984: 4479).

But the RCPA's over-riding objection to the APP scheme dated from a resolution agreed to at its annual general meeting in 1977 which recognised the dangers attendant in a scheme which gave power to the Minister for Health, after agreement with his Medical Benefits Advisory Committee, to change the code of ethical conduct which was binding on pathologists. It was an assault on the professionalism of this branch of medicine (Report 236: 49).

From another quarter came complaints about the Specialist Pathology (SP), Other Pathologist (OP) system of differential fees, from practising specialist pathologists Doctors Michael Barratt, Dermer Smith and Michael Harrison. They took the unusual step of publicising their analysis of its failings in the

press, with half page advertisements in *The Australian* and *The Sydney Morning Herald* under the title “Pathology...A Disgusting State of Affairs in New South Wales”.

They explained that there are two types of APP, those who are O.P. Approved Pathology Practitioners, medical practitioners with little or no postgraduate training in pathology and those who are S.P. Approved Pathology Practitioners, that is, those who are specialists in pathology. They argued that the quality of the work of the O.P. Approved Pathology Practitioners was often substandard, except in the case of the minority who did perform satisfactory work on the simpler pathology tests. It was the O.P. Approved Pathology Practitioners who were subcontracting their work to pathology laboratories under fee-splitting arrangements. Barratt, Smith and Harrison calculated that, depending on the agreement reached between the referring doctor and the pathology laboratory performing the test, the laboratories would be receiving between 38.2 per cent and 51.0 per cent of the Schedule Fee. Such an arrangement meant testing was delegated to inadequately trained staff and not performed at the level the work required. This enabled the laboratory to still make a profit, but at the expense of professional standards. While the referring doctor and the laboratory received some form of financial benefit, those not benefiting from the arrangement were the patients and specialist physicians. Patients’ health or lives were jeopardised and the specialists were less than impressed by unreliable test results.

Barratt, Smith and Harrison called for the return of ethical medical practice, the accreditation of pathology laboratories and Commonwealth legislation to make it compulsory for private pathology practices to be owned and operated by pathology specialists (*SMH*, 28 September 1985: 28). Their media activism prompted an invitation to them to appear before the Joint Committee of Public Accounts to express their concerns in more detail about fee-splitting, entrepreneurial medicine and the business practices of their largest competitor, Macquarie Pathology Services (JCPA Vol. 16, 23 October 1985: 6108).

Macquarie Pathology Services

These were subjects close to the heart of the Committee. In its hearings Barratt and Smith accused Macquarie Pathology Services of low standards of quality assurance. They argued that if its pathology reports could describe a case of leukaemia as glandular fever, or an inflammatory condition could be described as a tumour, then accurate diagnosis was not a primary concern of the company (JCPA 23 October 1985, Vol. 16: 6116). They pointed out that Macquarie was twice the size of their practice but employed half the number of specialist pathologists (JCPA 23 October 1985, Vol. 16: 6108). In addition they gave kickbacks, cut corners and used insufficient qualified staff (JCPA 23 October 1985, Vol. 16: 6120). Dr. Dermer Smith continued

These people in this game have these strange corporate structures which make everything legal. So fee-splitting is legal; kickbacks are legal; things that would normally have them deregistered under the law of the State of New South Wales are all legal because they have been able to form these convoluted company structures (JCPA 23 October 1985, vol. 16: 6108).

Macquarie Pathology Services were under investigation by the HIC, the DoH, the AFP and the DPP (JCPA Report 236: 92). Notwithstanding this, its director, Dr. Thomas Wenkart, and its general manager, Dr. Ross Sutton, were invited to give evidence before the Committee. Wenkart presented himself to the Committee as an industry leader, discharging services to the public in an ethical fashion, and well positioned to detail measures to enhance the standing of the profession.

Wenkart said he supported the government's regulatory approaches to fraud and overservicing, he urged accreditation legislation and suggested other reform initiatives. Wenkart argued that inducements and kickbacks are used by smaller pathology practices to gain greater market share. Overservicing, he argued, could be controlled through counselling and "education" not by legislation (JCPA Vol. 12: 4687). Wenkart provided an elaborate rationalisation for the giving of inducements. He argued that if the kickbacks are a small enough amount, say five to ten per cent, then the kickbacks "may be a legitimate commercial cost", but if it were in the range of \$5,000-\$10,000 then they would be kickbacks within the meaning of the law (JCPA vol. 12: 4690). He admitted that "there were some bad eggs in the industry" (JCPA vol. 12: 4753) but not that his company could be counted among its number.

The confrontation between Barratt and Smith on the one hand and Wenkart and Sutton on the other was a conflict between medicine as ethically practised and medicine as business ruthlessly promoted. Wenkart's performance was brash in public but defensive in private; his backstage behaviour betrayed an anxiety that public criticism could be detrimental to his enterprise. He circulated a memorandum to staff stating that the allegations were unfounded, and that his company did not "cut corners" or give kickbacks (Wenkert and Sutton 25 October 1985). To referring doctors Wenkart wrote that the company had grown to be the largest private pathology company in New South Wales only through the hard work of its dedicated staff. He argued that Macquarie Pathology was not involved in fee-splitting, but qualified this with his assertion that

The law has permitted contract pathology which is often misrepresented as fee splitting. Contract pathology involves a laboratory performing tests on a contract basis for another party. This party is not always an approved pathology provider...under this arrangement the laboratory charges a realistic fee for contracted services (Wenkert October 1985 see Appendix).

Wenkert asked doctors to refer pathology to his company's intermediate company's Omniman and Macquarie Professional Services, which then referred the work on to Macquarie Pathology Services. Doctors received forty per cent of the fee for service and the Macquarie Pathology Services took the remaining sixty per cent. In this way the fee-splitting remained within the letter of the law (Buckley 1985: 1). However, in the minutes of a Macquarie management

meeting, Dr. Ross Sutton acknowledged that their associated pathology company, Omniman owned by Dr. Geoffrey Edelsten, could be a public relations liability

If our name becomes too closely connected with Dr. E [Edelsten] there is the potential for very grave and swift damage to be done to our reputation, and therefore our workload. Despite the fact that our relationship with Omniman is strictly legal and known to the government one day's "sensationalism" by the media can undo years of careful promotion (see *Appendix*).

Despite Wenkart's protestations before the Committee that the company did not offer kickbacks Sutton was aware that this was the case and was at pains to cover-up the evidence. Sutton argued that, "our present arrangements, whereby Omniman is paid 'up front' and we collect the revenue leaves us open to charges of fee-splitting and kickbacks". His proposed solution was a "simple contract arrangement ...where we send out an account, payable in 30 days, for services rendered" (Sutton Minutes 17 September 1985, see *Appendix*).

Report 236 on entrepreneurial medicine

The dispute between Barratt and Smith on the one hand and Wenkart and Sutton on the other was a manifestation of a continuing conflict within medicine over its primary orientation. The question was did medicine exist to care for the sick or was it a business enterprise for the maximisation of profits? As Ray Moynihan noted, when the imperative is to make money, entrepreneurs will exploit the opportunities at hand and this has meant the over-ordering of

diagnostic services and overservicing (Moynihan 1998: 170). This has been facilitated by entrepreneurial medicine.

It is a style of medicine that is practised in a clinic where doctors were paid by salary or by contract by people who also had ownership interests in other medical services. The attraction for the public was that these clinics offered short waiting times, no appointments, extended surgery hours, bulk-billing and the convenience of having general practitioner, diagnostic and ancillary health services located in the one building. The attraction for entrepreneur was the profits to be generated by a general practitioner seeing sixty to eighty patients in a ten to twelve hour day, while in a more leisurely age the rate would be two to three patients per hour (Health Issues Centre 1986: 9). In addition there were profits in referrals. Dr. Barry Catchlove calculated for every dollar earned by a general practitioner another \$1.60 is generated in diagnostic and specialistic services (Catchlove 2001: 68). The danger was that the quality of patient care could be compromised and that the ethical practice of medicine would be secondary to commercial considerations (Sax 1990: 154; White 2000-1; Aloizos 2001; Fitzgerald 2001; Fitzgerald 2002; Lavelle 2003).

It left many uneasy. Sidney Sax took up the concerns raised by Arnold Relman that this represented “a new medical industrial complex” where large integrated corporations with multiple medical specialist services on site could offer unprecedented opportunities for profit generation. Others expressed

forebodings for the future of medicine. Anthony Moore and Anthony Tarr saw a conflict of interest between these entrepreneurial medical clinics that are funded through Medicare without any provision for the government to control the number of services provided to patients, the nature of these services or where referrals are directed (Moore & Tarr 1988: 5-6).

Report 236 of the JCPA gave a negative appraisal of the current state of entrepreneurial medicine. The Committee argued that entrepreneurs did not place ethics foremost in their considerations, scrutinised regulatory measures for loopholes and worked just within the limits of the law (JCPA Report 236: 89). As with the majority of commentators on this subject the Committee expressed concerns that these clinics were a conduit for overservicing (JCPA Report 236: 90). One specialist pathologist recalled that, "some GP request forms were like the scenario to an MGM spectacular. Sometimes the paper was not big enough for GPs to write all the tests down in three columns" (JCPA Report 236: 97). Dr. Davies, vice-president of the RCPA, believed that savings could be made of the order of \$20 million per year in pathology if the incentives for fraud and overservicing were removed and a system of accreditation put into place to ensure that work was being performed to a satisfactory standard (JCPA Report 236: 95).

Irrespective of the findings of the Committee, Liberal coalition governments lent their support to entrepreneurial medicine. Prior to 1996 general

practitioners were the only individuals who could legally own surgeries, but a change in the law in 1996 meant that third parties could now buy these practices (Lavelle 2002). This led to a surge in GP corporatisation in 1998-99. Again the debate over entrepreneurial medicine came to life. The AMA wrote a scoping paper outlining the risks involved in this style of medical practice. It involved the risk of loss of clinical independence. It meant that corporations could influence the volume and directions of referrals (AMA 2000: 2). They argued that if corporations controlled referrals from a substantial section of the GP market then this would lay the foundations for U.S. styled managed care (AMA 2000: 6). The AMA's position had not altered from the evidence it gave to the JCPA on this subject in the 1980s.

The Federal Government commissioned the financial auditing company KPMG to write a scoping paper on the corporatisation of general practice. Its author was Barry Catchlove, former Chairman of the HIC, and a senior executive with Mayne Nickless. It was a peculiar choice. He was a long time promoter of entrepreneurial medicine and one whose impartiality could be called into question (Moynihan 2000). It was not surprising that Catchlove was supportive of the corporatisation of general practice and in his somewhat brief literature review argued that there was no concrete evidence that corporatisation resulted in the decline of quality of care. He noted "practitioners can directly influence the revenue capacity of other providers...it is ironic that the most regulated

area (pathology), could be argued as the most unsuccessful in containing inappropriate behaviour” (KPMG 2000: 42).

Catchlove continued this line of argument in an article he wrote for the *Medical Journal of Australia*. He could foresee no conflict between the ethical practice of medicine and corporatised medicine, nor was there evidence that GPs were being pressured into overservicing. He agreed that corporatisation laid the foundations for a U.S. style of managed care, but the move away from what he called medicine as a cottage industry to a corporatised model of health care was to be commended for it offered improved efficiency and service (Catchlove 2001: 69). In Geoffrey Edelsten’s assessment the push to corporatisation had less to do with the ideal of service and higher productivity and more to do with profits. In a newspaper interview he commented,

The success of Ed Bateman’s Primary Health Care has demonstrated the enormous economies of scale that can be reaped by merging solo practices...if you can then vertically integrate it with pathology and radiology and visiting specialists, and have day-care and in-patient care hospital facilities, then the profitability is extraordinary (Moynihan *AFR* 23 May 2000: 1).

Moynihan and Dr. John Aloizos, president of the Queensland Division of General Practice, argued that this profitability was being driven by the public funding provided through Medicare and this was propelling corporatisation (Moynihan 2001; Aloizos 2001). A similar process had occurred in the United States with the introduction of Medicare and Medicaid where public financing

made the health care industry increasingly attractive to investors and this was encouraging the growth of corporate medicine (Starr 1983: 428). As in Australia this affected the practice of medicine and the politics of medical care (Starr 1983: 421).

JCPA Report 236 (1985)– its other recommendations

It would appear that governments have encouraged entrepreneurial medicine since the reports of the Pathology Working Parties of the late 1970s, with the one exception being the JCPA, whose findings in 1985 were that such a style of medicine compromised patient care and involved considerable overservicing (JCPA Report 236: 89-90). The Committee could have felt free to be outspoken because this was a joint committee of both houses now serving under a Labor government. It was critical of the working parties for making fee-splitting legal. It recommended that the *HIA* be amended to specifically prohibit this practice (JCPA Report 236: 61), but was not specific about whether they mean legal or illegal fee-splitting (JCPA Report 236: xvii). It does say that HIC should be able to search company records to determine the ownership of pathology companies (JCPA Report 236: 103).

It critiqued the Department of Health for failing to review the APP scheme (JCPA Report 236: 41). It recommended that measures be taken to check the growth of entrepreneurial practices in pathology, which it judged as socially undesirable (JCPA Report 236: xxiv-xxv). It noted that the MSCI system was not workable and should be replaced by a Medical Tribunal system. It

recommended that the *HIA* be amended to ensure that the offences, recovery and disqualification provisions of the Act can be effectively used to deal with medical fraud and overservicing (JCPA Report 236: xviii). The Committee argued for appropriate resources to be given to the HIC for the development of its claims review systems (JCPA Report 236: xviii).

Finance Minute Report 260 (1986)

These recommendations were approved by the Department of Finance but in regard to resources to deal with the crime management of medical fraud in all its forms, there was equivocation evident in their response in 1986 that this would be considered by the government “in the normal budgetary context” (JCPA Report 260: 43). The same devaluation for crime management was apparent in the failure of the Department to support a medical tribunal system to hear cases of overservicing. It gave support instead to an ineffective committee system (JCPA Report 260: 44). It would appear that the government was ill-disposed to lending its support to conventional policing, and the DPP and the HIC were like minded and expressed their positions on this before the JCPA. The Office of the Director of Public Prosecutions preferred that the HIC should delay or withhold payment on suspicious claims for medical benefits and that there should be greater use made of civil proceedings. The HIC was of the view that judicial remedies were ill suited to matters as complex as medical fraud and was of the opinion that the profession itself should discipline its own members (JCPA Report 260: 11).

Results of Report 236

The Committee did not assign any responsibility or accountability to the policy makers responsible, made no indictment of poor policy design, no assessment of why this was done in the first place or who was to gain from it, nor did it assess the implications for best professional practice within pathology. Its recommendations on the strengthening of the APP scheme, mandatory accreditation of pathology laboratories and the belief that a heightening community awareness of the dangers of entrepreneurial medicine would lead to greater accountability were ineffective. Its most important proposal, that the HIC be adequately resourced for its fraud investigations, would have been successful had the government financially supported it.

However, it did make many recommendations, some of which were implemented. One proposal with merit was a scheme for the continuing education of doctors throughout their careers on the cost benefits of pathology tests. Another was for a reduction in pathology rebates. The Committee noted that

The widespread application of advanced technology has greatly reduced the cost of many pathology investigations and the Medicare benefits do not appear to have been proportionately reduced (JCPA 1985: xxi).

In 1986 Medicare rebates for 18 of the most commonly performed pathology tests, that is, 43 per cent of pathology benefits, were reduced by 25 per cent. There were further reforms in 1988 and 1989, with the 1988 changes being

subject to legal challenge. The committee also recommended that benefits for venepuncture, the taking of blood samples, be removed altogether, and this recommendation put into effect (Deeble 1991: 10).

The Committee believed it was desirable that all pathology companies be assessed by the National Association of Testing Authorities (NATA). It argued the case for this on two grounds, firstly to discourage unscrupulous laboratories from the fraudulent practice of 'sink tests', that is pouring the specimen in the sink and reporting a normal test result. Secondly the government needed a guarantee that public moneys were being spent on work that was performed to a high standard (JCPA Report 236: 43). This proposal was implemented, but the Committee made no recommendations in regard to NATA publishing the results of its findings. If such a scheme was to be effective then general practitioners needed to access this information so they could refer their patients to pathology companies that could return accurate results.

Highlighting this problem was the case of Rhonda O'Shea. In 1988 her general practitioner referred O'Shea's pap smear to Macquarie Pathology Services. A technician found abnormal cells but the slide was not shown to a specialist pathologist and a negative finding was returned to the GP. O'Shea developed cervical cancer and she sued the pathology company as well as her general practitioner. As she was dying she was left with the consolation that she was the first to win a case of negligence against a pathology company (Donovan *The*

Australian 1994: 13; Fife-Yeomans *The Weekend Australian* 1994: 5). Some months after her death NATA threatened Macquarie Pathology with the loss of accreditation for inadequate staffing of specialist pathologists in its histology and cytology departments, but the company was able to have the decision reversed on appeal to the Administrative Appeals Tribunal (Norman *CT* 1994: 1; Meade *SMH* 1994: 3).

Macquarie Pathology was not alone in its poor work practices. A research study published in 1996 in the *MJA* was not encouraging. The problem was widespread. It surveyed work performed by pathology laboratories across five Australian states and found they had a transcription error rate of up to 39 per cent and an error rate on analytical results of 26 per cent. The worst performing laboratory had errors in 46 per cent of requests and the best laboratory had a 5 per cent error rate. These findings demonstrated that medical resources were being wasted and patients' lives endangered. The study reported that all medical testing laboratories in Australia are required to be accredited and to participate in quality assurance programs but there were no minimum standards of performance which laboratories are required to maintain (Khoury *et al* 1996: 128-130).

The sorry history of accreditation was symptomatic of the recommendations of the Committee. It had formulated many worthwhile ideas but they were not extended to the point where they had regulatory effectiveness. The committee

needed a clearer focus on legislative reform of the *HIA* and administrative reform within the *HIC*. As Backhouse noted the reforms of the pathology industry were limited both in terms of accountability and the constraints needed to rein in the growing cost of pathology under Medicare (Backhouse 1994: 203).

At the conclusion of the Committee's hearings the issue faded from political consciousness. The Health Minister, Dr. Neal Blewett, acknowledged that in the period after 1985 he did not give it his attention.

It certainly wasn't high on my agenda and I think we played it fairly low key in that period anyhow, so I probably did neglect it a bit. There were so many other things on my plate. And I suppose because the media has passions about these things and bursts of interest and then the Minister has got to be aware of things, but they fell off I think, in pursuing it, probably feeling the *HIC* was doing a reasonable job (Blewett *pers. comm.* 2002).

Blewett paused to reflect on the advice he was receiving from his department at that time.

I can't remember much in the way of myself being alerted to problems...I don't think that Wilcox [managing director *HIC*] was as enthusiastic about it as some of his younger subordinates. And I think he may have kept a bit of restraining hand on them (Blewett *pers. comm.* 2002).

The Bates Report

What was missing from the Committee was evidence from those with expertise in public administration. In 1992 the HIC, under the leadership of a new managing director, Lawrie Willett, was able to draw upon such knowledge when it commissioned a report from consultant Harvey Bates, formerly of Customs, on procedures for the conduct of investigations. The review was prompted, among other matters, by allegations of the release of unauthorised information by staff of the HIC to former NSW police officers. The NSW Independent Commission Against Corruption found that a number of former police officers were engaged in the sale of confidential information, a trade that was both illicit and highly profitable (ICAC 1992 vol. 1: 4). ICAC had no powers of investigation over a Commonwealth government agency but was concerned at the extension of a network of serving and former members of the NSW police into the HIC who were engaged in this illegal activity (ICAC 1992 vol. 3: 1081). It found a number of staff involved including one with a key managerial position.

Peter Anthony Crymble, Manager of the Professional Review Branch of the New South Wales office of the Health Insurance Commission, had released confidential Medicare information. Mr Crymble is also a former New South Wales police officer, and he released the information to a private inquiry agent, Guy David Oakley, who is yet another former New South Wales police officer (ICAC 1992 vol. 1: 50-51)

Apart from investigating this issue Bates was asked to address the effectiveness of the Commission's fraud control program and the degree of success it was achieving in dealing with complex and organised fraud (Bates 1992: 1). It

identified problems in dealing with the financial abuse of medical benefits and suggested ways for improving systems.

The Bates Report found there was no adequate policy developed to manage fraud control activity; neither had it been given a specific budget allocation. The HIC provided no staff training in investigative work. The existing legislation was inadequate to support investigative action into major cases of fraud. The function of detecting and prosecuting fraud against Medicare has never been successfully integrated into the HIC's operations. Senior management needed to make a commitment to ensuring that incorrect benefit payments whether obtained in error, misunderstanding or deceit, are given the same level of attention, support and effort as other areas of the Commission's functions. Bates noted that the level of medical fraud was likely to have increased since the HIC assumed this function in 1985. He found that with the transfer of operational activity to state managers there has been a reduction of the number of experienced staff allocated to these activities with the result that state managers have had to assume this responsibility and they have little or no knowledge of fraud control or investigation (Bates 1992: 11). He made a plea for increased resource allocation to fight fraud and for better training and improved research and analysis (Bates 1992: 2-6). On the subject of current legislation to deal with fraud he argued that the *National Health Act* and the *Health Insurance Act* were "complex, inconsistent and in some cases unenforceable". He continued

It is somewhat incongruous that the *Health Insurance Act* acknowledges the possibility of serious frauds being committed in the area of medical benefits payments but is totally silent on the issue of powers which would support investigative activity (Bates 1992: 14).

Senator Sue Knowles tabled the report in Federal parliament in 1993, but Bates himself was sceptical that his recommendations would be implemented as “organisational reviews have not been responded to with any degree of enthusiasm and have therefore not achieved the desired effect” (Bates 1992: 3).

The Bachich case

One case, which demonstrated the difficulties inherent in prosecuting cases of fraud by pathology companies, was that against Peter and Rosalind Bachich, the owners of the pathology company in Sydney. The case got to a committal hearing in the Sydney local court in 1990. The prosecution alleged that Peter and Rosalind Bachich who operated NCPS Laboratories Pty. Ltd. had a financial association with Dr. Ian McGoldrick, who was on criminal charges under the *Health Insurance Act*. On the APA form the Bachichs had denied any financial association with anyone with a criminal charge under the *Act*. There was sufficient evidence presented at the hearing to prove that the Bachichs knew of McGoldrick’s criminal record. This constituted an offence against section 23D (a) (1) of the *HIA*. The magistrate, Carl Milovanovich, said this was a *prima facie* case and the matter would proceed to trial for “the evidence is capable of satisfying a jury as to the commission of each offence – of the offences charged”. However, the defence argued that the case would go to trial on questions of law but a jury would dismiss the case on the basis of giving the

defendants “a fair go”! This adroit persuasion by the defence convinced the magistrate to dismiss the case. He then argued

The case is one which involves a great deal of complexity, a case of considerable financial arrangement, re-arrangement and perhaps even manipulation. It is a case which I believe on the evidence that I have seen here today a jury will have considerable difficulty in determining exactly what the financial flow, what the particular associations were with various persons.

He added that the McGoldrick brothers Ian, Bryan and Peter were unreliable witnesses who offered questionable evidence. A reader reviewing this case would be puzzled by Milovanovich’s reversal of his earlier finding, as the case was not complex and there were no evidentiary hurdles to be overcome (Police v Peter George Bachich and Margaret Rosalind Bachich 1990: 39-40 also cited in ANAO Report no. 17: 14). If this matter had been won in court it would have been the first successful prosecution by the HIC and the DPP against a pathology company.

The Australian National Audit Office and the media respond

The matter was certainly a puzzle to the Australian National Audit Office. In Audit Report no. 17 of 1992-93 they delivered their verdict on this matter. They judged it was a travesty of justice to dismiss such a case on the basis that the evidence was too complex for the prosecution to effectively present their case. Their judgement was that such a finding would encourage unethical pathologists to continue abusing the medical benefits system. The value of mentioning this case in the audit report was that it underlined the problems

facing the HIC. The issues facing the organization were that it needed more resources and a change of culture away from narrow notions of efficiency and towards one that more fully addressed fraud and its prevention. But beyond this was yet another difficulty: the HIC did not have the support of the judiciary (ANAO Report no. 17: 14).

For the Professional Review Division of the HIC, already understaffed and under-resourced, the magistrate's finding would have further lowered morale. However, the media responded to the case. *The Age* newspaper reported the matter on its front page (Chandler *The Age* 4 May 1990) and ABC television's investigative journalism series *Four Corners* used the case as the basis for an exposé on the abuse of medical benefits. On the program Bachich denied a financial relationship with Ian McGoldrick, but the reporter had documents proving Super Clinics Australia, half owned by McGoldrick, was sending its pathology to Peter Bachich's NCPS company and receiving a kickback of \$20,800 per month. Before the program went to air Bachich had threatened the ABC with defamation and in spite of the ABC's best efforts to avoid this reprisal, it did face court action after the program was broadcast. Fortunately for the ABC it won by default, as the Bachichs did not have the financial resources to sustain protracted litigation (ABC V. Peter Bacich, Rosalind Bacich, 18 June 1992 and Judith Walker, Manager Legal & Copyright Department, Australian Broadcasting Corporation, *pers. comm.*).

The program also mentioned that a Melbourne pathology company, Gribbles, was also involved in kickbacks, but no defamation suits ensued. Gribbles was paying Dr. Ian McGoldrick over \$70,000 a year for space for a collection centre in his Frankston clinic, paying \$30,000 to Dr. Chris Towie of the Five Star chain of medical clinics and paying \$100,000 to the Complete Health Care Group a year for rental space. Dr. John Nearhos, the Medical Director of the HIC, believed these were inducements not commercial arrangements. The mention of these cases served to underline the fact that ethical pathology providers were losing business to unethical providers, who were progressively dominating the industry. It was this group who as Ed Wilson, a spokesman for the Australian Association of Pathology Providers, said, “looked for opportunities to defeat the spirit of the law”. However, the legal system itself offered no redress, as the lack of successful prosecutions for kickbacks further encouraged unethical practice. It allowed scope for “a small band of sharp operators – for almost two decades – to hijack an industry and get away with millions of dollars in public funds”. All the while the publicly funded hospital system was being depleted of the resources to offer basic services for the critically ill (*4 Corners* 27 April 1992).

A new legislative approach

The legal difficulties inherent in prosecuting cases of fraud within the pathology industry drew the attention of legal academic Karen Wheelwright. She viewed the problem from an unusual perspective, that of the inadequacy of the Commonwealth’s regulatory powers over health under the Constitution (Wheelwright 1994: 95). Its powers are currently based on section 51 (23A) of

the Constitution which gives 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 (so as not to authorize any form of civil conscription), benefits to students and family allowances.

This is not a direct power to regulate the provision of health benefits. It is a limited power and its focus is on the provision of benefits and allowances. It was the states which held the power to rein in health expenditures and deal with the issue of entrepreneurial medicine, but they had no incentives to take this action (Wheelwright 1995: 82).

Wheelwright explored this constitutional conundrum. She suggested the idea of basing the regulation of pathology on a different constitutional basis. The legislative power of the Commonwealth is limited to what are called 'heads of power' which are found mainly in section 51 of the Constitution. The authority or head of power, which offered the opportunity for direct Commonwealth regulation, was the corporations power in section 51 (20) of the Constitution and this could be applied to the regulation of pathology companies (Wheelwright 1994: 114). The corporations power regulated "trading corporations" and pathology companies fell within this ambit. This, she argued, provided the basis for a comprehensive regulatory framework. There were two drawbacks to this idea. The first was that section 51 (20) could not force

pathology companies to become incorporated. This meant that for other types of business practice, like partnerships, would have to be based on other heads of power. The problem was that in using multiple heads of power the legislation was weaker and therefore more likely to be beset by legal challenges (Wheelwright 1994: 115). The second problem was that for all its merits the concept of the regulation of corporate medicine by this means had not been attempted (Wheelwright 1995: 83).

She believed that any initiatives in this direction could be thwarted by any of the major interest groups in the health sector, the medical profession, pharmaceutical manufacturers and the private health insurance industry. The fear of the political leverage of these groups could be sufficient to deter the federal government from experimenting with new legal powers (Wheelwright 1995: 55).

The culture of kickbacks continues

While Wheelwright's innovative approach to dealing with a basic legislative problem has much to commend it the problems of kickbacks and inducements continued. The Australian Association of Pathology Providers, a peak industry body representing sixty per cent of specialist pathology providers, voiced its frustrations. The legislation, they said, should be both 'enforceable and enforced'. They were aware that a range of abuses prevailed. Examples of this were the

Claiming of Medicare benefits when specimens are collected in an unlicensed collection centre by quoting the licence number of a Licensed Collection Centre at a different location;

Provision of staff to a requesting doctor (where the staff are subsidised or wholly paid for by the pathology practice, often through an 'arm's length' third party company under the control of the owners of the pathology practice) in return for a level of pathology requests which meets the cost of providing the staff;

Financial inducements or the provision of goods and services to a requesting practitioner in return for a level of pathology requests in excess of what is medically appropriate;

Rental of space within a doctor's rooms for the storage of equipment owned by the laboratory, where the rental is quite excessive and the space may be limited to a drawer in a doctor's desk or to a fridge in the corner of the surgery (AAPP Annual Report 1993-94: 13-14).

They argued that while they worked to develop reforms the government did not uphold its side of the arrangement with the provision of "bullet-proof legislation, effective administration or prevention of fraud and abuse". The government all too often sought the simple solutions of fee cuts or changes to delivery systems, solutions that all too often favoured those who were already financially abusing the system (*AAPP Annual Report 1993-94*: 8).

In 2000, Dr. Ben Haagsma, president of the Australian Association of Pathology Providers, called for new laws to deal with corruption within the industry. He cited some of the current inducements as being free cars, cash kickbacks and overseas holidays. Haagsma argued

The crux of the problem now is that with current health insurance legislation, it's just too easy to sidestep the penalties, or too onerous to provide the level of proof required to put someone in jail. The level of proof has to be lowered to make it less difficult to present cases to the Director of Public Prosecutions (Verghis 2000: 3).

The first prosecution for kickbacks in New South Wales came belatedly in 1996, a sign of the difficulty in obtaining prosecutions under the present laws.

The view from the Department of Health and Aging

In a move that brought little joy to the pathology industry was the Commonwealth's decision to introduce fixed funding in 1996 (*AAPP Annual Report* 1995-96: 4). Under this arrangement pathology spending was capped regardless of the number of tests undertaken (Allen 2004: 12), and this was a move that did succeed in controlling Medicare expenditure in pathology (*AAPP Annual Report* 2002: 12).

The Department of Health and Aging in its *Report of the Review of Commonwealth Legislation for Pathology Arrangements Under Medicare* 2002 expressed confidence that current regulatory arrangements should be working effectively. It was aware that this was not the case and pinpointed some problematic areas. The DPP was reluctant to accept cases unless a high standard of evidence had been marshalled and there was a reasonable chance of winning a successful prosecution. The DPP, quite reasonably, was reluctant to carry the financial burden of unsuccessful litigation. The alternative to the court system, the

Medicare Participation Review Committee,² was infrequently used and its range of determinations was too limited. It recommended that a new range of offences be established, the Medicare Participation Review Committee process be strengthened and a system of direct administrative action by the HIC be introduced (*Report of the Review of Commonwealth Legislation for Pathology Arrangements under Medicare December 2002: 30*).

What is lacking from this analysis is a discussion of what direct administration action might mean. It most likely refers to the capacity of the Medicare Participation Review Committee to disqualify those abusing from access to Medicare benefits. What is not mentioned in the document is that fraud losses are much higher than officials like to acknowledge and for this reason there needs to be systematic measurement of fraud losses, in order to allocate resources for crime detection. The inherent problem is that routine control systems can be circumvented by those determined enough to beat them. American academic Malcolm Sparrow, on the ABC-TV's *Four Corners* program 'Doctoring the Figures', said in relation to the Australian Medicare program

The nature of the fraud risks are tied directly to the structure of the payment system. And you and your Medicare program and your other fee-for-service programs have exactly the same structure as the traditional

² The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who has been successfully prosecuted for medifraud. The Committee has a discretionary range of options from taking no further administrative action against the practitioner to counselling and reprimand and full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

American fee-for-service systems. So you face the same risks, whether you like it or not (*Four Corners*, 6 September 2004).

Since 1992 the United States Department of Justice has given a top priority to fraud control against Medicare and Medicaid (Sparrow 1998: 1), but such attention has not been forthcoming from Australian officials.

Conclusion

The history of fraud control over pathology benefits has been marked by a failure of the regulatory apparatus. Administrative measures have been ineffective, as have legislative measures. This ineffectiveness extends to the law's commanding heights, Commonwealth power under the constitution. The Commonwealth has no direct power to regulate the provision of health benefits under section 51 (23A) of the Constitution. However, there is scope to pursue fraud control at the administrative level along the lines advocated by Malcolm Sparrow. Also needed for a program of ongoing reform are the media and a managing director of the HIC energetic enough to keep fighting for change. The example of the effectiveness of this approach is seen in the reform agenda of Lawrie Willet and dramatically in the strategies deployed by Allan Fels, who as chairman of the Australian Competition and Consumer Commission, used adverse publicity for regulatory enforcement (Brenchley 2003; Yeung 2002).

Conclusion

There are *no* circumstances, however unfortunate, from which clever people do not extract some advantage

- Extract from the Christmas greeting of Lt. Michael Flynn on behalf of 2/6 Field Company, Royal Australian Engineers, 2nd AIF, 7th Division, at the Roberts Hospital, Changi, Singapore, 1942, cited in L. J. Robertson and A.E. Field *et al*, 1982 *The Gap is Bridged part 2*.

This thesis analyses the way in which medical fraud and overservicing became entrenched within systems of publicly funded universal health insurance in Australia. The key period covered is that between 1975 and 1996, with reference to an earlier period in the growth of both health policy and types of health insurance. This thesis focuses on the role of those with little institutional power, the whistleblowers, and to a lesser extent the unauthorised unofficial confidential sources, within the Department of Health and the HIC who were aware of the regulatory failures for cost containment in this area of health insurance. By themselves their voices would not have been heard but by their successful alliance to journalists, parliamentarians and a key stakeholder, the

Australian Medical Association, the issue received the attention of the Joint Committee of Public Accounts and its interest was ongoing for over three years. Health insurance covered hospital benefits and the health services provided by general practitioners and specialists. It did not cover the services given by allied health professionals, physiotherapists, chiropractors, podiatrists, dentists or those practising alternative medicine. The private health funds covered some of these services but often the gap payments were high. The private funds employed their own investigators to detect and deal with fraud and overservicing. In the area of dental fraud it is noteworthy that in New South Wales, the NSW Dental Board had powers under its Act to prosecute cases of dental fraud and overservicing, and reportedly has had an enviable success rate with these prosecutions. This has meant that dentists have secured tight disciplinary control over their own practitioners and this in turn has meant that politicians have not been able to use the excuse of the existence of high rates of fraud and overservicing as the leverage for political control over the dental profession. Systems of fraud control used by the private funds are mentioned in passing but it is not a subject that has been covered in detail in this thesis.

One account that analysed the issue of medical fraud and overservicing was that by Gillespie that covered the period up to 1960. Others explored the wealth of information uncovered by the JCPA's inquiry into this subject in the post 1985 period (Wilson *et al*), and others have focused on the financial abuses in

the pathology industry and legal avenues for address of this problem (Deeble, Wheelwright). This thesis draws upon all these works but stresses the influence of the philosophy and practice of insurance, the political interests that have exploited the lack of regulatory controls over publicly funded health insurance and the corrective influence of both formal and informal systems of accountability. The media has had a direct and indirect influence over regulatory systems. Direct influence has been exercised through publicity and indirect influence via the threat of potential negative publicity. This threat galvanised the new managing director of the HIC in 1990, Lawrie Willett, to implement a range of measures to deal with issue of the abuse of medical benefits, and these, he argued, were best reviewed every four to five years.

Foucault's theory of governmentality has provided a tool for understanding the way in the modern era the state has extended its interest into ever-new areas of governance. The task for government is to keep pace with these functions and responsibilities and this is done through its delegation to independent offices of accountability. In the area of publicly funded health insurance, weaknesses can be seen in its regulatory structure. To understand how fraud and overservicing became a feature of first Medibank and then Medicare, documents were consulted that were available on the public record, as well as confidential documents. Relevant academic texts and articles were consulted. Interviews were conducted with many of those who were participants to the events

described in these pages. They included former Federal Ministers for Health and other politicians, former presidents of the Australian Medical Association, former Medical Directors of Medibank and Medicare, former managing directors of the HIC, academics, journalists and whistleblowers.

This thesis has drawn attention to regulatory failures over medical fraud and overservicing. They would not be a subject of concern if the levels of financial abuse were at a reasonable level. This thesis has argued that this is not the case. There is a level of abuse which is politically acceptable and in Australia the last audit conducted by the Australian National Audit Office in 1996/97 put these figures at between 1.3 to 2.3 per cent of medical benefits. The argument of this thesis is that these figures have been based in information supplied by the HIC that is not a realistic indication of the extent of the abuse of medical benefits¹. This in itself is a fraud. The reason why truer figures are important is so that the level of resources needed for this area which requires intensive policing can be gauged and allocated. This is important for the cost containment of medical benefits and so that medical resources can be directed to other much needed areas, like the public hospital system. One problem for the future is that the use of electronic funds transfer, which while giving the illusion of efficiency, is

¹ However, an indication that the HIC does have an accurate idea of the amount of fraud and overservicing can be gained from a recent newspaper article that revealed that the HIC had done an audit in June of this year in Victoria that said that doctors had overcharged by a minimum of 500 percent more than 3000 times in May of 2004 (Frenkel 2004 'Doctors in Medicare Sting', in *The Herald Sun* 15 July: 1).

problematic as it is not immediately evident whether the patient had the type of medical service claimed or was present for the service at all. Medical fraud and overservicing have been committed at the individual, syndicate and corporate levels and have allowed scope for financial abuse not only by medical practitioners but also from practice managers, receptionists, ancillary health-care workers, and computer hackers and criminals who were versed in the vulnerabilities of the system.

Not only does medical fraud and overservicing incur large costs on the health system but this thesis has also explored the way in which the Labor Party has used the issue to its benefit both as one of the justifications for the introduction of health insurance in 1975 and the justification for further conflict with the medical profession in the period 1983 to 1985. The Liberal Coalition government from 1996 onwards, on the receipt of low figures for fraud and overservicing as indicated in the ANAO Report, reduced resources to the Program Review Division of the HIC, the area for fraud investigations, by thirty percent in line with reductions to the HIC overall.

This thesis has been indebted to the innovative work of Malcolm Sparrow in the area of medical fraud. His arguments that governments prefer to ignore the real level of medical fraud, that scandals in the media on this subject propel public

policy, and that academic literature on this subject is scant, has been found to also apply in Australia.

Possible avenues for research in this area in the future would be a comparative study of fraud control mechanisms in Australia, Canada and the United States, as well as for comparisons of the political contexts in which these public policies are operating.

Interviewees

Katherine Beauchamp

Researcher, Joint Committee of Public Accounts, Parliament House Canberra
February to September 1982

Canberra: 4 August 1995, phone, 31 January 2000

The Hon. Dr. Neal Blewett A.C.

Former Federal Minister for Health and Minister for Community Services and Health, 1983 – 1990, High Commissioner, UK

Currently: Visiting Professor, Faculty of Medicine, University of Sydney

Leura, NSW: 19 March 2002

Professor Pierre Bourdieu

Former Professor of Sociology at the Collège de France and Director of Studies at the École des Hautes Études en Sciences Sociales

London: 2 March 2001

Michael Boyle

Former ASIO officer

Currently Consultant, National Archives of Australia

Canberra: 5 November 2003

Grahame Cannon,

Former: NSW Manager, Health Insurance Commission

Sydney: 5 February 2002

The Hon. Don Chipp

Former leader of the Democrats

Kallista, VIC: 30 January 1996

Emeritus Professor Anne Crichton

University of British Columbia

Vancouver, Canada: 24 November 1999

Peter Cullen

Canberra lobbyist

Canberra: 9 June 1998

Associate Professor John Dale A.M.

Adjunct Associate Professor, Faculty of Dentistry, University of Sydney

President, Australian Dental Council 1997-2000

President, Dental Board of New South Wales since 1988

Sydney: 20 June 2002

Professor John Deeble,

Co-author of the original national health insurance proposal (Medibank)

Commissioner, Health Insurance Commission, 1983 - 96

National Centre for Epidemiology and Population Health

Australian National University

Canberra: 27 March 2000, 12 June 2001; 26 June 2001

Brian Donavon Q.C.

Barrister Rhonda O'Shea case

Sydney: 21 April 1994

Dr. Ken Doust

Former NSW Medical Director, Medibank, 1975 to 1980

Currently: Medical Practitioner

Narooma, NSW: 1 February 2002

Professor Richard Ericson

Former Professor of Law, Professor Sociology, Principal of Green College

University of British Columbia, Canada

Vancouver, Canada: 23 November 1999

Professor Bob Evans

Centre for Health Sciences and Policy Research

University of British Columbia, Canada

Vancouver, Canada: 25 November 1999

John Evered,

Asst. General Manager, Processing & Control, Health Insurance Planning

Committee 1972. Asst. General Manager, Audit and Control, Medibank Private

Former: Project Manager for the Implementation of Medicare

Manager internal audit and investigations Health Insurance Commission 1985

General Manager Personnel Management, 1995

Managing Director, Health Insurance Commission, 1995-6

Canberra: 26 September 2001

Professor Peter Grabosky,

Regulatory Institutions Network, Research School of the Social Sciences

Australian National University

Canberra: 27 September 2001

Dr. Warwick Graco,

Former Manager Research, Professional Review Division,

Health Insurance Commission

email, 14 August 2001, Canberra: 18 October 2001

Dr. Steve Gray

Legislative and Professional Regulation Branch

B.C. Ministry of Health, Victoria, British Columbia, Canada

Phone: 29 November 1999

Dr. Jeff Harmer

Former Managing Director, Health Insurance Commission

Now: Secretary, Department of Education, Science and Training

Canberra: 26 August 2002.

Associate Professor Roy Harvey,

1974-1979 Statistician, head of the Actuarial and Statistics Branch, Medibank

1979-1984 Research Fellow, Health Economics Research Unit, ANU

1984-1995 Head of the Health Service Division, Australian Institute of Health and Welfare

1995-present. Associate Professor, Centre for Health Service Development, University of Wollongong.

Canberra: 20 September 1995

Chris Haviland,

Fraud investigator NSW branch, Commonwealth Department of Health

Union Official - Administrative and Clerical Officers' Association

Member of Federal Parliament – 1993-6

Canberra: 22 June 1995, Sydney 26 July 2001

Ken Hazell

Former: General Manager Government Programs, Health Insurance Commission

Canberra: 12 August 1994

Dr. John Holmes

Director - Professional Services Review

Canberra: 16 July 2002

Dr. James Ironside

Dental practitioner and fraud investigator, Dental Board of New South Wales

Sydney: 11 June 2002

John Kelly,

Former: Director, Development Section, Operations Branch
Commonwealth Department of Health

Canberra: 11 December 1995, 17 February & 17 December 1996

David Kindon

CEO Australian Association of Pathology Practitioners

Canberra: 6 June 1994

Bernie McKay

Head Department of Health 1984-87

Sydney: 18 February 2002

John McMillan

Former Senior Lecturer, Faculty of Law

Australian National University

Currently Commonwealth Ombudsman

Canberra: 9 June 1998

The Hon. Michael MacKellar,

Minister for Health 1979-1982

Melbourne: 3 May 2001

The Hon. Jenny Macklin, (and policy advisor Andrew Herington)

Former: Federal Shadow Health Minister

Canberra: 1 June 2000

Dr. John Nearhos

Former General Manager, Professional Review Division, Health Insurance
Commission

Currently: CEO, DTech

Phone: 20 May 1994, Canberra, 3 February 1995

Laurie Oakes

Journalist, Political editor, The Nine Television Network, Columnist *The Bulletin*
magazine

Canberra: 27 October 1998

Paul Orwin (with Geoff Proban)

Former: Co-ordinator Investigations Health Insurance Commission

Canberra: 18 October 2001

Garry Patterson,

Former Asst./Mgr. processing branch
Commonwealth Department of Health

Sydney: 13 July 1995

Geoff Proban (with Paul Orwin)

Former: Investigator Vic Department of Health

Former: Investigator Health Insurance Commission – based in Vic till 1994

Co-ordinator Investigations Health Insurance Commission – based in Canberra
1994-2001

Canberra: 18 October 2001

Dr. George Repin

Former Secretary-General, Australian Medical Association

Sydney: 7 March 2002

The Hon. Graham Richardson,

Federal Minister for Health 1993-9

Sydney: 27 November 1994

Peter Roberts,

Policing Studies,

Charles Sturt University & Australian National University

Canberra: 27 September 2001

Regina Robertson

Manager, Medical Testing

National Association of Testing Authorities

Sydney: 31 March 1995

Dr Martin Scheckter

Department of Health Services and Epidemiology

University of British Columbia, Canada

Vancouver, Canada: 25 November 1999

Professor Philip Schlesinger

Director of the Stirling Media Research Institute

University of Stirling

Stirling, Scotland: March 2001

Dr. Richard Scotton, AO

Co-Author of original national health insurance proposal (became Medibank)
 Former: Chairman of Health Insurance Commission 1975 – 1976
 Honorary Professorial Fellow, Centre for Health Program Evaluation, Monash
 University, Melbourne
Melbourne: 11 April 1996; email: 28 March 2002

Professor Chris Selby Smith,

Former: First Assistant Director-General Insurance, Hospitals and Nursing
 Homes Division, Commonwealth Department of Health
 Currently: Department of Management, Faculty of Business and Economics
 Monash University
Melbourne: 31 January 1996

Joe Shaw

Former: Medical fraud investigator, Medibank Private (Qld)
Brisbane: 12 April 2002

Michael Smith,

Former editor, *The Age* newspaper
Phone: 31 January 2000

Dr. Russell Smith

Deputy Director of Research, Australian Institute of Criminology, 2001-2004
 Currently Principal Criminologist, Australian Institute of Criminology
Phone: 10 July 2001

Professor Malcolm Sparrow

Professor of the Practice of Public Management
 Kennedy School of Government, Harvard University
 Author: "License to Steal: Why Fraud Plagues America's Health Care System"
Email 24 July 2001

Dr. Peter Taylor

Former: Medical Director, Health Insurance Commission
 Director: The Health Bureau and consultant to Medibank Private
Greenwell Point, NSW: 27 August 2002

Dr. Lindsay Thompson, AM

Former: President of the Australian Medical Association 1982-1985
 Now: Associate Professor, Department of General Practice, Faculty of Medicine
 Sydney University
Sydney: 13 February 2002

Senator Amanda Vanstone

Former Shadow Minister for Justice

Now: Minister for Immigration & Multicultural & Indigenous Affairs

Canberra: 6 June 1994

Dr. Lorne Verhulst

Medical consultant

B.C. Ministry for Health, Victoria, British Columbia, Canada

Phone, 29 November 1999

Judith Walker

Former, General Manager, Legal and Copyright

Australian Broadcasting Corporation

Sydney: 1997

Ralph Watzlaff

NSW Manager, Health Insurance Commission

Former: Manager Compliance, Health Insurance Commission

Sydney: 20 May 1994

Dr. David Weedon

Former: President Australian Medical Association

Pathologist: Sullivan and Nicolides Pathologists

Southport, Queensland: 25 October 1994

Karen Wheelwright

Lecturer, School of Law

Deakin University, Melbourne

Melbourne: 11 June 1998

Lawrence (Lawrie) Willett A.O.

Director-General, Commonwealth Department of Health 1983-1984

Managing Director, Health Insurance Commission 1990-1995

phone, 19 February 2002

The Hon. Dr. Michael Wooldridge,

Former: Minister for Health 1996 - 2001

phone, 9 January 1996, Melbourne, 11 April 1996

Dr. Peter R. Young

Former: Defence Editor of *The Australian* and Defence and Foreign Affairs

Editor for *Network Ten Television*

Former: Associate Professor, Defence Media Studies in the Centre for the Study of Australia-Asia Relations, Griffith University

Gold Coast, Qld: 17 November 1998

Nick Zaitzieff

Initiatives group, Program Review Division

Health Insurance Commission

Canberra: 16 July 2002

Note: In addition to this list some interviewees preferred to be interviewed “off the record”.

Bibliography*

* All relevant items consulted are listed here. Not all are cited in the text.

Alford, C. F. 2001 *Whistleblowers: Broken Lives and Organizational Power*, Ithaca, London: Cornell University Press.

Alford, R. R. 1975 *Health Care Politics: Ideological and Interest Group Barriers to Reform*, Chicago: University of Chicago Press.

Allen, L. 2004 'Pathologists say industry stretched', *AFR*, 24 September: 12.

Aloizas, J. 2001 'Corporatization: is it a risky business?' *AFR* 14 March: 15.

'AMA calls for the sacking of government medical fraud investigators', *The Australian*, 7 September 1984: 3.

Anthony, J. M. 1975 'The politics of the bureaucracy and the role of the ministerial staff, in R. Scott & J. Richardson (eds) *The First Thousand Days of Labor, Proceedings of the 17th Annual Conference of the Australasian Political Studies Association, Canberra*, 11–13th July, Vol. 2: 124-36.

Armstrong, D. 1977 'How to Stop Doctor Frauds', *The Bulletin*, 9 July: 45-46.

Armstrong, D. 1984 'Why Doctors Are Our Richest Militants', *The Bulletin*, 19 June: 24-28.

Arnold, P. C. 1975 'The GPSA – The Anatomy and Physiology of a Pressure Group', in R. Scott & J. Richardson (eds), *The First Thousand Days of Labor, Proceedings of the 17th Annual Conference of the Australasian Political Studies Association, Canberra*, 11-13 July, Vol. 1: 2-18.

Arnold, P. C. 1983 'Health Care Financing in Australia: There is No Solution', *British Medical Journal*, 286, 6359: 159-160.

Auditor-General's Office 1977 *Report of the Auditor-General 1977*, Canberra: AGPS.

Auditor-General's Office 1978 *Report of the Auditor-General 1978*, Canberra: AGPS.

Auditor-General's Office 1982 *Report of the Auditor-General 1982*, Canberra: AGPS.

Auditor-General's Office 1984 *Report of the Auditor-General 1984*, Canberra: AGPS.

Australia. Attorney-General's Department: Office of Strategic Crime Assessments, 2000 *The Changing Nature of Fraud in Australia*, Canberra: Australian Government Publishing Service.

Australia. Attorney-General's Department, 2002 *Commonwealth Fraud Control Guidelines*, May 2002, Canberra: Australian Government Publishing Service.

Australia. Department of Health, 1985 'Health's Role in Surveillance and Investigation Examined as Responsibility is Transferred to Health Insurance Commission'. In *Health Reporter: Journal of the Commonwealth Department of Health*, 2 (6): 2.

Australia. Department of Human Services and Health, 1995 *Guidelines for the Implementation of Clinical Practices Guidelines*, Standing Committee on Quality of Care and Health Outcomes, Office of National Health and Medical Research Council, Canberra.

Australia. Department of Health and Ageing, 2000 *The Australian Health Care System: An Outline*, Canberra: Ausinfo.

Australia. Department of Health and Ageing, 2002 *Report of the Review of Commonwealth Legislation for Pathology Arrangements under Medicare. Final Report*. [<http://www.health.gov.au/haf/branch/dtb/review.pdf>].

Australia. Department of Health and Ageing, 2003 *Medicare Statistics 1984/85 to June Quarter 2003*. Canberra: Department of Health and Ageing.

Australia. Health Insurance Commission, 1996 *Annual Report 1995-1996*. Canberra: Australian Government Publishing Service.

Australia. Health Insurance Commission, 1997 *Annual Report 1996-1997*. Canberra: Australian Government Publishing Service.

Australia. Health Insurance Commission, 1998 *Annual Report 1997-1998*. Canberra: Australian Government Publishing Service.

Australia. Health Insurance Commission, 1999 *Annual Report 1998-1999*. Canberra: Australian Government Publishing Service.

Australia. Health Insurance Commission, 2000 *Annual Report 1999-2000*. Canberra: Australian Government Publishing Service.

Australia. Health Insurance Commission, 2001 *Annual Report 2000-2001*. Canberra: Australian Government Publishing Service.

Australia. Health Insurance Commission, 2002. *Annual Report 2001-2002*. Canberra: Australian Government Publishing Service.

Australia. Report to the Commonwealth Government. National Commission of Audit 1996 Canberra: Australian Government Publishing Service.

Australian Association of Pathology Practices Inc. *Annual Report 1993-94*.

Australian Association of Pathology Practices Inc. *Annual Report 1994-95*.

Australian Association of Pathology Practices Inc. *Annual Report 1996-97*.

Australian Association of Pathology Practices Inc. *Annual Report 2001*.

Australian Association of Pathology Practices Inc. *Annual Report 2002*.

Australian Clerical Officers Association, 1984 *Submission*, Joint Parliamentary Committee of Public Accounts, Inquiry into Medical Fraud and Overservicing, November.

Australian Labor Party, 1972 *It's Time. Political Advertisement*. National Film and Sound Archive, ID 253354-01. VHS, Dur: 2 mins. 12 secs.

Australian Medical Association, 1969 'Why Mr. Whitlam's proposals should be rejected', *AMA Gazette*, 6 February 1969: 5 - 9.

Australian Medical Association, 1969 'Health benefits compared: Poor deal under Labor plan', *AMA Gazette*, 4 September 1969: 1, 3.

Australian Medical Association, 1969 'Careful costing claim misleading – PM', *AMA Gazette*, 2 October 1969: 5.

Australian Medical Association, 1974 *Annual Reports 1973 to 1986*, Glebe, NSW: AMA Publishing Co. Ltd.

Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1998 *Medical Workforce Supply and Demand in Australia: A Discussion Paper*, AMWAC Report 1998.

Australian National Audit Office, 1984 *Audit Report*, Department of Health, 3 September 1984.

Australian National Audit Office, 1992. *Audit Report No. 17, 1992-93, Medifraud and Excessive Servicing*, Health Insurance Commission, Australian Government Publishing Service, Canberra.

Australian National Audit Office, 1996 *Audit Report No. 24, 1995-96, Impact of Sunset Clauses on Investigatory Powers*, Health Insurance Commission, Australian Government Publishing Service, Canberra.

Australian National Audit Office, 1997 *Audit Report No. 31, 1996-97, Medifraud and Inappropriate Practice*, Health Insurance Commission, Australian Government Publishing Service, Canberra.

Australian National Audit Office, 2002 *Audit Report No.5, The Strategic Partnership Agreement between the Department of Health and Ageing and the Health Insurance Commission*, Australian Government Publishing Service, Canberra.

Ayres, P. 1987 *Malcolm Fraser*, Richmond, Vic.: William Heinemann Australia.

Ayres, I. & J. Braithwaite, 1992 *Responsive Regulation. Transcending the Deregulation Debate*, New York, Oxford: Oxford University Press.

Backhouse, P. J. 1994 *Medical Knowledge, Medical Power: Doctors and Health Policy in Australia*, unpublished PhD thesis, University of Adelaide.

Bacon, W. 1985 'Drug Profits in the Professions', *The National Times*, April 5-11: 20-22.

Bacon, W., C. Ryan, D. Smith, 1985 'Crisis in Health Care', *The National Times*, 11-17 October: 3-5 & 1.

Barer, M., M. Nicoll, M. Diesendorf & R. Harvey, 1990. 'From Medibank to Medicare: Trends In Australian Health Care Costs and Use from 1976 to 1986', *Community Health Studies*, 14 (1): 8-17.

Barer, M., L. Lomas, C. Sanmartin, 1996 'Reminding our Ps and Qs: Cost Controls in Canada', *Health Affairs*, Summer, 15 (2): 216-234.

Barnes, J. A. 1994 *A Pack of Lies: A Sociology of Lying*. Cambridge: Cambridge University Press.

Barrett, M., D. Smith & M. Harrison, 1985 'Advertisement: Pathology. A Disgusting State of Affairs in New South Wales', *SMH* 28 September: 28.

Bauman, Z. 1989 *Modernity and the Holocaust*, Ithaca, New York: Cornell University Press.

Bates, E. M. 1983 *Health Systems and Public Scrutiny: Australia, Britain and the United States*, London & Canberra: Croom Helm.

Bates, H. 1992 *Review of the Operations & Procedures for the Conduct Of Investigations*, Canberra: Health Insurance Commission.

Beauchamp, K. 1984 *Medifraud: A Professionally Induced Cancer. A Report on Inaction*. Rupert Public Interest Movement Inc.: Canberra.

Beauchamp, K. 1985 'Medifraud unabated: ACOA', *The Age* 2 March: 9.

Beauchamp, K. 1985 'The Medifraud Scandal: Corruption and Coverups', *Matilda*, 3, May 1985: 41-45.

Beauchamp, K. 1985 'Australian Sport Gets a Godfather', *Matilda*, 7, September: 27 -29.

Beck, U. 1992 *Risk Society: Towards a New Modernity*, London: Sage Publications.

Beck, U. & J. Willms, 2004 *Conversations with Ulrich Beck*. Trans. M. Pollak, Cambridge, UK: Polity Press.

Beddie, F. 2001 *Putting Life into Years: The Commonwealth's Role in Health Since 1901*, Canberra: Commonwealth Department of Health and Aged Care.

Beilharz, P. & T. Moynihan, 1983 'Medibank: Monument or Mausoleum of the Whitlam Government?' *Thesis Eleven*, vol. 7: 151-158.

Bentham, J. 1843 'Of Publicity', in *The Works of Jeremy Bentham*, London: Simpkin Marshall & Co. Vol. 2: 310-317.

Bentham, J. 1843 *The Works of Jeremy Bentham*, London: Simpkin Marshall & Co. Vol. 4: 316-317.

Bentham, J. 1843 'Of Publicity and Privacy', in *The Works of Jeremy Bentham*, London: Simpkin Marshall & Co. Vol. 6: 35-380.

Best, J. 1989 'Wastage among the Tall Poppies', *MJA*, Vol. 151, 4 September: 294-297.

Blass T. (ed.) 2000 *Obedience to Authority: Current Perspectives on the Milgram Paradigm*, New Jersey, London: Lawrence Erlbaum Associates, Publishers.

Blewett, N. 1982 'The Challenge of the New Conservatism', in *Labor Essays 1982: Socialist Principles and Parliamentary Government*, Richmond, Vic.: Drummond Publishing.

Blewett, N. 1983 'Medical Fraud and Overservicing. Ministerial Statement' *Historic House Hansard 15 November 1983*, articles 248 of 430:1-9.

Blewett, N. 1983 'What Medicare Will Mean to You', *New Doctor*, Dec. 30 : 5-7.

Blewett, N. 1984a Address delivered by Neal Blewett, Minister for Health, at the National Press Club Canberra, 31 January 1984 [transcript from sound recording], ORAL TRC 1577, National Library of Australia.

Blewett, N. 1984b 'Australian Labor Party Viewpoint', *Perspectives on Health Policy*, Australian National University, Canberra

Blewett, N. 1989 'What is Wrong with the Australian Medical Association', *Canberra Survey*, 42 (7), 7 April: 1-8.

Blewett, N. 1999 *A Cabinet Diary. A Personal Diary of the First Keating Government*. South Australia: Wakefield Press.

Blewett, N. 2000a 'The Politics of Health', *Australian Health Review*, 23 (2): 10-19.

Blewett, N. 2000b 'Robert James Lee Hawke' in M. Grattan (ed.) *Australian Prime Ministers*, Sydney: New Holland.

Blewett, N. 2003 'The Hawke Cabinets', in S. Ryan & T. Bramston (eds), *The Hawke Government: a Critical Retrospective*, North Melbourne: Pluto Press.

Bok, S. 1978 *Lying: Moral Choice in Public and Private Life*. Vintage Books, New York.

Bok, S. 1981 'Blowing the Whistle', in J. L. Fleishman, L. Liebman & M. H. Moore (eds) *Public Duties: The Moral Obligations of Government Officials*, Cambridge Massachusetts: Harvard University Press.

Bok, S. 1982 *Secrets: On the Ethics of Concealment and Revelation*, London: Oxford University Press.

Bornhurst, P. 1982 'State to inquire into fraud by doctors', *The Australian* 23 September: 3.

Bossence, J. 1988 *Poison Arrows: A History of 'The Age' Insight Team*, B.A. Thesis, Melbourne: Royal Melbourne Institute of Technology.

Botsman, P. 2001 'Australia's New Health Care Challenge', in P. Botsman & M. Latham (eds) *The Enabling State: People Before Bureaucracy*, Sydney: Pluto Press.

Bourdieu, P. 1977 *Outline of a Theory of Practice*, Cambridge, Cambridge University Press.

Bourdieu, P. 1990a *The Logic of Practice*. Stanford: Stanford University Press.

Bourdieu, P. 1990b *In Other Words*. Cambridge: Polity Press.

Bourdieu, P. 1991 *Language and Symbolic Power*, Cambridge: Polity Press.

Bourdieu, P. 1998a *Acts of Resistance: Against the New Myths of our Time*, Cambridge, UK: Polity Press.

Bourdieu, P. 1998b *Practical Reason: On the Theory of Action*, Cambridge: Polity Press.

Bourdieu, P. 1998c *On Television and Journalism*, London: Pluto Press.

Bourdieu, P. et al. 1999 *The Weight of the World: Social Suffering in Contemporary Society*, Cambridge, UK: Polity Press.

Bowne, A. 1984 'The Doctors' Dilemma: the Money or the Image', *Business Review Weekly*, 5-11 May 1984.

Braithwaite, J. 1997 'On Speaking Softly and Carrying Big Sticks: Neglected Dimensions of a Republican Separation of Powers', *University of Toronto Law Journal* 47: 305-361.

Braithwaite, J. 1999 'Accountability and Governance Under the New Regulatory State', *Australian Journal of Public Administration*, 58 (1), March: 90-94.

Braithwaite, J. 2000 'The New Regulatory State and the Transformation of Criminology', *British Journal of Criminology*, 40 (2): 222-238.

Braithwaite, J. & B. Fisse 1985 'Why Exposing Drug Dealers Won't Work', *Australian Society*, January: 21-23.

Braithwaite, J. & P. Drahos 2002 'Zero Tolerance, Naming and Shaming: Is There a Case for it with Crimes of the Powerful?' *The Australian and New Zealand Journal of Criminology*, 35 (3): 269-288.

Brandt, P. 1998 'Fraud Control by the Health Insurance Commission: A Multifaceted Approach', in R. G. Smith (ed.) *Health Care, Crime and Regulatory Control*, The Australian Institute of Criminology, Sydney: Hawkins Press: 179-189.

Brenchley, F. 2003 *Allan Fels: A Portrait of Power*, Milton, Qld: John Wiley & Sons.

Broadbent, D. 1977 'Kickbacks fact of life, says doctor', *The Age*, 12 February 1977: 5.

Broadbent, D. & J. Wiles 1977 'Medi could save \$30m', *The Age*, 26 March 1977: 5.

Brown, K. E. 1987 'Social Security and Medical Frauds', in D. Lanham, M. Weinberg, K. E. Brown, G. W. Ryan (eds) *Criminal Fraud*, Sydney: Law Book Company Ltd.

Brown, M. 2004 'Doctor got \$380,000 for bogus operations', *SMH* 6 September: 3.

Brown, M. (ed.) 2001 *Australian Crime*. Sydney: New Holland Publishers.

Brown, M. C. 1983 *National Health Insurance in Canada and Australia: A Comparative Analysis*, Canberra: Health Economics Unit, Australian National University Printing Service.

Buckley, A. 1984 'Medifraud campaign bungled, Govt. told', *SMH*, 5 September: 3.

Buckley, A. 1984 'Edelsten complains of 'bias and prejudice'', *SMH* 28 November: 3

Buckley, A. 1985 'Pathologists kill and cheat', *SMH* 24 October: 1, 4.

Buckley, A. & M. Rice 1985 'Government backs down on doctors' row', *SMH* 3 April: 1.

Butler, J. 1991 'Health Care', in B. Galligan, O. Hughes, & C. Walsh, (eds) *Intergovernmental Relations and Public Policy*, North Sydney: Allen & Unwin.

Butler, L. 2000 'Medicare Criticised for Failing to Measure Fraud', *American Medical News*, 6 March 2000
[http://www.ama-assn.org/sci-pubs/amnews/pick_00/gvsc0306.htm]

Cahill, D. C. 2004 'The Radical Neo-Liberal Movement as a Hegemonic Force in Australia 1976-1996', unpublished PhD thesis Wollongong: University of Wollongong.

Cameron, D. 1985 'Shake-out of pathologists threatened', *CT* 25 October: 1.

Campbell, C. & J. Halligan, 1992 *Political Leadership in an Age of Constraint: Bureaucratic Politics Under Hawke and Keating*, Sydney, Allen & Unwin.

Campbell, E. 1982 'Appearance of Officials as Witnesses before Parliamentary Committees', in J. R. Nethercote (ed.) *Parliament and Bureaucracy: Parliamentary Scrutiny of Administration: Prospects and Problems in the 1980s*, Sydney: Hale & Iremonger.

Campbell, R. 1986 'Medifraud inquiry sparks animosity among officials', *CT*, 25 June: 11.

Campbell, R. 2003 'Ruling throws secrecy laws into disarray', *CT*, 11 December: 1, 2.

Carey, J. W. 1974 'Journalism and criticism: The case of an undeveloped profession', *Review of Politics*, 36 (2): 227-249.

Carey, J. W. 1986 'The Dark Continent of American Journalism', in R. K. Manoff & M. Schudson (eds) *Reading the News*, New York: Pantheon Books.

Carey, J. W. 1989 *Communication as Culture: Essays on Media and Society*, Unwin Hyman, Boston.

Carey, J. W. 1995 'The Press, Public Opinion and Public Discourse', in T. L. Glasser & C. T. Salmon (eds) *Public Opinion and the Communication of Consent*, New York, London: The Guilford Press: 373-402.

Carlton, J. J. 1985 'Medicare: The Mortal Combat of Doctors and Governments', *Quadrant*, April: 13-15.

Carney, T. & P. Hanks 1986 *Australian Social Security Law, Policy and Administration*, Melbourne: Oxford University Press.

Carter, M. 1993 *Submission to the Senate Standing Committee on Community Affairs on the Health Legislation (Professional Services Review) Amendment Bill 1993*, Health Issues Centre, Melbourne.

Cashman, P. 1982 'Medical Benefit Fraud: Prosecution and Sentencing of Doctors, Part 1', *Legal Service Bulletin*, 7, 2: 58-61.

Cashman, P. 1982 'Medical Benefit Fraud: Prosecution and Sentencing of Doctors, Part 2', *Legal Service Bulletin*, 7, 2: 116-121.

Cass, M. H. 1964 *A National Health Scheme for Labor*, Fabian Society Pamphlet 9, Wilson Service Press, Croyden West, Vic.

Castel, R. 1991 'From Dangerousness to Risk', in G. Burchell, C. Gordon and P. Miller (eds) *The Foucault Effect: Studies in Governmentality*, Chicago: The University of Chicago Press.

Castle, P. 1986 'Police blamed for delays', *CT* 1 August: 3.

Castles, F. C. 1989 'Social Protection by Other Means: Australia's Strategy for Coping With External Vulnerability', in F. C. Castles (ed) *The Comparative History of Public Policy*. Cambridge: Polity Press: 281-298.

Catchlove, B. R., S. Spring, C. Garrick & J. Hall 1978 'Medical Training and the Costs of Health Care', *MJA*, 2: 318-321.

Catchlove, B. R. 1982 'Community Demands for Health Services', in M. Tatchell (ed.) *Perspectives on Health Policy*, Canberra: Australian National University, 63-68.

Catchlove, B. R. 2001 'GP Corporatisation. The Why and the Wherefore', *MJA*, 16 July, 175 (2): 68-70.

Challinger, D. 1988 'Fraud on Government. A Criminological Overview', *Canberra Bulletin of Public Administration*, No 56 Sept. 1988: 18-24.

Chandler, J. 1990 'Medicare case too complex: magistrate', *The Age*, 4 May: 1.

Clarke, M. 1990 'The Control of Insurance Fraud. A Comparative View', *The British Journal of Criminology*, 30 (1): 1-23.

Cohen, J. 2004 'In the Firing Line'. A *Four Corners* television program, Australian Broadcasting Corporation, Sydney 23 February 2004.
[URL <http://www.abc.net.au/4corners/content/2003/transcripts/s1051405.htm>]

Cole, R. W. 1988 'The Public Sector: The conflict between accountability and efficiency', *Australian Journal of Public Administration*, 47 (3): 223-232.

Commonwealth Committee of Enquiry into Health Insurance, 1969 *Report* Canberra: Australian Government Publishing Service.

Commonwealth Department of Health, 1976 *Annual Report of the Director-General of Health 1975-76*, Australian Government Publishing Service: Canberra.

Commonwealth Department of Health, 1977 *Annual Report of the Director-General of Health 1976-77*, Australian Government Publishing Service: Canberra.

Commonwealth Department of Health, 1978 *Annual Report of the Director-General of Health 1977-78*, Australian Government Publishing Service: Canberra.

Commonwealth Department of Health, 1979 *Annual Report of the Director-General of Health 1978-79*, Australian Government Publishing Service: Canberra.

Commonwealth Department of Health, 1980 *Annual Report of the Director-General of Health 1979-80*, Australian Government Publishing Service: Canberra.

Commonwealth Department of Health, 1981 *Annual Report of the Director-General of Health 1980-81*, Australian Government Publishing Service: Canberra.

Commonwealth Department of Health, 1982 *Annual Report of the Director-General of Health 1981-82*, Australian Government Publishing Service: Canberra.

Commonwealth Department of Health, 1983 *Annual Report of the Director-General of Health 1982-83*, Australian Government Publishing Service: Canberra.

Commonwealth Director of Public Prosecutions, 1986 *Annual Report 1985-86*, Canberra: Australian Government Publishing Service.

Commonwealth Director of Public Prosecutions, 1991 *Annual Report 1990-91*, Canberra: Australian Government Publishing Service.

Commonwealth Director of Public Prosecutions, 1992 *Annual Report 1991-92*, Canberra: Australian Government Publishing Service.

Commonwealth Director of Public Prosecutions, 1993 *Annual Report 1992-93*, Canberra: Australian Government Publishing Service.

Commonwealth Director of Public Prosecutions, 2000 *Annual Report 1999-2000*, Canberra: Australian Government Publishing Service.

Commonwealth Department of Prime Minister and Cabinet, 1979 *Annual Report 1978-79*, Canberra: Australian Government Publishing Service: 29-47.

Corbett, D. 1992 *Australian Public Sector Management 2nd ed.*, Sydney: Allen & Unwin.

Cornfield, P. 1976 'Medibank: Clamp-down on cheats', *The Australian*, 3 February: 7.

Costa, M. & M. Duffy 1993 'Labor and Economic Rationalism', in C. James, C. Jones & A. Norton, *A Defence of Economic Rationalism*, St. Leonards, NSW: Allen & Unwin.

Costar, B & P. Vlahos 2000 'Sir Earle Page', in M. Grattan (ed.) *Australian Prime Ministers*, Sydney: New Holland Publishers.

Costin, W. 1986 'Medi-fraud blitz is on the way', *Sunday Telegraph*, 18 May: 21.

'Court order cancels '4 Corners': ABC', *CT* 15 September 1984: 3.

Cranston, R. 1987 *Law, Government and Public Policy*, Melbourne: Oxford University Press: 79-106.

Crichton, A. 1990 *Slowly Taking Control?: Australian Governments and Health Care Provision, 1788-1988*, Sydney: Allen & Unwin.

Crichton, A. 1998 *Children of a Common Mother: A Comparative Analysis of the Development of the Australian and Canadian Health Care Systems to 1995*, School of Health Services Management, University of New South Wales.

Cullen, P. 1991 *No is not an Answer: Lobbying for Success*, Sydney: Allen & Unwin.

Cullen, P. 1998 'Lobbying Parliamentarians: Does it Make a Difference?', in D. Lovell, I. McAllister, W. Maley, C. Kukathas (eds), *The Australian Political System*, 2nd edition, Melbourne: Longman.

Cumming, F. 1982 'Fraud check-up widens', *The Australian*, 8 February: 1.

Curran, J. 1991 'Rethinking the Media as a Public Sphere', in P. Dahlgren and C. Sparks (eds), *Communication and Citizenship: Journalism and the Public Sphere*, London: Routledge: 27-57.

Curran, J. 1996 'The New Revisionism in Mass Communication Research: a Reappraisal', in J. Curran, D. Morley and V. Walkerdine (eds) *Cultural Studies and Communications*, London: Arnold: 256-278.

Curran, J. 2002 *Media and Power*, London and New York: Routledge.

Dale, J. M. 1994 *Dental Board of New South Wales: Record of Decisions 1988-1993*, Sydney: Dental Board of NSW and Pluto Press.

Dale, J. M. 2002 *Dental Board of New South Wales: Record of Decisions II 1994-2001*, Sydney: Dental Board of NSW & Hippo Books.

Daniel, A. 1990 *Medicine and the State: Professional Autonomy and Public Accountability*, Sydney: Allen & Unwin.

Daniel, A. 1995 'The Politics of Health: Medicine versus the State', in G. M. Lupton and J. M. Najman (eds), *Sociology of Health and Illness: Australian Readings* South Melbourne: University of Queensland Press.

Davis, A. 2000 'Public Relations, News Production and Changing Patterns of Source Access in the British National Media', *Media, Culture & Society* 22 (1): 39-59.

Davis, G., J. Wanna, J. Warhurst & P. Weller 1993 *Public Policy in Australia*, 2nd edition, Sydney: Allen & Unwin.

Davis, I. 1982 '2500 doctors cheated, says report', *The Age*, 8 February: 3.

Davis, I. 1982 'MPs denied documents on medifraud', *The Age*, 20 October: 4.

Davis, I. 1982 'MPs find medical frauds not investigated'. *The Age*, 27 October: 3.

Davis, I. & M. Gordon 1982 'Medi inquiry told of PS corruption', *The Age*, 28 October: 1.

Dean, M. 1999 *Governmentality: Power and Rule in Modern Society*, London: Sage Publications.

Deeble, J. S. 1982 'Unscrambling the Omelette: Public and private health care financing in Australia', in G. McLachlan & A. Maynard (eds) *The Public/Private Mix for Health: The relevance and effects of change*, London: The Nuffield Provincial Hospitals Trust.

Deeble, J. S. 1989 'Health Care Under Universal Insurance: The First Three Years of Medicare', in R. G. Butler & D. P. Doessel, *Health Economics: Australian Readings*, Sydney: Australian Professional Publications: 189-211.

Deeble, J. S. 1991 *Medical Services Through Medicare*, National Health Strategy Background Paper No 2, February.

Deeble, J. S. 2000 'Medicare's Maturity: Shaping the Future from the Past', *Medibank: 25 Years On*, *MJA* 173 (1): 44-47.

Deeble, J. & P. Lewis-Hughes, 1991 *Directions for Pathology*, National Health Strategy Background Paper No 6, July.

Deeble, J. S. & R. B. Scotton, 1977 'Health Services and the Medical Profession', in Tucker, K. (ed.), *The Economics of the Australian Service Sector*, London: Croom Helm.

De Maria, W. 1995a 'Quarantining Dissent: The Queensland Public Sector Ethics Movement', *Australian Journal of Public Administration*, 54 (4) December.

De Maria, W. 1995b 'Whistleblowers and Secrecy: Ethical Emissaries from the Public Sect [or]' Paper presented at the Freedom of the Press Conference, Bond University, 11 November 1996.

[<http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/DeMaria-wbs.html>]

De Maria, W. 1999 *Deadly Disclosures. Whistleblowing and the Ethical Meltdown of Australia*. Kent Town, South Australia: Wakefield Press.

De Maria, W. & J. Cyrelle 1996 'Behold the Shut-Eyed Sentry! Whistleblower Perspectives on Government Failure to Correct Wrongdoing', *Crime, Law & Social Change* 24: 151-166.

Dempster, Q. 1997 *Whistleblowers*, Sydney: ABC Books.

Dewdney, J. C. H. 1972 *Australian Health Services*, School of Health Administration, UNSW, Sydney: John Wiley & Sons.

Dewdney, J. C. H. 1987 'Health Policy Formulation in Australia', in M. W. Raffel, & N. K. Raffel, (ed.) *Perspectives on Health Policy: Australia, New Zealand, United States*, New York: John Wiley & Sons.

Department of Health, 1982 'Submission to the Joint Parliamentary Committee of Public Accounts: Inquiry into Payments under the Commonwealth Medical Benefits Schedule – Medical Fraud and Overservicing: Main Report', June.

Department of Health, 1984 'Submission to the Joint Parliamentary Committee of Public Accounts: Inquiry into Payments under the Commonwealth Medical Benefits Schedule – Medical Fraud and Overservicing', March.

DeVoe, J. 2001 *The Politics of Health Care Reform: A Comparative Study of National Health Insurance in Britain and Australia*, Kensington, NSW: School of Health Service Management, University of New South Wales.

DeVoe, J. 2003 'A Policy Transformed by Politics: The Case of the 1973 Australian Community Health Program', *Journal of Health Politics, Policy and Law*, Vol. 28 (1): 77-108.

Dix, A., M. Errington, K. Nicholson, & R. Powe, 1996 *Law for the Medical Profession in Australia*, 2nd edition, Melbourne: Butterworth-Heinemann, Australia.

'Doctor remanded on 318 health act fraud charges', *The Age*, 19 September 1986: 5.

'Doctors' Billing Fraud Alleged', a *Nationwide* television program, Australian Broadcasting Corporation Television, Sydney 8 February 1982.

Donezelot, J. 1991 'Pleasure in Work', in G. Burchell, C. Gordon & P. Miller (eds) *The Foucault Effect: Studies in Governmentality*, Chicago: University of Chicago Press: 251-280.

Donovan, B. 1994 'Fighter for justice whose victory lives on' *The Australian* 27 June: 13.

Downing, J. 1986 'Government Secrecy and the Media in the United States and Britain', in P. Golding, G. Murdoch & P. Schlesinger *Communicating Politics*, Leicester: Leicester University Press: 153-170.

Drewe, R. 1981 'Death of a doctor: the hounding of Shik Aun Low', *The Bulletin* 20 January: 32-40.

Drewe, R. 1981 'Minister silent on GP's suicide', *The Bulletin* 27 January: 22-23.

Drewe, R. 1981 'Patient denies complaining', *The Bulletin* 10 March: 22-27.

Drewe, R. 1981 'Scandal over police seizure of doctors' files', *The Bulletin* 17 March: 56-61.

Drewe, R. 1981 'Doctors' resent unwarranted examinations' *The Bulletin* 24 March: 117

Drewe, R. 1982 'Report due on Dr. Low', *The Bulletin* 1 June: 30.

Dreyfus, H. L. & P. Rabinow, 1986 'What is Maturity? Habermas and Foucault on 'What is Enlightenment?' in D. C. Hoy (ed.) *Foucault: A Critical Reader* Oxford, UK, NY: Blackwell.

Duckett, S. J. 1984 'Structural Interests and Australian Health Policy', *Social Science and Medicine* 18: (11): 959-966.

Duckett, S. J. 1995 'The Australian Health Care System: An Overview', in G. Lupton & J. M. Najman (eds) *Sociology of Health and Illness. Australian Readings 2nd edition*, South Melbourne: Macmillan.

Duckett, S. J. 1996 'The new market in health care: Prospects for managed care in Australia', *Australian Health Review*, 19 (2): 7-22.

Duckett, S. J. 2000 *The Australian Health Care System*, South Melbourne, Victoria: Oxford University Press.

Duckett, S. J. 2003 'Making a Difference in Health Care', in *The Hawke Government: A Critical Retrospective*, North Melbourne, Victoria: Pluto Press.

Dunleavy, P. 1991 *Democracy, Bureaucracy and Public Choice: Economic Explanations in Political Science*, London: Prentice Hall.

Eccles-Smith, C. B. 1982 *Submission*, Joint Committee of Public Accounts, Medical Fraud and Overservicing Inquiry, 10 June.

Electoral & Administrative Review Commission, Qld, 1991 *Report on the Protection of Whistleblowers*, October.

Emy, H. V. & D. E. Hughes, 1991 *Australian Politics: Realities in Conflict*, 2nd edition. South Melbourne: Macmillan.

Encel, S. 1974 *Cabinet Government in Australia*, Melbourne: Melbourne University Press.

English, L. & J. Guthrie 2000 'Mandate, Independence and Funding: Resolution of a Protracted Struggle between Parliament and the Executive over the Powers of the Australian Auditor-General', *Australian Journal of Public Administration*, 59 (1) March: 98-114.

Ericson, R. V. 1996 'Why Law is Like News', in D. Nelken (ed.) *Law as Communication*, Aldershot: Dartmouth: 105-230.

Ericson, R. V. 1998 'How Journalists Visualize Fact', *The Annals of the American Academy of Political and Social Science*, 560 (12): 83

Ericson, R. V., P. M. Baranek & J. B. L. Chan, 1987 *Visualizing Deviance: A Study of News Organization*, Open University Press, Milton Keynes.

Ericson, R. V., P. M. Baranek & J. B. L. Chan B, 1989 *Negotiating Control: A Study of News Sources*, University of Toronto Press.

Ericson, R. V., P. M. Baranek & J. B. L. Chan, 1991 *Representing Order: Crime Law and Justice in the News Media*, University of Toronto Press.

Ericson, R., D. Barry & A. Doyle, 2000 'The moral hazards of neo-liberalism: lessons from the private insurance industry', *Economy and Society*, 29 (4): 532-558.

Ericson, R. V. & K. D. Haggerty, 1997 *Policing the Risk Society*, Toronto: University of Toronto Press.

Ericson, R. V. 1998 'The Culture of Surveillance: Discipline and Social Control in the United States' book review *Social Forces* 76 (3): 1154-1156.

Ettema, J. S. & T. L. Glasser, 1985 'On the Epistemology of Investigative Journalism' *Communication*, 8: 183-206.

Ettema, J. S. & T. L. Glasser, 1988 'Narrative Form and Moral Force: The Realization of Innocence and Guilt Through Investigative Journalism' in *Journal of Communication*, 38 (3): 8-26.

Ettema, J. S. & T. L. Glasser, 1998 *Custodians of Conscience: Investigative Journalism and Public Virtue*, New York: Columbia University Press.

Evans, G. 1982 'Scrutiny of the executive by parliamentary committees', in J.R. Nethercote (ed.) *Parliament & Bureaucracy: Parliamentary Scrutiny of Administration: Prospects & Problems in the 1980s*, Hale & Iremonger, Sydney: 78-92.

Evans, R. G. 1984 *Strained Mercy: The Economics of Canadian Health Care*, Toronto: Butterworths.

Evans, R. G. 2000 'Canada', *Journal of Health Politics, Policy and Law*, 25, October: 889-1009.

Ewald F. 1991 'Insurance and Risk', in G. Burchell, C. Gordon and P. Miller (eds.) *The Foucault Effect: Studies in Governmentality*, Chicago: The University of Chicago Press: 197-210.

Feeley, M. & J. Simon 1998 'Actuarial Justice: the Emerging New Criminal Law', in P. O'Malley (ed.) *Crime and Risk Society*, Aldershot England: Ashgate Dartmouth: 375-402.

Fein, R. 1980 'Social and Economic Attitudes Shaping American Health Policy', *The Milbank Memorial Fund Quarterly/ Health and Society*, 58 (3): 349-385.

Feldstein, M. 1995 'The Economics of Health and Health Care: What Have We Learned? What Have I Learned?', *American Economic Review*, 85 (2) 28-31.

Fels, A. 1982 'The Political Economy of Regulation', *UNSW Law Journal* 5 (1): 29-60.

Field, G. G. 1984 '*The Respective Involvements of the Health Insurance Commission and the Department in Combating Abuse of the Medical Benefits Arrangements*', Report for the Commonwealth Department of Health, December.

Fife-Yeomans, J. 1994 'Rhonda's tragic victory inspires Pap smear rush', *The Weekend Australian* June 25-26: 5.

Findlay, R. J. 1981 'The Interests of Government and the Health Funds in the Pattern of Servicing', in *Proceedings of the Institute of Criminology*, No. 50, *Crime and the Professions; The Provision of Medical Services*, Sydney: Government Printer; 26- 35.

Finn, P. 1993 'Public Trust and Public Accountability', *Australian Quarterly*, Winter 65 (2): 50-59.

Finn, P. 1994 'The Abuse of Public Power in Australia: Making Our Governors Our Servants', *Public Law Review* 5: 43-57.

Fisse, B. 1986 'Controlling Governmental Crime: Issues of Individual and Collective Liability', in P. Grabosky & I. Le Lievre *Government Illegality*, Canberra: Australian Institute of Criminology.

Fisse, B. & J. Braithwaite, 1983 *The Impact of Publicity on Corporate Offenders*, Albany: State University of New York Press.

Fitzgerald, P. D. 2001 'The Ethics of Doctors and Big Business', *MJA*, 16 July: 175 (2): 73-75.

Fitzgerald, P. D. 2002 'General practice corporatisation: the half-time score', *MJA*, 177 (2): 90-92.

Flanigan, S. & M. Power (eds) 1995 *Commission Connection Number 31*, 29 June 1995, Canberra: Health Insurance Commission.

Flynn, K. 1996 'Northern Endeavour', Radio Eye, *Radio National*, Australian Broadcasting Corporation, 1 September.

Forell, C. 1982 'Malpractice needs a remedy', *The Age*, 10 February: 13.

Foucault, M. 1986 *The Foucault Reader* (ed. P. Rabinow), Harmondsworth: Penguin Books.

Foucault, M. 1988 'The Dangerous Individual', in L. D. Kritzman, (ed.) *Michel Foucault: Politics, Philosophy, Culture. Interviews and other Writings 1977-1984*. New York, London: Routledge, Chapman & Hall Inc. : 125-151.

Foucault, M. 1988 'Social Security', in L. D. Kritzman, (ed.) *Michel Foucault: Politics, Philosophy, Culture. Interviews and other Writings 1977-1984*. New York, London: Routledge, Chapman & Hall Inc. : 159-177.

Foucault, M. 1991 'Governmentality', in G. Burchell, C. Gordon & P. Miller (eds) *The Foucault Effect: Studies in Governmentality*, Chicago: University of Chicago Press: 87-110.

Foucault, M. 1997 *Ethics: Subjectivity and Truth* vol. 1, (ed. P. Rabinow), Trans. R. Hurley and others, London: Allen Lane, The Penguin Press: 67-79.

Fox, T. 1963 'The Antipodes: Private Practice Publicly Supported', *The Lancet*, 20 April 1963: 875-9; 27 April 1963: 933-9.

Fraser, M. 1980 'The Philosophical Basis of Liberalism', *AFR* 9 December: 10-11.

Frankel, B. 1997 'Confronting Neoliberal Regimes: the Post-Marxist Embrace of Populist Realpolitik', *New Left Review* No. 226, Nov./Dec.: 57-92.

Freddi, G & J. W. Bjorkman. 1989 *Controlling Medical Professionals. The Comparative Politics of Health Governance*. London, New Delhi: Sage Publications.

Frenkel, J. 2004 'Doctors in Medicare Sting', *The Herald-Sun*, 15 July: 1.

Frieberg, A. 1992 'Confiscating the Proceeds of White-Collar Crime', in P. Grabosky (ed.) *Complex Commercial Fraud: Proceedings of a Conference held 20-23*

August 1919, Canberra: Australian Institute of Criminology, (AIC) Conference Proceedings; No. 10): 173-188.

Freudenberg, G. 1977 *A Certain Grandeur: Gough Whitlam in Politics*, Sun Books: Melbourne.

Fuchs, V. R. 1993 *The Future of Health Policy*, Cambridge, Massachusetts: Harvard University Press.

Fullerton, T. (reporter), Q. McDermott (producer) S. Kernot & K. Flynn (researchers) 2004 'Doctoring the Figures', a *Four Corners* television program, Australian Broadcasting Corporation, Sydney 6 September.
<http://www.abc.net.au/4corners/content/2004/s1193609.htm>].

Funnell, W. 2001 *Government by Fiat: The Retreat from Responsibility*, Sydney: University of NSW Press.

Funnell W. & K. Cooper 1998 *Public Sector Accounting and Accountability in Australia*, Sydney: University of NSW Press.

Gandy, O. H. Jr. 1982 *Beyond Agenda Setting: Information Subsidies and Public Policy*, Norwood, New Jersey: Ablex Publishing Company.

Gans, H. 1979 *Deciding What's News: A Study of CBS Evening News, NBC Nightly News, Newsweek and Time*, New York: Pantheon Books.

Gardner, H. (ed.) 1995 *The Politics of Health: The Australian Experience* 2nd edition. Melbourne: Churchill Livingstone.

Gardiner, J. A. and T. R. Lyman, 1984 *The Fraud Control Game: State responses to fraud and abuse in AFDC and Medicaid Programs*. Bloomington: Indiana University Press.

Gay, P. 1977 *The Enlightenment: An Interpretation*, 2 volumes. New York: Knopf.

Gaze, B. 1993 'Resource Allocations – The Legal Implications', *Journal of Contemporary Health Law and Policy*, 9: 91-107.

Gaze, B. & M. Jones, 1990 *Law, Liberty and Australian Democracy*, Sydney: The Law Book Company Ltd.

Gillard, J. 2004 'AM – Labor to Boost Bulk Billing' on ABC Local Radio: 6 September [<http://www.abc.net.au/am/content/2004/s1192822.htm>]

Gillespie, J. A. 1991 *The Price of Health: Australian Government and Medical Politics 1910-1960*, Oakleigh Melbourne: Cambridge University Press.

Gitlin, T. 1980 *The Whole World is Watching: Mass Media in the Making and Unmaking of the New Left*, Berkeley: University of California Press.

Gittins, R. 1982 'A Health System that Spreads the Doctors' Disease', *SMH*, 11 February 1982: 7.

Glasheen, I. 1997 'Interview with Dr. Malcolm Sparrow', *AARP Bulletin*, October. URL consulted June 2001
[<http://www.aarp.org/bulletin/oct97/sparrow1.html>]

Glazer, M. P. & P. M. Glazer 1989 *Whistleblowers: Exposing Corruption in Business and Government*, New York: Basic Books.

Glazer, M. 1992 'Whistleblowers', in D. H. Ermann & R. Lundman (eds) *Corporate and Government Deviance*, Oxford University Press.

Glasser, T. L. & J. S. Ettema. 1991 'Investigative Journalism and the Moral Order', in R. K. Avery and D. Eason (eds) *Critical Perspectives on Media and Society*, New York, London: The Guilford Press.

Glasser, T. L. & J. S. Ettema, 1993 'When the Facts Don't Speak for Themselves: A study of the use of irony in daily journalism', in *Critical Studies in Mass Communication*, 10: 322-338.

Golding, P., G. Murdoch & P. Schlesinger, P. 1986 *Communicating Politics*, Leicester: Leicester University Press.

Golding, P. & G. Murdoch 1996 'Culture, Communications and Political Economy', in J. Curran & M. Gurevitch (eds) *Mass Media and Society 2nd edition*: London, New York: Arnold.

Gordon, G. 1991 'Governmental rationality: an introduction', in G. Burchell, C. Gordon & P. Miller (eds) *The Foucault Effect. Studies in Governmentality*, Chicago: University of Chicago Press.

Gordon, M. 1982 'AMA urges caution on fraud laws', *The Age*, 29 March 1982: 3.

Gorring, P. & P. R. Wilson 1986 *The Structure of Medical Fraud and Overservicing: How Doctors Commit Crime*, Paper presented to the Annual Meeting of the American Society of Criminology, San Diego.

Gorta, A. 1998 *Minimising Corruption: Some Lessons from the Literature*, Sydney: NSW Independent Commission Against Corruption.

'GP alleges threat by Medifraud network', *The Australian*, 11 March 1986: 3.

Grabosky, P. N. 1989 *Wayward Governance: Illegality and its Control in the Public Sector*, Canberra: Australian Institute of Criminology.

Grabosky, P. N. 1991 *Controlling Fraud, Waste and Abuse in the Public Sector*, Canberra: Australian Institute of Criminology.

Grabosky, P. N. (ed.) 1992 *Complex Commercial Fraud: Proceedings of a Conference held on 20-23 August 1991*. Canberra: Australian Institute of Criminology.

Grabosky, P. N. 1993 'Australian Regulatory Enforcement in Comparative Perspective', in P. Grabosky & J. Braithwaite (ed.) *Business Regulation and Australia's Future*, Canberra: Australian Institute of Criminology.

Grabosky, P. N. 1994 *Organisational Leverage and the Technologies of Compliance Administration*, Compliance and Governability Program Working Paper No. 24, October, Canberra: Research School of Social Sciences, Australian National University.

Grabosky, P. N. 1995 'Counterproductive Regulation', *International Journal of the Sociology of Law*, 23: 347-369.

Grabosky, P. N. & J. Braithwaite, 1986 *Of Manners Gentle: Enforcement Strategies of Australian Business Regulatory Agencies*, Melbourne: Oxford University Press.

Grabosky, P. N. & P. Larmour, 2000 *Public Sector Corruption and its Control, Trends & Issues in Crime and Criminal Justice*, Canberra: Australian Institute of Criminology.

Grabosky, P. N. & I. Le Lievre, (eds) 1987 *Government Illegality*, Canberra: Australian Institute of Criminology.

Grabosky, P. N., C. Shearing & J. Braithwaite, 1993 'Introduction', in P. Grabosky & J. Braithwaite (eds) *Business Regulation and Australia's Future*, Canberra: Australian Institute of Criminology.

Grabosky, P. N., R. Smith & G. Dempsey, 2001 *Electronic Theft: Unlawful Acquisition in Cyberspace*, Cambridge, Oakleigh, Vic.: Cambridge University Press.

Grabosky, P. N. & P. Wilson, 1989 *Journalism and Justice: How crime is reported*, Sydney: Pluto Press.

Graco, W. 1999 *Neural Networks: Automated Health Services Classification Systems*, (departmental discussion paper) Canberra: Health Insurance Commission.

Graco, W. 2002 *Identification and Classification of 'Doctor Shopper' Patterns in Patient Pharmaceuticals*, unpublished PhD thesis, Armidale: University of New England.

Grattan, M. 1982 'When a minister takes the blame', *The Age*, 13 September: 13.

Grattan, M. 1982 'Health Department tale of ineptness', *The Age*, 20 September: 9.

Grattan, M. 1995 *Headline/Deadline/Bottom Line: The Case for Good Journalism*, Walter Murdoch Memorial Lecture, Perth.

Grattan, M. 1998 'The Politics of Spin', *Australian Studies in Journalism* 7: 32-45.

Grattan, M. 2000 (ed.) *Australian Prime Ministers*, Sydney: New Holland Publishers.

Grattan, M. & M. Metherell 1982 'Clamp on health: AMA Says \$100m Milked Each Year', *The Age*, 4 February: 1.

Gray, B. H. 1991 *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*, Cambridge, Massachusetts: Harvard University Press.

Gray, D. 1997 'Crackdown on \$700m Medi-fraud', *The Sunday Age*, 12 January: 5.

Gray, G. 1984 'The Termination of Medibank', *Politics* 19(2): 1-17.

Gray, G. 1990 'Health Policy', in C. Jennett and R. G. Stewart, *Hawke and Australian Public Policy: Consensus and Restructuring*, Crows Nest NSW: The Macmillan Company of Australia Pty Ltd.

Gray, G. 1991 *Federalism and Health Policy: The Development of Health Systems in Canada and Australia*, Toronto: University of Toronto Press.

Gray, G. 1996 'Reform and Reaction in Australian Health Policy', *Journal of Health Politics, Policy and Law*, 21, 3 (Fall): 587-615.

Gross, P. 1984 'Medical Technology, Health Cost and Government: Regulation or Controlled Innovation?', in M. Tatchell (ed.) *Perspectives on Health Policy*, Australian National University, Canberra.

Green, R. 1984 'Talks may reduce friction', *CT*, 30 November: 13

Green, D. & P. A. Castaldi 1985 'A Crisis in Australian Medicine: Doctors' Response to the Introduction of Government-Sponsored Universal Health Care', *The New England Journal of Medicine* 312, 1: 62-63.

Gruen, F. & M. Grattan, 1993 *Managing Government: Labor's Achievement and Failures*, Melbourne: Longman Cheshire.

Habermas, J. 1974 'The Public Sphere: An Encyclopædia Article', *New German Critique* Vol. 1 (3): 49-55.

Habermas, J. 1986 'Taking Aim at the Heart of the Present', in D. C. Hoy (ed.) *Foucault: A Critical Reader*, Oxford, UK: Basil Blackwell Publishers: 103-108.

Habermas, J. 1989 *The Structural Transformation of the Public Sphere*, Cambridge, Polity Press.

Habermas, J. 1999 'The European Nation-State and the Pressures of Globalisation', *New Left Review*, No. 235 May/June: 56-59.

Hagan, J. 1981 *The History of the A.C.T.U.*, Melbourne: LongmanCheshire.

Hage, G. 2002 'Radical agonised over society's ills', *The Australian*, 6 February: 15.

Hall, S. 1974 'Deviance, Politics, and the Media', in P. Rock & M. McIntosh, *Deviance and Social Control*, London: Tavistock Publications: 261-305.

Hall, S. 1975 'Introduction', in A. C. H. Smith, *Paper Voices. The Popular Press and Social Change 1935-1965*, London: Chatto & Windus: 11-24.

Hall, S. 1986a 'Media Power and Class Power', in J. Curran, J. Ecclestone, G. Oakley & A. Richardson (eds) *Bending Reality: The State of the Media*, London: Pluto Press.

Hall, S. 1986b 'Variants of Liberalism', in J. Donald & S. Hall (eds) *Politics and Ideology: A Reader*, Milton Keynes: Open University Press: 34-69.

Hall, S., I. Connell, & L. Curti 1976 'The "Unity" of Current Affairs Television', in *Working Papers in Cultural Studies* 9: 51-94.

Hall, S., C. Critcher, T. Jefferson, J. Clarke & B. Roberts 1978 *Policing the Crisis. Mugging, The State, and Law and Order*, London: Macmillan.

Hall, T. 1979 *White Collar Crime in Australia*, Sydney: Harper and Row.

Halligan J. & J. Power 1992 *Political Management in the 1990s*, Melbourne: Oxford University Press.

Hallin, D. 1994 *We Keep America on Top of the World: Television Journalism and the Public Sphere*, London and New York: Routledge.

Halpin, D. 1984 'Marathon man of medical overservicing', *The National Times*, 8-14 June: 24.

Hancock, L. (ed.) 1999 *Health Policy in the Market State*, Sydney: Allen & Unwin.

Harvey, R. 1991 *Making it Better: Strategies for improving the effectiveness and quality of health services in Australia*. National Health Strategy Background Paper No. 8, Melbourne.

Hawke, R. J. L. 1994 *The Hawke Memoirs*, Melbourne: William Heineman, Australia.

Hawley, J. 1977 'How the kick-back racket works - by a pathologist', *The Australian*, 17 February: 1.

Hayden, B. 1996 *Hayden: An Autobiography*, Sydney: Angus & Robertson.

Hayden, B. 2000 'The battle to put Medibank in place', *MJA*, 3 July 2000: 173 (1): 24-26.

Hayek, F. A. 1944 *The Road to Serfdom*, Sydney: Dymock's Book Arcade Ltd.

Head, B. and A. Patience 1979 'Labor and Liberal: how different are they?', in

Patience, A. & B. Head (eds) *From Whitlam to Fraser*, Melbourne: Oxford University Press.

Head, B. & A. Patience (eds) 1989 *From Fraser to Hawke: Australian public policy in the 1980s*, Melbourne: Longman Cheshire.

Health Insurance Commission 1993 'Medical Fraud and Overservicing: What the Health Insurance Commission Proposes', *Health Issues*, 36 (September): 6-10.

Health Insurance Commission, 1993 'Submission', *Joint Committee of Public Accounts on ANOA Report No. 17 of 1992-93*, October 1993.

Health Insurance Commission 1994 'Submission no. 93', *Senate Select Committee on Public Interest Whistleblowing*.

Health Insurance Planning Committee, 1973 *Report of the Health Insurance Planning Committee to the Minister for Social Security*, Canberra: Australia Government Printing Service.

Health Issues Centre 1986 *Medical Business: Entrepreneurial Style*, Melbourne.

Health Issues Centre 1987 *Medicare: A Double-Edged Sword*, Melbourne.

Henderson, G. 2003 'Hawke's Opposition', in S. Ryan & T. Bramston, *The Hawke Government, A Critical Retrospective*, North Melbourne: Pluto Press.

Hess, S. 1984 *The Government /Press Connection. Press Officers and Their Offices*, Washington, D. C.: The Bookings Institute.

Hewett, J. 1982 'Medifraud: the \$100m coincidence' *SMH* 13 October: 7

Hewett, J. 1982 'Health chief hits back on medifraud', *SMH*, 11 December: 5.

Hewett, J. 1982 'Challenge to AMA's role in discipline of doctors', *SMH*, 14 December: 3.

Heywood, P. 1997 'Political corruption: problems and perspectives', in P. Heywood (ed.) *Political Corruption*, Oxford: Blackwell 1-19.

Hickie, D. 1981 'Patient's Guide to Medical Rip-Offs', *The National Times*, 17-23 May: 12 & 14.

Hicks, R. 1977 'Medical racket doctors liable to 2 years jail', *The Australian*, 12 February: 3.

Hicks, R. 1977 'Doctors' Incomes Soar to \$70,000 a Year', *The Australian*, 4 November: 3

Hicks, R. 1977 'Do Australians pay too much for their medical care?' *The Australian*, 30 December: 9.

Hicks, R. 1981 *Rum, Regulation and Riches: The Evolution of the Australian Health Care System*, Sydney: R. T. Kelly Pty. Ltd.

Himmelfarb, G. 1985 'Introduction', in J. S. Mill *On Liberty*: London: Penguin Books.

Hodge, P. 1978 'Medibank Fraud'. In P. R. Wilson & J. Braithwaite, *Two Faces of Deviance*, St. Lucia, Queensland: University of Queensland Press.

Hood, C., C. Scott, O. James, G. Jones & T. Travers, 1999 *Regulation Inside Government: Wastewatchers, Quality Police and Sleaze-Busters*, Oxford: Oxford University Press.

House of Representatives Standing Committee on Banking, Finance and Public Administration, 1993 *Focusing on fraud: Report on the Inquiry into Fraud on the Commonwealth*, Canberra: Australian Government Printing Service.

House of Representatives Standing Committee on Legal & Constitutional Affairs, 1995 *In Confidence; a report of the inquiry into the protection of confidential information personal and commercial information*, Canberra: Australian Government Printing Service.

'How to Rob Medibank Blind', *Australian G.P.*, January 1976: 5-6.

Howe, B. 1993 'Howe's detailed response to criticisms of HIC's medifraud efforts', *Healthcover*, 3 (2): 14-18.

Howells, G. 1990 'Conversations with Departmental Secretaries oral history project' Transcript of sound recording by Robert Hyslop 16 July, 1990. ORAL TRC 25/4, Oral History Collection, National Library of Australia.

Hoy, D. C. (ed.) 1986 *Foucault: A Critical Reader*, Oxford, UK, NY: Blackwell.

Hunter, T. 1969 *The Politics of National Health*, unpublished PhD Thesis, Canberra: Australian National University.

Hunter, T. 1980 'Pressure Groups and the Australian Political Process: The Case of the Australian Medical Association', *The Journal of Commonwealth and Comparative Politics*, Vol. 18, (2): 190–206.

Hunter, T. 1984a 'The Politics of National Health Insurance: 'Plus Ca Change'?' In M. Thatchwell, (ed.) *Perspectives on Health Policy*. Proceedings of a Public Affairs Conference held at the Australian National University, Canberra, 27-29 July, 1982, Canberra: ANU: 28–36.

Hunter, T. 1984b 'Medical Politics: Decline in the Hegemony of the Australian Medical Association', *Social Science and Medicine* 18 (11): 973-980.

Hurst, J. 1988 *The Walkley Awards: Australia's best journalists in action*, Richmond, Vic, John Kerr Pty Ltd.

IBM, 'HIC Data Mining Saves Millions of Healthcare Dollars'.
[<http://www1.s390.ibm.com/customer/gk206613.html>]

Illich, I. 1975 *Medical Nemesis: The Expropriation of Health*, London: Lothian Publishing.

Independent Commission Against Corruption, 1992 *Report on Unauthorized Release of Government Information*, Volume 1, August.

Independent Commission Against Corruption, 1992 *Report on Unauthorized Release of Government Information*, Volume 3, August.

Islam, S. 2001 'The making of a corrupt society: an understanding of the sociology of corruption in the context of state-people relationship in Bangladesh', Paper delivered at the TASA Conference, The University of Sydney, 13-15 December.

Jackall, R. 1988 *Moral Mazes: The World of Corporate Managers*, New York, Oxford: Oxford University Press.

Jackson, M. W. 1988 'The Public Interest, Public Service and Democracy', *Australian Journal of Public Administration*, 47 (3): 241-251.

Jamous, H. & B. Peloille, 1970 'Professions or Self-Perpetuating Systems? Changes in the French University-Hospital System', in J. A. Jackson (ed.) *Professions and Professionalization*. Cambridge: Cambridge University Press.

James, C., C. Jones & A. Norton, 1993 *A Defence of Economic Rationalism*, St. Leonards, NSW: Allen & Unwin.

Janis, I. L. 1982 *Groupthink: Psychological Studies of Policy Decisions and Fiascoes*, Boston: Houghton Mifflin Company.

Jesilow, P., H. N. Pontell & G. Geis, 1993 *Prescription for Profit: How Doctors Defraud Medicaid*, Berkeley: University of California Press.

Johnson, T., G. Larkin & M. Saks, (eds) 1995 *Health Professions and the State in Europe*, London, New York: Routledge.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing* 1 July, Parliament of the Commonwealth of Australia, Canberra, Volume 1.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing*, 14 & 27 July, Parliament of the Commonwealth of Australia, Canberra, Volume 2.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing*, 4 August, Parliament of the Commonwealth of Australia, Canberra, Volume 3.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing*, 5 & 6 August, Parliament of the Commonwealth of Australia, Canberra, Volume 4.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing*, 24 August, Parliament of the Commonwealth of Australia, Canberra, Volume 5.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing*, 21-29 August, Parliament of the Commonwealth of Australia, Canberra, Volume 6.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing*, 12 & 19 October, Parliament of the Commonwealth of Australia, Canberra, Volume 7.

Joint Committee of Public Accounts, 1982 *Minutes Evidence. Medical Fraud and Overservicing*, 26 & 27 October, Parliament of the Commonwealth of Australia, Canberra, Volume 8.

Joint Committee of Public Accounts, 1982 203rd *Report, Medical Fraud and Overservicing Progress Report*, Parliament of the Commonwealth of Australia, Canberra.

Joint Committee of Public Accounts, 1982 *Minutes of Evidence. Medical Fraud and Overservicing*, 5 & 6 August, 7 September & 11 November, Parliament of the Commonwealth of Australia, Canberra, Volume 9.

Joint Committee of Public Accounts, 1983 212th Report. *Finance Minute on the Committee's 203rd Report Medical Fraud and Overservicing, Progress Report*, Parliament of the Commonwealth of Australia, Canberra.

Joint Committee of Public Accounts, 1984 *Minutes of Evidence. Medical Fraud and Overservicing*, 11 July 1983, 2 April & 19 April 1984, Parliament of the Commonwealth of Australia, Canberra, Volume 10.

Joint Committee of Public Accounts, 1984 *Minutes of Evidence. Medical Fraud and Overservicing*, 30 April, 21 May & 4 June, Parliament of the Commonwealth of Australia, Canberra, Volume 11.

Joint Committee of Public Accounts, 1984 *Minutes of Evidence. Medical Fraud and Overservicing*, 4 & 5 July, Parliament of the Commonwealth of Australia, Canberra, Volume 12.

Joint Committee of Public Accounts, 1984 *Minutes of Evidence. Medical Fraud and Overservicing*, 3 September, Parliament of the Commonwealth of Australia, Canberra, Volume 13.

Joint Committee of Public Accounts, 1984 *Minutes of Evidence. Medical Fraud and Overservicing*, 4 & 8 October, Parliament of the Commonwealth of Australia, Canberra, Volume 14.

Joint Committee of Public Accounts, 1985 *Minutes of Evidence. Medical Fraud and Overservicing*, 27 March, Parliament of the Commonwealth of Australia, Canberra, Volume 15.

Joint Committee of Public Accounts, 1985 *Minutes of Evidence. Medical Fraud and Overservicing*, 23 and 27 November, Parliament of the Commonwealth of Australia, Canberra, Volume 16.

Joint Committee of Public Accounts, 1985 *Medical Fraud and Overservicing Inquiry: Report on Pathology*. Joint Committee of Public Accounts 236th Report. Parliament of the Commonwealth of Australia, Canberra: Australian Government Publishing Service.

Joint Committee of Public Accounts, 1986 *Medical Fraud and Overservicing Inquiry: Response to Pathology Report*. Joint Committee of Public Accounts 260th report. Parliament of the Commonwealth of Australia, Canberra: Australian Government Publishing Service.

Joint Publication of the Management Advisory Board and its Management Improvement Advisory Committee. June 1993. *Accountability in the Commonwealth Public Sector*. Canberra: Australian Government Publishing Service.

Jones, K. S. 2000 'Medibank: looking back after 25 years', *MJA* 173, 3 July: 15-16.

Jos, P.H., M. E. Thompkins & S. W. Hays, 1989 'In Praise of Difficult People: A Portrait of the Committed Whistleblower', *Public Administration Review*, 49 (6): 552-561.

Kamien, M. 2004 "'Doctor Shoppers": at risk by any other name", *MJA*, March, 180 (5): 204-205.

Karstedt, S. 1997 'Inequality, Power and Morality: Criminality of elites and their impact on society'. Paper presented at an Occasional Seminar, Australian Institute of Criminology, Canberra, ACT, 12 August.
[<http://www.aic.gov/conferences/occasional/karstedt.html#1>]

Keane, J. 1991 *Media and Democracy*, Cambridge: Polity.

Keating, M. 1993 'The Influence of Economists', in *Economic Rationalism?: Economic Policies for the 90s*, Conferences proceedings University of Melbourne, 15-16 February 1993.

Keating, M. 2001 'Can Government Cope?', *Australian Journal of Public Administration*, 60 (3) September 2001: 98-109.

Keating, M., J. Wanna & P. Weller (eds) 2000 *Institutions on the Edge?: Capacity for Governance*. Sydney, NSW: Allen & Unwin

Keating, P. 1987 'Traditions of Labor in Power, Whitlam and the Continuum', in *Traditions for Reform in New South Wales: Labor history essays*, Sydney: Pluto Press.

Kelly, P. 1982 'Medifraud set to take up where tax frauds left off', *SMH*, 17 September: 7.

Kelly, P. 1984 *The Hawke Ascendancy 1975-1983*, Sydney: Angus & Robertson Publishers.

Kelly, P. 1992 *The End of Certainty: The Story of the 80s*, Sydney: Allen & Unwin.

Kelly, P. 1994 *The End of Certainty: Power, Politics and Business in Australia*, Sydney: Allen & Unwin.

Kelly, P. 1995 *November 1975: The Inside Story of Australia's Greatest Political Crisis*, Sydney: Allen & Unwin.

Kelly, P. 2000 'John Malcolm Fraser', in M. Grattan (ed.) *Australian Prime Ministers*, Sydney: New Holland.

Kelly, P. 2001 *100 Years: The Australian Story*, Sydney: Allen & Unwin.

Kemp, D. 1988 'Liberalism and Conservatism in Australia since 1944', in B. Head & J. Walter (eds) *Intellectuals Movements and Australian Society*, Melbourne: Oxford University Press.

Kerin, J. 2000 'Turnstile doctors in medifraud', *The Australian*, 18 October: 5.

Kerin, J. 2002 'Court hamstrings medical watchdog', *The Australian*, 23 January: 7.

de Kervasdoué, J. Kimberley, J. R. & Rodwin, V. G., 1984 *The End of an Illusion: The Future of Health Policy in Western Industrialised Nations*. Berkeley: University of California Press.

Khoury, M., L. Burnett & M. A. Mackay 1996 'Error Rates in Australian Chemical Pathology Laboratories' *MJA* 165: 128-130.

[<http://www.mja.com.au/public/issues/aug5/khoury/khoury.html>].

- Konner, M. 1993 *The Trouble with Medicine*, Sydney: ABC Enterprises.
- Kramnick, I. (ed.) 1995 *The Portable Enlightenment Reader*, New York: Penguin.
- Latour, B. 1986 'The Powers of Association' in J. Law (ed.) *Power, Action and Belief: A New Sociology of Knowledge?* Sociological Review Monograph 32. London and Boston: Routledge & Kegan Paul.
- Lavelle, P. 2002 'Trust me, I'm a corporation' *Health Matters* ABC Radio National, 19 September.
[<http://www.abc.net.au/health/features/corporation/default.htm>].
- Leeder, S. R. 1999 *Healthy Medicine. Challenges Facing Australia's Health Services*, Sydney: Allen & Unwin.
- Leeder, S. & I. McAuley 2000 'The Future of Medicare and Health Service Financing', *Medibank: 25 Years On*, *MJA* 173 (1): 48-51.
- Legge, K. 1984 '25 pathologists earned \$36m by overservicing: MP', *The Age*, 29 October: 3.
- Legge, K. 1986 'The Medicare Pot Boils Over', *The National Times*, 30 May-5 June: 8.
- Lennane, K. L. 1993 'Whistleblowing': a health issue', *The British Medical Journal*, (307), 11 September: 660-670.
- Lennane, K. L. 1995 'The canary down the mine: what whistleblowers' health tells us about their environment', Paper given at Dept. of Criminology, Melbourne University, conference *Whistleblowers: protecting the nation's conscience?* 17 November 1995.
- Lennane, J. 1993 'What Happens to Whistleblowers and Why' paper delivered at the Whistleblowers Conference, Canberra 27-28 March.
- Lewis, M. J. & S. R. Leeder, 2001 *Where to from here? The need to construct a comprehensive national health policy*, Sydney: The Australian Health Policy Institute at the University of Sydney.
- Light, D. W. 1993 'Countervailing Power: The Changing Character of the Medical Profession in the United States', in F. W. Hafferty & J. B. McKinlay *The Changing Medical Profession: An International Perspective*, New York: Oxford University Press.

Light, E. 1999 'A Case of the Hiccups for the PSR', *Australian Medicine* 6 September: 12-13.

Lippmann, W. 1954 *Public Opinion*, New York: Macmillan.

Lipson, N. & J. Dargaville, 1982 '\$100 million medi swindle! A little crook? So is one doctor in thirty', *The Daily Telegraph*, 4 February: 1.

Lloyd, C. 2000 'Edward Gough Whitlam', in M. Grattan (ed.) *Australian Prime Ministers*, Sydney: New Holland Publishers (Aust.) Pty. Ltd.

Lord, R. 1983 'AMA accepts government estimate of \$100m', *Medical Practice*, July: 12-13.

Lord, R. 1984 'Big brother has his sights set on you', *Medical Practice*, March: 40-44.

Lord, R. 1984 'FODS cannot be used to estimate cost', *Medical Practice*, July: 10-11.

Lord, R. 1993 'Biting criticism of Medifraud efforts elicits detailed Howe response'. *Healthcover* 3 (1): 5-6.

Lovell, D., I. McAllister, W. Maley & C. Kukathas, 1998 *The Australian Political System*, 2nd ed., Melbourne: Longman.

Lupton, D. & J. McLean, 1998 'Representing doctors: Discourses and images in the Australian press', *Social Science and Medicine*. 46(8): 947-958

Lupton, G. M. & J. M. Najman, (ed.) 1995 *Sociology of Health and Illness. Australian Readings* 2nd edition. South Melbourne: Macmillan.

Lynch, P. 1982 'Doctors' in 'substantial' medifrauds', *The Australian*, 6 March: 3.

Macarthur, J. 1997 'Sex, Lies and Other Secrets: the Media and Confidential Information', *Communication Law Bulletin*, Winter.

Mack, M. P. 1962 *Jeremy Bentham: An Odyssey of Ideas 1748-1792*, London: Heinemann.

Mackay, A. & McCauley, J. 1984 'Comments on the Field Report', Surveillance and Investigation Division, Department of Health, Canberra

Mackay, D. 1984 'On Medibank', in *Thesis Eleven*, (8): 116-118.

Mackay, D. 1995 'The Politics of Reaction', in H. Gardner (ed.), *The Politics of Health: The Australian Experience*, 2nd edition, Churchill Livingstone, Melbourne: 370-433.

Mackeller, J. 1976 'Medibank Statistics', *The Australian G.P.*, October 1976: 21

Macklin, J. 1990 *The National Health Strategy: Setting the Agenda for Change*. Background Paper No 1. Melbourne.

Madison, J. 1999 *Writings*, New York: Library of America.

Main, G. and B. Robson 2001 *Scoping Identity Fraud*, Canberra: Attorney-General's Department.

Management Advisory Board, 1993 *Accountability in the Commonwealth Public Sector*, Canberra: Australian Government Publishing Service Press.

Management Advisory Board, 1996 *Ethical Standards and Values in the Australian Public Service*, Canberra: Australian Government Publishing Service Press.

Mancini, P. 1991 'The Public Sphere and the Use of News in a 'Coalition' System of Government', in P. Dahlgren & C. Sparks (eds), *Communication and Citizenship: Journalism and the Public Sphere*, London: Routledge: 137-154.

Maniarty, T. 1989 'Malcolm Fraser: 8 December 1975', in *The Power of Speech: 25 Years of The National Press Club*, Sydney: Bantam Books.

Manne, R. 1992 'The Rift in Conservative Politics', in J. Carroll & R. Manne (eds) *Shutdown: The Failure of Economic Rationalism and How to Rescue Australia*, Melbourne: Text Publishing.

Mannix, T. 1984 'Serious faults revealed in PS accounting', *CT*, 5 September: 1, 17.

Marmour, T. R., D. A. Wittman, & T. C. Heagy, 1976 'Politics, Public Policy and Medical Inflation', in Zubkoff, M. (ed.) *Health: A Victim or Cause of Inflation?* New York: Milbank Memorial Fund, Prodist.

Marmour, T. R., 1994 *Understanding Health Care Reform*, New Haven, London: Yale University Press.

Marr, D. 1976 'The Gold Fleece in the Bush', *The Bulletin* 20 March: 21-22.

Martin, B., S. Callaghan, C. Fox, R. Wells, M. Cawte, 1997 *Challenging Bureaucratic Elites*, Schweik Action Wollongong, University of Wollongong Printery Services also at
[<http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/>]

Martin, B. 1999 *The Whistleblowers Handbook: How to be an Effective Resister*, Charlbury, Oxfordshire, Sydney: John Carpenter and Envirobook.

Martin, B. 2002 *The Dynamics of Employee Dissent: Whistleblowers and Organizational Jiu-Jitsu*. Unpublished paper.

Marsh, I. 1993 *Governing in the 1990s: An agenda for the decade*, Melbourne: Longman Cheshire.

Masters, C. 1984 'What the Doctor Ordered', a *Four Corners* television program, Australian Broadcasting Corporation, Sydney 7 July 1984.

Masters, C. 1984 'Branded', a *Four Corners* television program, Australian Broadcasting Corporation, Sydney 3 November 1984.

Masters, C. 1990 'Tackling Corruption – Some Strategies', in S. Prasser, R. Wear & J. Nethercote (eds) *Corruption and Reform. The Fitzgerald Vision*, St. Lucia, Qld: University of Queensland Press: 45-48.

Masters, C. 1992 *Chris Masters: Inside Story*, Sydney, NSW: Angus & Robertson.

Mathews, R. 1988. 'Health Wars', in *Whitlam, Wran and the Labor Tradition*, Sydney: Pluto Press.

Matthews, T. 1993 'Australian Interest Groups', in J. J. Richardson (ed) *Pressure Groups*, Oxford: Oxford University Press.

Marx, G. T. 1981 'Ironies of Social Control: Authorities as Contributors to Deviance Through Escalation, Nonenforcement and Covert Facilitation', *Social Problems*, 28 (3): 221-243.

Meade, A. 1994 'Pathology lab. nearly lost licence', *SMH* 13 August: 10.

Mechanic, D. 1981 'Some Dilemmas in Health Care Policy', *Milbank Memorial Quarterly/Health and Society* 59 (1): 1-15.

Medical Practice Amendment Act 2000 New South Wales Legislature.

'Medifraud investigators accused of intimidation', *The Australian*, 20 September 1984: 3.

Mellor, B. 1985 'The Vampires of Pathology', *S-H*, 6 October 1985: 15.

Menadue, J. L. 1999 *Things You Learn Along the Way*. Melbourne: David Lovell Publishing.

Mercer, N. 1992 'Blood Money' a *Four Corners* television program, Australian Broadcasting Corporation, Sydney 27 April 1992.

Mercer, N. 1995 'Pathology Scam', *Today Tonight*, Channel 7, 13 November 1995.

Metherell, M. 1984 'Government is Losing the \$130m Medifraud Fight', *The Age*, 8 August: 1 & 3.

Metherell, M. 1984 'Heath sleuths told to put away their cameras', *The Age*, 8 November: 1.

Metherell, M. & K. Beauchamp, 1985 'Destroy computer data on \$170m medifraud, official told'. *The Age*, 21 March: 1.

Milgram, S. 1974 *Obedience to Authority: An Experimental View*, New York, London: Harper & Row, Publishers.

Mill, J. S. 1948 *Utilitarianism, Liberty and Representative Government*, London: J. M. Dent & Sons Ltd.

Miller, D. 1993 'Official sources and 'primary definition': the case of Northern Ireland, *Media, Culture and Society* 15 (3): 385-406.

Miraldi, R. 1990 *Muckraking and Objectivity: Journalism's Colliding Traditions*, New York, London: Greenwood Press.

McCombs, M. & D. Shaw, 1991 'The Agenda-Setting Function of the Mass Media', in D. L. Protess & M. McCombs (eds) *Agenda Setting: Readings on Media, Public Opinion and Policymaking*, Hillsdale, New Jersey: Lawrence Erlbaum Associates Publishers: 17-26.

- McGinness, J. 1990 'Secrecy Provisions in Commonwealth Legislation', *The Federal Law Review*, 19 (1): 49-97.
- McIntosh, P. 1984 'Pathology claim a gross distortion: AMA', *The Age*, 30 October: 15.
- McKay, B. 1986 'A Participant's Account of the New South Wales Doctors' Dispute', *Community Health Studies*, 10 (2): 220-231.
- McKay, D. 1995 'The Politics of Reaction', in H. Gardner (ed.) *The Politics of Health: The Australian Experience*, Melbourne: Churchill Livingstone.
- McKnight, D. 1999 'The Investigative Tradition in Australian Journalism 1945-1965', in A. Curthoys & J. Schultz (eds) *Journalism: Print, Politics and Popular Culture*, St Lucia Qld: UQP: 155-167.
- McKnight, D. 2001 'Facts Versus Stories: From Objective to Interpretative Reporting', *Media International Australia*, 99 May: 49-58.
- McKnight, D. 2003 "'A World Hungry for a New Philosophy": Rupert Murdoch and the Rise of Neo-Liberalism', *Journalism Studies*, 4 (3): 347-358.
- McMillan, J. 1986 'Whistleblowing', in P. Grabosky & I. Le Lievre (eds) *Government Illegality*, Canberra: Australian Institute for Criminology.
- McMillan, J. 1990 'Legal Protection of Whistleblowers', in S. Prasser, R. Wear, & J. Nethercote *Corruption and Reform: The Fitzgerald Vision*, St. Lucia Qld: University of Queensland Press.
- McMillan, J. 1992 *Commonwealth Constitutional Power over Health*, Canberra: Consumers' Health Forum.
- McMullin, J. 1986 'The Edelsten Practice' (transcript). A *Sixty Minutes* television program, the nine television network, Sydney, 24 August 1986.
- McMullin, R. 1991 *The Light on the Hill: The Australian Labor Party 1891-1991*. Melbourne: Oxford University Press.
- McNair, B. 1994 *News and Journalism in the UK*, London, New York: Routledge.
- McNair, B. 1998 *The Sociology of Journalism*, London: Arnold.
- McNair, B. 2003 *An Introduction to Political Communication*, 3rd edition, London: Routledge.

McNair, B. 2000 *Journalism and Democracy: An Evaluation of the Political Public Sphere*, London and New York: Routledge.

McQuail, D. 1994 *Mass Communication Theory: An Introduction*, 3rd Edition, London: Sage Publications.

Miceli, M.P. & J. P. Miceli 1992 *Blowing the Whistle: The Organizational & Legal Implications for Companies and Employees*, Lexington Books, New York

Miller, B. 1984 'Whistleblowers' still have no protection', *CT*, 1st April: 4

Millikin, R. 1983 'The Man in the Medicare Hot Seat', *The National Times*, 1-7 April: 10-11.

Milliner, K. 1984 'Duplication' in detection of medical frauds', *CT*, 1 May 1984: 7.

Moloch, H. & M. Lester 1974 'News as Purposive Behaviour: On the Strategic Use of Routine Events, Accidents, and Scandals', *American Sociological Review*, 39, Feb.: 101-112.

Moffitt, A. 1985 *A Quarter to Midnight. The Australian Crisis: Organised Crime and the Decline of the Institutions of State*, Sydney: Angus & Robertson Publishers.

Mooney, G. & R. Scotton. 1999 *Economics and Australian Health Policy*, Sydney: Allen & Unwin.

Mooney, N. 1985 'Crushing of a rebel', *The National Times*, 22-28 February: 3, 4 & 7.

Moore, A. P. & A. A. Tarr 1988 'Regulatory Mechanisms in Respect of Entrepreneurial Medicine', *Australian Business Law Review*, 16 (1): 4-44.

Moore, M. H. & M. K. Sparrow 1990 *Ethics in Government: The Moral Challenge of Public Leadership*, New Jersey: Prentice Hall.

Moore, T. 2003 'Hawke's Big Tent: Elite Pluralism and the Politics of Inclusion', in S. Ryan & T. Bramston (eds), *The Hawke Government: A Critical Retrospective*, North Melbourne: Pluto Press.

Monday, I. 2002 'Supplier-induced demand: its nature, extent and some policy implications', in *Health Policy Roundtable, Conference Proceedings, Productivity Commission*, Melbourne 7-8 March 2002, Canberra: AusInfo, 217-244.

Moran, M. & B. Wood 1993 *States, Regulation and the Medical Profession*. Buckingham, Philadelphia: Open University Press.

Morgan, B. P. 2000 'Medibank and Medicare: A Case for Surgery, *MJA* 173: 1, 3 July 2000: 35-36.

Morton, T. 1998 'Shrinking Democracy', on *Background Briefing*, Radio National, 1 November [<http://www.abc.net.au/rn/talks/bbing/stories/s19075.htm>]

Moynihan, R. 1998 *Too Much Medicine? The Business of Health – and its Risks for You*, Sydney: ABC Books.

Moynihan, R. 2000 'Big business targets GPs in national buying spree' *AFR* 23 May: 1.

Moynihan, R. 2001 'The rise and rise of the Medicare millionaires' *AFR* 20 November: 1, 53.

Munday, J. 1985 'Doctors artistry in white collar crime unbeaten' says sociologist', *The Age* 30 August: 5.

Murphy, D. 1980 *Hayden: A Political Biography*, Sydney: Angus & Robertson Publishers.

Najman, J. M. & J. S. Western, 1984 'A Comparative Analysis of Australian Health Policy in the 1970s', *Social Science and Medicine*. 18 (11): 949-958.

Nash, C. 2003 'Freedom of the Press in Australia'. [<http://www.democratic.audit.anu.edu.au/debates.htm>].

National Archives of Australia: Public Accounts Committee; A983/1; 1982/9/203 Part B 27 Part 1; Miscellaneous submissions.

National Association of Testing Authorities, Australia, 1984 *Submission, Joint Parliamentary Committee of Public Accounts Inquiry into Medical Fraud and Overservicing*, 20 July 1984.

Navarro, V. 1976 *Medicine under Capitalism*. New York: Prodist.

Norman, B. 1994 'Macquarie Pathology's accreditation secretly threatened', *CT* 10 August: 1.

Oakes, L. 1973 *Whitlam PM: A Biography*. Sydney: Angus & Robertson.

Oakes, L. 1976 *Crash Through or Crash: The Unmaking of a Prime Minister*, Richmond, Victoria: Drummond.

Oakes, L. 1984 'Summit soon on doctors' dispute', *The Daily Telegraph*, 18 November: 44.

Oakes, L. 1985 'Government holds back on fighting fraud', *The Bulletin*, 5 March: 34-36.

Oakes, L. & D. Solomon, 1973 *The Making of an Australian Prime Minister*, Melbourne, Cheshire.

Oakes, L. & D. Solomon 1974 *Grab for Power: Election '74*, Melbourne: Cheshire.

O'Connor, S. 1978 'Multi-Million \$ Fraud in Bulk-Billing', *Sunday Mail* 22 October: 1

O'Faircheallaigh, J. Wanna & P. Weller, 1999 *Public Sector Management in Australia: New Challenges, New Directions*, 2nd edition. South Yarra, Melbourne: Macmillan Education.

O'Malley, P. 1996 'Risk and Responsibility', in A. Barry, T. Osborne & N. Rose (eds) *Foucault and Political Reason: Liberalism, Neo-Liberalism and the Rationalities of Government*, London: University College London Press: 189-207.

O'Malley, P. 1998 'Risk, Power and Crime Prevention', in P. O'Malley (ed.) *Crime and Risk Society*, Aldershot England: Ashgate Dartmouth: 71-93.

Opit, L. J. 1981 'Medical Overservicing as a Criminal Activity', in *Proceedings of the Institute of Criminology*, No. 50, *Crime and the Professions; The Provision of Medical Services*, Sydney: Government Printer: 39-48.

Opit, L. J. 1983 'Wheeling, Healing and Dealing: The Political Economy of Health Care in Australia', *Community Health Studies*, 7 (3): 238-246.

Opit, L. J. 1984a 'Viewpoint', in M. Tatchell (ed.) *Perspectives on Health Policy*, Australian National University, Canberra.

Opit, L. J. 1984b 'The Cost of Health Care and Health Insurance in Australia: Some Problems Associated with the Fee-For-Service System', *Social Science and Medicine*, 18 (11): 967-972.

Organisation for Economic Co-operation and Development 1994 *The Reform of Health Care Systems: a Review of Seventeen OECD Countries*. Paris: France.

Ormonde, T. 1982 "Health chief may quit early", *The Age* 15 November: 3.

Ormonde, T. 1982 'New health head is named; first non-doctor', *The Age*, 24 November: 5

Ormonde, T. 1982 'Medifraud rap for PS', *The Age*, 10 December: 1, 5.

Osborne D. & T. Gaebler 1992 *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*, Reading, Massachusetts: Addison-Wesley.

Page, E. 1963 *Truant Surgeon: The Inside Story of Forty Years of Australian Political Life*. Sydney: Angus and Robertson

Palmer, G. R. 1979 'Health' in A. Patience & B. Head (eds) *From Whitlam to Fraser. Reform and Reaction in Australian Politics* Melbourne: Oxford University Press.

Palmer, G. R. 1983 'Politics, Power and Health: From Medibank to Medicare', *New Doctor*, Sept/Oct. 19-22.

Palmer, G. R. 1989 'Health Insurance and Financing' in B. Head & A. Patience (eds) *From Fraser to Hawke*. Melbourne: LongmanCheshire.

Palmer, G. R. & S. D. Short 2000 *Health Care & Public Policy. An Australian Analysis 3rd edition*. South Melbourne: Macmillan Education Australia.

Park, R. E. 1940 'News as a Form of Knowledge: A Chapter in the Sociology of Knowledge', *American Journal of Sociology*, 45 (5), 669-686.

Parloff, R. 1998 'How *The Times* nailed a health care giant', *Brill's Content* July/August: 100-107.

'Pathological Profiteering', *The Age* 14 February 1977: 9.

Pathology Ordering by General Practitioners in Australia 1998, Westmead, NSW: GP Statistics and Classifications Unit 1999
[<http://www.health.gov.au/haf/docs/pathorder.htm>].

Payne, J. 1985 "\$170 million medifraud statistics shredded", *Sun-Herald*, 24 March 1985: 24.

Pengelley, J. 2004 'Heart expert fraud probe', *The Advertiser*, 18 February 2004: 1.

Penington, D. G., J. D. Cashman & B. J. Kearney, 1984 *Committee of Inquiry into Rights of Private Practice in Public Hospitals. Final Report*, (September) Canberra: Australian Government Publishing Service.

Penington, D. 1987 'Australia's Health System – Where Did We Go Wrong?' Text of the Lambie-Dew Oration, delivered in Sydney, May 1987, Australian Hospital Association, Deakin, A.C.T.

"Penington sees Medicare as a 'blank cheque'", *CT*, 30 November 1985: 1.

Penkethman, R. 1977 'Abuse of the Medibank Program', Australian Institute of Criminology, Training Project No. 60 'White Collar Offences' 20-21 June, Australian National University, Canberra.

Pensabene, T. S. 1986 'The New South Wales doctors' strike end of an era', *New Doctor*, No. 36, June: 5-8.

Pensabene, T. S. 1986 'Implications of the NSW Doctors Dispute', in Butler J. & Doessel, D. P. *Economics and Health 1985: Proceedings of the 7th Australian Conference of Health Economics*, School of Health Administration, Kensington: UNSW.

Peterson, E. 1982 'Medifraud trap closes', *The Australian*, 2 November: 1.

Pickering, E. 1984 'Medicare; Myths, Mysteries and Myopias', *Australian Health Review*, 7 (1): 24-27.

Pirani, C. 2003 'System stuck in the queue', *The Australian*, 8 September: 12.

Plueckhahn, V. D. 1977 'Healthier ways to practice pathology', *The Age* 15 February 1977: 8.

'Political Intervention in Medicine', *The Australian G.P.* July 1976: 22-23.

Pontell, H. 2002 'Medical Crime', in S. M. Rosoff, H. N. Pontell & R. Tillman (eds) *Profit Without Honor: White-Collar Crime and the Looting of America*. 2nd edition, Upper Saddle River, New Jersey, USA: Prentice-Hall.

Ponting, C. 1985 *The Right to Know: The Inside Story of the Belgrano Affair*, London: Sphere Books.

Power, M. 1999 *The Audit Society: Rituals of Verification*, Oxford: Oxford University Press.

Pradham v Holmes, Federal Court of Australia 2001. 8 November 2001. [<http://austlii.edu.au/cgi-bin/disp.pl/au/cases/cth/federal%5fct/2001/1560.html>]

Prasser, S, R. Wear & J. Nethcote, 1990 *Corruption and Reform: The Fitzgerald Vision*, St. Lucia Qld: University of Queensland Press.

Priorities Review Staff, 1974 *Goals and Strategies: Interim Report December 1973*, Canberra: Australian Government Publishing Service.

Proceedings of a Seminar on Crime and the Professions – The Provision of Medical Services. Institute of Criminology, Sydney University Law School, 16 September 1981. Chairman: Sir Laurence Street.

Productivity Commission and Melbourne Institute of Applied Economic and Social Research 2002, *Health Policy Roundtable*, Conference Proceedings, Canberra: AusInfo.

Professional Services Review 2001, *Annual Report 2000 – 2001*, Canberra: Paragon Printers.

Professional Services Review 2002, *Annual Report 2001 – 2002*, Canberra: Paragon Printers.

Professional Services Review 2003, *Annual Report 2002 – 2003*, Canberra: Paragon Printers.

Protess, D. L., F. Cook, J. Doppelt, J. Ettema, M. Gordon, D. Leff & P. Miller (eds), 1991 *The Journalism of Outrage: Investigative Reporting and Agenda Building in America*, New York: The Guilford Press.

Pullan, R. 1986 *Four Corners: Twenty Five Years*, Sydney: ABC Books.

Pusey, M. 1991 *Economic Rationalism in Canberra: A Nation Building State Changes its Mind*, Cambridge and Sydney: Cambridge University Press.

Pusey, M. 1993a "Australia: State and Polity", in J. M. Najman, & J. S. Western, *A Sociology of Australian Society*, Melbourne: Macmillan Education Australia: 26-53.

Pusey, M. 1993b *Reclaiming the Middle Ground...From New Right Economic Rationalism*. Discussion Paper No. 31, Public Sector Research Centre, UNSW.

Quiggin, J. 1989 'The Role and Consequences of Special Interest Groups and Political Factors', in Bruce Chapman (ed.) *Australian Economic Growth*, MacMillan.

Rees, S. J. & L. Gibbons 1986 *A Brutal Game. Patients and the Doctors' Dispute*, North Ryde: Angus & Robertson Publishers.

Rees, S. 1986 'Authoritarianism in State Bureaucracies: The Psychology of State Conformity' in B. Martin, C. Baker, C. Manwell & C. Pugh, (ed.) 1986 *Intellectual Suppression*, Sydney: Angus & Robertson: 213-223.

Reichman, N. 1998 'Managing Crime Risks: Toward an Insurance Based Model of Social Control', in *Crime and Risk Society*, Aldershot England: Ashgate Dartmouth: 49-67.

Reid, A. 1971 *The Gorton Experiment*, Sydney: Shakespeare Head Press.

Relman, A. S. 1980 'The New Medical-Industrial Complex', *The New England Journal of Medicine*, 303 (17): 963-970.

Repin, G. D. 1972 *The Development of Australian Health Services*. Lecture notes. Department of Public Health, Sydney University.

Repin, G. D. 1983 'Status: How Important is it to Medical Practice', *Medical Practice*, October: 46-54.

Repin, G. D. 1984 'The AMA's Attitude to Medicare', *Australian Health Review*, 7 (1): 31-33.

Repin G. D. 2000 'They can't say they weren't warned!', *MJA* 173, 3 July: 17-19.

Report of the Pathology Services Working Party, 1977 Canberra: Australian Government Publishing Service, March.

Report of the Pathology Services Working Party, 1978 Canberra: Australian Government Publishing Service, October.

Report of the House of Representative Standing Committee on Finance and Public Administration September 1990 *Not Dollars Alone: Review of the Financial Management Improvement Program*. Canberra, AGPS.

Report of the Royal Commission into Deep Sleep Therapy. The Honourable Mr Acting Justice J. P. Slattery, 1990. Vol. 6, 8 and 13, Sydney: Government Printing Service.

Report of the Senate Select Committee on Public Interest Whistleblowing, 1994 *In the Public Interest*, Parliament of the Commonwealth of Australia, August.

Report by the Senate Standing Committee on Legal and Constitutional Affairs, 1994 *Off the Record*, Parliament of the Commonwealth of Australia, October.

Review of Commonwealth Administration (Australia), 1983 *Report January 1983*, Canberra: Australian Government Publishing Service.

Review of Commonwealth Legislation regarding Pathology, 2000 Submission by the Australian Association of Pathology Practices Inc. [<http://www.aapp.asn.au/LR%20submission.PDF>].

Review of Systems for Dealing with Fraud on the Commonwealth (Australia) 1987 Canberra: Australian Government Publishing Service.

Rice, M. 1985 'Government's \$166m cave-in to doctors', *The Australian*, 3 April: 1

Rice, M. 1985 'GPs slip through pathology loopholes', *The Australian*, 11 April: 3.

Rice, M. 1985 'Radical surgery for doctors' big brother', *The Australian*, 14 May: 11

Rice, M. 1985 'How pathology failed the Medicare test', *SMH Good Weekend*, 19 October 1985: 18-21.

Richardson, G. 1994 *Whatever It Takes*, Sydney: Bantam Books.

Richardson, J. R. 1982 'The Use of Hospital and Medical Services in Australia: Some Policy Issues', in M. Tatchell (ed.) *Perspectives on Health Policy*, Canberra: Australian National University: 81-98.

Richardson, J. R., 1987a 'Does Bulk Billing Cause Abuse of Medicare?' *Community Health Studies*, Vol. XI, No. 2: 98-107.

Richardson, J. R., 1987b *Financial Incentives and Entrepreneurial Medicine. Problems and Solutions*, Australian Studies in Health Administration No. 61, Sydney: University of New South Wales.

Richardson, J. R. 1989a 'Ownership and Regulation in the Health Care Sector', in R. G. Butler & D. P. Doessel (eds) *Health Economics: Australian Readings*, Sydney: Australian Professional Publications: 87-108.

Richardson, J. R. 1989b 'The Inducement Hypothesis: That Doctors Generate Demand for Their Own Services', in R. G. Butler & D. P. Doessel (eds) *Health Economics: Australian Readings*, Sydney: Australian Professional Publications: 215- 237.

Richardson, J. R. 1999 'The Health Care Financing Debate', *Economics and Australian Health Policy*, Sydney: Allen & Unwin.

Richardson, J. R. & R. H. Wallace 1989 'Health Economics', in R. G. Butler & D. P. Doessel (eds) *Health Economics: Australian Readings*, Sydney: Australian Professional Publications: 2-58.

Rigakos, G. S. 1999 'Risk Society and Actuarial Criminology: Prospects for a Critical Discourse', *Canadian Journal of Criminology*, 41 (2): 137-150.

Ritzer, G. 1993 *The McDonaldization of Society*, Thousand Oaks, California Pine: Forge Press.

Robertson, L. J. & A. E. Field 1982 *The Gap is Bridged Part 2* unpublished.

Rodwin, M. A. 1993 *Medicine, Money and Morals: Physicians' Conflicts of Interest*, New York, Oxford, Oxford University Press.

Rodwin, V. G. 1981 *The Marriage of National Health Insurance and La Medecine Liberale in France: A Costly Union*. In Milbank Memorial Fund Quarterly, Vol. 59, 1:16-43

Roe, M. 1976 'The Establishment of the Australian Department of Health' *Historical Studies*, 17 (67): 176–192.

Rose, N. 1996 'Governing "advanced" liberal democracies', in A. Barry, T. Osborne & N. Rose, *Foucault and Political Reason: Liberalism, Neo-Liberalism and Rationalities of Government*, Chicago, University of Chicago Press: 37–64.

Rose, N. 1999 *Powers of Freedom: reframing political thought*, Cambridge, UK: Cambridge University Press.

Rose, N. & P. Miller, 1992 'Political Power Beyond the State: problematics of government', *British Journal of Sociology*, 43 (2): 173–205.

Rosen, J. 1997 'Introduction/ "We'll Have that Conservation": Journalism and Democracy in the Thought of James W. Carey', in E. S. Munson & C. A. Warren (eds) *James Carey: A Critical Reader*, Minneapolis: University of Minnesota Press.

Royal Commission on Australian Government Administration, 1976 *Report and Four Volumes of Appendices*, Parliamentary Papers: 185-189/1976, Canberra: Australian Government Publishing Service.

Russell, R. 1995 *Building Strength Through Change: Twenty Years of the Health Insurance Commission*, Tuggeranong, A.C.T.: Health Insurance Commission.

Ryan, C. 1985 'The Sporting Life of a Millionaire Doctor', *The National Times*, May 24–30: 3–4.

Sackville, R. 1973 'Social Welfare in Australia: the Constitutional Framework' *Federal Law Review* 5: 248.

Samuel, P. 1972 'Government Secrecy', *Australian Quarterly*, 44 (2): 5–8.

Samuel, P. 1975 'The big Medibank muck-up', *The Bulletin*, 27 September: 14–16.

Sarre, R. 1988 'Alternative Remedies for Fraud: The Rule of Law Versus Administrative Remedies', *Canberra Bulletin of Public Administration*, No. 56 Sept. 1988: 110–117.

Sax, S. 1972 *Medical Care in the Melting Pot*, Sydney: Angus & Robertson.

Sax, S. 1974 'A Proposal for a Scheme to Accredite Pathology Services in Australia'. Prepared by the Hospitals and Health Services Commission.

Sax, S. 1977 'Are Health and Medicine in Conflict?' *MJA*, 1: 357-362

Sax, S. 1984 *A Strife of Interests: Politics and Policies in Australian Health Services*, Sydney: Allen & Unwin.

Sax, S. 1989a 'The Politics of Health in Australia', in Lupton, G. M. & J. M. Najman 1989 (eds) *Sociology of Health and Illness: Australian Readings*, South Melbourne: Macmillan: 101-117.

Sax, S. 1989b 'Organization and Delivery of Health Care', in H. Gardner (ed.) *The Politics of Health: The Australian Experience*, Melbourne, Sydney: Churchill Livingstone: 225-251.

Sax, S. 1990 *Health Care Choices and the Public Purse*, Sydney: Allen & Unwin.

Schlesinger, P. 1989 'From Production to Propaganda?' in *Media, Culture and Society*, Sage Publications, London, 11: 283-306

Schlesinger, P. 1990 "Rethinking the Sociology of Journalism: Source Strategies and the Limits of Media-Centrism" in M. Ferguson (ed.) 1990. *Public Communication: The New Imperatives*. London: Sage Publications: 61-83.

Schlesinger, P. & H. Tumber, 1994 *Reporting Crime: The Media Politics of Criminal Justice*, Oxford: Clarendon Press.

Schudson, M. 1978 *Discovering the News: A Social History of American Newspapers*, New York: Basic Books.

Schudson, M. 1991 'Sociology of News Production Revisited' in J. Curran & M. Gurevitch *Mass Media and Society*, London, New York: Edward Arnold.

Schudson, M. 1995 *The Power of News*, Cambridge, Mass., University of Harvard Press.

Schudson, M. 1997 'Introduction: The Problem of Journalism History', in E. S. Munson & C. A. Warren (eds), *James Carey, A Critical Reader*, Minneapolis: University of Minnesota Press.

Schultz, J. 1992 'Investigative Reporting Tests Journalistic Independence', *Australian Journalism Review*, 14 (2), 18-30.

Schultz, J. 1998 *Reviving the Fourth Estate: Democracy, Accountability and the Media*, Cambridge: Cambridge University Press.

Scott, C. 2002 'Private Regulation of the Public Sector: A Neglected Facet of Contemporary Governance', *Journal of Law and Society*, March 29 (1): 56–76.

Scotton, R. B. 1974 *Medical Care in Australia: an economic diagnosis*, Melbourne: Institute for Applied Economic and Social Research, Sun Books.

Scotton, R. B. 1989 'The Role of Government in Health Care', *Australian Health Review*, 12 (4): 75–88.

Scotton, R. B. 1992 'Demand side socialism and managed competition: do they add up?' in C. Selby Smith (ed.), *Economics and Health 1991*, Proceedings of the 13th annual conference of the Australian Health Economics Society, National Centre for Health Program Evaluation and Graduate School of Management, Monash University.

Scotton, R. B. 1999 'The Doctor Business', in G. Mooney & R. Scotton (eds), *Economics and Australian Health Policy*, Sydney: Allen & Unwin.

Scotton, R. B. 2000a 'Medibank: from Conception to Delivery and Beyond', Medibank: 25 years on, *MJA*, 173 (1) 3 July: 9–11.

Scotton, R. B. 2000b 'Medicare: Options for the Next 25 Years', Medibank: 25 years on, *MJA*, 173 (1) 3 July: 41–43.

Scotton, R. B. & J. S. Deeble, 1968 'Compulsory Health Insurance for Australia', *Australian Economic Review*, 4th quarter: 9–16. Reprinted in R. G. Butler & D. P. Doessel (eds) 1989 *Health Economics: Australian Readings*, Sydney; Australian Professional Publications: 128–144.

Scotton, R. B. & J. S. Deeble, J. 1969 'The Nimmo Report', *Economic Record*, 45: 258–275.

Scotton, R. B. & C. R. Macdonald, 1993 *The Making of Medibank*, Kensington, NSW: School of Health Service Management, University of New South Wales.

Sekules, P. 1991 *Lobbying Canberra in the Nineties: The Government Relations Game*, Sydney: Allen & Unwin.

Selby-Smith, C. 1991 'Public Service Ethics in Conflict Situation – Public Servants, Ministers, Parliament and the Public', *Public Sector Management Institute Working Paper 33*, Monash University, Vic.

Selby-Smith, C. & D. Corbett, 1995 'Parliamentary Committees, Public Servants and Due Process', *Australian Journal of Public Administration*, 54 (1): 19–34.

Senate Select Committee on Public Interest Whistleblowing, 1994 *In the Public Interest*, Canberra: Parliament of the Commonwealth of Australia.

Senate Standing Committee on Legal and Constitutional Affairs, 1994 *Off the Record – Shield Laws for Journalists' Confidential Sources*. Canberra: Parliament of the Commonwealth of Australia.

Sexton, M. 1979 *Illusions of Power. The Fate of a Reform Government*, Sydney: George Allen & Unwin.

Shanahan, D. 1985 'Edelsten linked to hit-man', *SMH*, 15 November: 1.

Sigal, L. V. 1973 *Reporters and Officials: The Organization and Politics of Newsmaking*, Lexington: D.C. Heath and Company.

Sigal, L. V. 1986 'Who? Sources Make the News', in R. K. Manoff & M. Schudson (eds) *Reading the News*, New York: Pantheon Books.

Simms, M. 1987 *Militant Public Servants: Politicisation, Feminisation and Selected Public Service Unions*, South Melbourne: Macmillan.

Simon, J. 1998 'The Emergence of the Risk Society: Insurance, Law and the State' in P. O'Malley (ed) *Crime and Risk Society*, Aldershot England: Ashgate Dartmouth: 3–31.

Simons, M. 2002 'Lies and Power'. On *Perspective*, ABC Radio National, 5 March 2002 [<http://www.abc.net.au/rn/talks/perspective/stories/s49637.htm>].

Simson, S. 1976 'Medibank under the microscope', *AFR* 12 January: 1.

Simson, S. 1976 'Confidential report reveals government's anti-Medibank tactics', *AFR* 3 June: 1.

Smark, P. & M. Harris, 1985 'Sydney's leading doctors: a Medicare cheque list', *SMH* 29 April: 1.

Smith, J. 1985 'Bitter and Black Days for Neal Blewett', *The Bulletin* 16 April: 30–33.

Smith, M. 1982 'Medifraud cover-up suspected', *The Age* 11 September: 1.

Smith, M. 1982 'Medifraud: A Tale of Political Failure', *The Age* 13 September: 1 & 3.

Smith, R. G. (ed.) 1998 *Health Care, Crime and Regulatory Control*, Sydney: The Australian Institute of Criminology, Hawkins Press.

Smith, R. G. 1999 'Defrauding Governments in the Twenty-First Century', *Trends and Issues in Crime and Criminal Justice*, No. 111, April 1999, Canberra: Australian Institute of Criminology.

Smith, R. G. 1999 'Electronic Medicare Fraud: Current & Future Risks', *Trends and Issues in Crime and Criminal Justice*, No. 114, May 1999, Canberra: Australian Institute of Criminology.

Smith, R. G. 2002a 'Regulating Dishonest Conduct in the Professions'. Paper delivered at the Australian Institute of Criminology Conference *Current Issues in Regulation: Enforcement and Compliance*, Melbourne 2–3 September 2002.

Smith, R. G. 2002b 'White-collar Crime', in A. Graycar & P. Grabosky (eds) *The Cambridge Handbook of Australian Criminology*, Cambridge: Cambridge University Press.

Smith, R. G. 2002c 'The Regulation of Professionals in the Digital Age', in R. G. Smith (ed.) *Crime in the Professions*, Aldershot England: Ashgate Publishing Company.

Snow, D. 1982 'Minister's aid sought for fraud inquiry', *AFR*, 15 April: 5.

Snow, D. 1982 'Staff shortage claim in medifraud inquiry', *AFR*, 27 October: 4.

Snow, D. 1982 'MacKeller Quizzed on Depth of Medifraud Briefings', *AFR*, 12 November: 7.

Snow, D. 1982 'Grave charges against Health Department', *AFR*, 10 December: 1.

Soloman, S. 1985 'Gatecrashers in medicine's cosy club', *Australian Society*, December: 8-12.

Soper, H. L. 1982 'Doctors face rebate muddle', *SMH* 15 February 1982: 6.

Sparrow, M. K. 1996 *License to Steal: Why Fraud Plagues America's Health Care System*, Colorado: Westview Press.

Sparrow, M. K. 1997 'A criminal's dream: automated payments systems, designed for honest providers, are easy targets for fraud', *Modern Healthcare*, Oct 6, 27 (40): 94 (1).

Sparrow, M. 1998 'Fraud Control in the Health Care Industry: Assessing the State of the Art' National Institute of Justice Research in Brief, December.

Sparrow, M. K. 1999 'Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles.' A Report from the "Executive Seminars on Fraud and Abuse in Medicaid," Washington D.C.: Health Care Financing Administration.

Sparrow, M. K. 2000a *Licence to Steal. How Fraud Bleeds America's Health Care System*, Colorado: Westview Press.

Sparrow, M. L. 2000b *The Regulatory Craft. Controlling Risks, Solving Problems, and Managing Compliance*, Washington, D. C.: Brookings Institution Press.

Starr, P. 1982 *The Social Transformation of American Medicine*. New York: Basic Books Inc.

Staunton, J. H. 1981 'Discussion', in *Proceedings of the Institute of Criminology*, No. 50, *Crime and the Professions; The Provision of Medical Services*, Sydney: Government Printer; 64-65.

Strange, S. 1996 *The Retreat of the State: The Diffusion of Power in the World Economy*, Cambridge: Cambridge University Press.

Steketee, M. 1993 'Medifraud: How crooks are caught', *SMH*, 6 July: 9.

Steketee, M. 1996 'The Press Gallery at Work', in J. Disney & J. R. Nethercote (eds), *The House on Capital Hill: Parliament, Politics and Power in the National Capital*, Sydney: The Federation Press.

Steketee, M. 2001 'Labor in Power: 1983-96', in J. Faulkner & S. Macintyre (eds) *True Believers: The Story of the Federal Labor Party*, Sydney: Allen & Unwin.

Stone, J. 1992 'Yes Minister? Politicians and Bureaucrats in Canberra', *Quadrant*, October: 14-19.

Stone, T. 1998 'Organized crime and Medicare fraud', *Crime and Justice International*, 14 (18 & 19): 14-15.

Strange, S. 1996 *The Retreat of the State: The Diffusion of Power in the World Economy*, Cambridge: Cambridge University Press.

Stubbs, J. N. 1989 *Hayden*, William Heinemann Australia, Port Melbourne.

Summers, A. 1981 'The Role and Ethics of Leaks', *Australian Quarterly*, 53 (2): 159-166

Swaan, A. de. 1989 'The Reluctant Imperialism of the Medical Profession', *Social Science & Medicine* 28 (11): 1165-1170.

Swan, N. & Doogue, G. 2001 'The Big Business of Medicine – Joint Broadcast with Life Matters' on *The Health Report and Life Matters*, ABC Radio National, 27 August [<http://www.abc.net.au/rn/talks/8.30/helthrp/stories/s353637.htm>].

Swartz, D. 2003 'From critical sociology to public intellectual: Pierre Bourdieu and politics', *Theory and Society*, Vol. 32 (5-6): 791-823.

Tatchell, M. (ed.) 1982 *Perspectives on Health Policy: Proceedings of a Public Affairs Conference held at the Australian National University, Canberra*.

Temby, I. 1988 'Impediments to Tackling Fraud', in *Canberra Bulletin of Public Administration*, September, 56: 77-80.

Templeton, T. 2001-2 'GATS: The End of Public Health?', *New Doctor*, Vol. 76, Summer 2001-2: 2-6.

Terrill, G. 2000 *Secrecy and Openness: The Federal Government from Menzies to Whitlam and Beyond*. Melbourne: Melbourne University Press.

Tesh, S. N. 1990 *Hidden Arguments: Political Ideology and Disease Prevention Policy*, New Brunswick, London: Rutgers University Press.

Thomas, D. G. 2002 *The Challenge to Medical Autonomy and Peer Review Embodied in the Complaints Unit/Health Care Complaints Commission of New South Wales*, unpublished PhD thesis, University of Sydney.

Thompson, H. L. 1985 'The New South Wales Hospitals Dispute', Address delivered by Dr. H. Lindsay Thompson, President of the Australian Medical

Association at the National Press Club Canberra, 20 March 1985 [transcript from sound recording], ORAL TRC 1747, National Library of Australia.

Thompson, J. B. 1995 *The Media and Modernity: A Social Theory of the Media*, Stanford, California: Stanford University Press.

Thompson, J. B. 1997 'Scandal and Social Theory', in J. Lull & S. Hinerman (eds) *Media Scandals: Morality and Desire in the Popular Culture Marketplace*, New York: Columbia University Press: 35-64.

Thompson, J. B. 2000 *Political Scandal: Power and Visibility in the Media Age*, Polity Press, Blackwell Publishers: Cambridge UK.

Thomson, E. F. 1969 'The health care debate: the AMA replies to Mr. Whitlam', *Medical Journal of Australia*, 19 April 1969, 1 (15): 826-827.

Tiffen, R. 1988 'Confidential Sources in the News: Conventions and Contortions', *Australian Journalism Review*, Vol. 10: 22-27.

Tiffen, R. 1989 *News and Power*, Sydney: Allen & Unwin.

Tiffen, R. 1999 *Scandals: Media, Politics & Corruption in Contemporary Australia*, Sydney: University of NSW Press.

Toohey, B. 1994 *Tumbling Dice: The Story of Modern Economic Policy*, Melbourne: Reed Books.

Tracy, R. T. 1861 'Address to the Medical Society of Victoria 16 January 1861', *Australian Medical Journal*, Vol. VI: 60-69.

Transcript – court proceedings Australian Broadcasting Corporation (Neil Mercer, Marian Wilkinson) and Peter George Bachich, Rosalind Margaret Bachich NCPS Laboratories P/L, 18 June 1992.

Transcript – court proceedings Police V Peter George Bachich and Margaret Rosalind Bachich, 3 May 1990.

Tuchman, G. 1972 'Objectivity as a Strategic Ritual', *American Journal of Sociology*, 77: 660-679.

Tuchman, G. 1978 *Making News: A Study in the Construction of Reality*, London: The Free Press.

Tumber, H. (ed.) 1999 *News: A Reader*, Oxford: Oxford University Press.

Tuohy, C. H. 1994 'Response to the Clinton Proposal: A Comparative Perspective', *Journal of Health Politics, Policy and Law*, 19 (1): 249-254.

Tuohy, C. H. 1999 *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada*, New York, Oxford: Oxford University Press.

Turner, B. S. 1987 *Medical Power and Social Knowledge*, London: Sage Publications.

Uhr, J. 1982 'Parliament and public administration', in R. Nethercote (ed.) *Parliament & Bureaucracy. Parliamentary Scrutiny of Administration: Prospects & Problems in the 1980s*, Sydney: Hale & Iremonger.

Uhr, J. 1989 'Corporate management and accountability: from effectiveness to leadership', in G. Davis P. Weller & C. Lewis C. (eds), *Corporate Management in Australian Government – Reconciling Accountability with Efficiency*, South Melbourne: Macmillan.

Uhr, J. 1993a 'Redesigning Accountability: From Muddles to Maps' in *Australian Quarterly*, Winter, 65 (2): 11-27.

Uhr, J. 1993b 'Parliamentary measures: Evaluating parliament's policy role', in I. Marsh (ed.) *Governing in the 1990s: An agenda for the decade*, Melbourne: Longman Cheshire: 346-375.

'Union health fund decision this week: Carlton', *The Age*, 9 August 1982: 3.

Valentine, T. 1993 'An Appraisal of Financial Deregulation', in C. James, C. Jones & A. Norton (eds) *A Defence of Economic Rationalism*, Sydney NSW: Allen & Unwin.

Verghis, S. 2000 'Doctors accept BMW bribes in kickback culture of creative fraud', *SMH* 31 July: 3.

Videnieks, M. 2001 'Edelsten's character defect keeps him out in the cold' *The Australian* 1 August: 4.

Vining, R. & P. Mara. 1996 *General Practitioners and Pathology: the Key to Pathology Reform: a Study of Pathology Ordering by General Practitioners*, Canberra: Department of Health and Family Services.

Vinten, G. (ed.) 1994 *Whistleblowing – Subversion or Corporate Citizenship?* London: Paul Chapman Publishing Ltd.

Walsh, P. 1995 *Confessions of a Failed Finance Minister*, Sydney: Random House Aust. Pty. Ltd.

Walsh, M. 1983 'Hawke finds a cuckoo in the nest', *The Bulletin*, 19 April: 22-24.

Wanna, J. C. Ryan & C. Nu 2001 *From Accounting to Accountability: A Centenary History of the Australian National Audit Office*, Crows Nest, NSW: Allen & Unwin.

Warby, M. 1993 'Scapegoating and moral panic: political reality and public policy versus anti-rationalism', in C. James, C. Jones & A. Norton (eds) *A Defence of Economic Rationalism*, St. Leonards, NSW: Allen & Unwin.

Warhurst, J. 1993 'Changing Relationships: Interest Groups and Policy-Making in the 1990s', in A. Hede & S. Prasser (eds) *Policy-making in Volatile times*, Sydney: Hale & Iremonger.

Waterford, J. 1982 'Willett to succeed Howells as Health Director-General', *CT*, 24 November: 31.

Watson, D. 2002 *Recollections of a Bleeding Heart: A Portrait of Paul Keating PM*. Milsons Point: Vintage.

Weber, M. 1946 *From Max Weber: Essays in Sociology*. Trans. and edited by H. H. Gerth & C. Wright Mills, New York: Oxford University Press.

Weinberg, S. 1996 *The Reporter's Handbook: An investigator's guide to documents and techniques* New York: St. Martin's Press.

Weir, D. & D. Noyes, 1983 *Raising Hell: How the centre for investigative reporting gets the story*, Massachusetts: Addison-Wesley Publishing Company.

Weinstein, D. 1979 *Bureaucratic Opposition: Challenging Abuses at the Workplace*. New York: Pergamon Press.

Weller, G. R. 1977 'From "Pressure Group Politics" to "Medical-Industrial Complex:" The development of approaches to the politics of health', *Journal of Health Politics, Policy and Law*, 1 (4): 444-470.

Weller, P. 1989 *Malcolm Fraser PM: A study in Prime Ministerial power in Australia*, Ringwood Vic.: Penguin Books.

Weller, P. 2001 *Australia's Mandarins: the Frank and the Fearless*, Sydney: Allen & Unwin.

Westergaard, J. 1977 'Power, Class and the Media' in J. Curran & M. Gurevitch & J. Woollacott (eds.) *Mass Communication and Society*, The Open University, London: 95-115.

Wheelwright, K. 1994 'Controlling Pathology Expenditure Under Medicare – A Failure of Regulation?' *The Federal Law Review*, 22 (1): 92-115.

Wheelwright, K. 1995 'Commonwealth and State Powers in Health – A Constitutional Diagnosis', *Monash University Law Review*, 21 (1): 53-83.

Wheelwright, K., J. Barnes & B. Gaze, 1996 'The Avoidance of Judicial Review: Lessons for Health Policy Implementation', *Australian Journal of Administrative Law* 3 (3): 145-163.

White, D. M. & D. A. Kemp (ed.) 1986 *Malcolm Fraser on Australia*, Melbourne: Hill of Content.

White, K. 2000-1 'What's Happening in General Practice: Capitalist Monopolisation and State Administrative Control: a Profession Bailing Out?' *Annual Review of Health Social Sciences*, Vol. 10: 5-18.

White, K. 2001 'From Professional to Sub-Contractor – the Swift Decline of General Practice: Rejoinder to Watts and Pinski', *Health Sociology Review*, Vol. 10 (2): 117-120.

Whitlam, E. G. 1965 *Labor and the Constitution*, Fabian Society Pamphlet 11, Croyden West, Vic.: Wilson Service Press.

Whitlam, E. G. 1968 *An Alternate Health Policy*, NSW Fabian Society, Sydney: Southwood Press.

Whitlam, E. G. 1969 'The Health Care Debate: Labor's Reply', *Medical Journal of Australia*, 1 (15): 783-5.

Whitlam, E. G. 1985 *The Whitlam Government, 1972-1975*, Ringwood Victoria: Penguin Books.

The Whitlam Phenomenon: Fabian Papers 1986. Fitzroy, Vic.: McPhee Gribble in association with Penguin Books.

Whitlam, E. G. 1997 *Abiding Interests*, St. Lucia Qld: University of Queensland Press.

Williams, R. 1977 *Marxism and Literature*. Oxford: Oxford University Press.

Willis, E. 1989 *Medical Dominance: The Division of Labour in Australian Health Care*, North Sydney: Allen & Unwin.

Willis, E. 1990 'Hierarchies, Bureaucracies and Professions: The Medicare Review Part Two', *Community Health Studies*, 14 (2): 97-107.

Willis, E. 1993 'The Medical Profession in Australia', in F. W. Hafferty & J. B. McKinlay (eds) *The Changing Medical Profession: An International Perspective*, New York: Oxford University Press.

Willis, R. 2003 'The Economy', in S. Ryan & T. Bramston, *The Hawke Government, A Critical Retrospective*, North Melbourne: Pluto Press.

Wilmot, B. 2002 'Caution remains at a premium for E-crime insurers', *AFR*, 25 July: 20.

Wilson, L. L. 2000 'The Medibank campaign', *MJA*, 173, 3 July 2000: 20-21.

Wilson, P. R., 1986 'Professional Crime: The Case of Doctors', in D. Chappell & P. R. Wilson, *The Australian Criminal Justice System*, Sydney: Butterworths: 97-114.

Wilson, P. R. 1989 'Medical Fraud and Abuse in Medical Benefit Programmes', in P. Grabosky & A. Sutton (eds), *Stains on a White Collar*, Sydney: The Federation Press: 76-91.

Wilson, P. R., D. Chappell & R. Lincoln, 1986 'Policing Physician Abuse in BC: An Analysis of Current Policies', *Canadian Public Policy – Analyse de Politiques*, XII (1): 236-244.

Wilson, P. R., G. Geis, H. N. Pontell & D. Chappell, 1985 'Medical Fraud and Abuse: Australia, Canada, and the United States', *International Journal of Comparative and Applied Criminal Justice*, 9 (2): 25-34.

Wilson, P. R. & P. Gorrington, 1985 'Social Antecedents of Medical Fraud and Overservicing: What Makes a Doctor Criminal?' *Australian Journal of Social Issues*, 20 (3): 175-187.

Wilson, P. & P. Grabosky, 1986 *Investigating and Detecting Medical Fraud and Overservicing: How serious are governments?* *Legal Service Bulletin*, 11, 4: 161-164.

Wise, R. 1982 'Back to Medibank is Labor health plan', *AFR*, 5 February 1982: 7.

Wohl, S. 1984 *The Medical Industrial Complex*. New York: Harmony Books.

Wooldridge, M. R. L. 1991 *Health Policy in the Fraser Years*, unpublished MBA thesis, Monash University, Melbourne.

Yeatman, A. (ed.) 1998 *Activism and the Policy Process*, Sydney: Allen & Unwin.

Yeung, K. 2002 'Is the Use of Informal Adverse Publicity a Legitimate Regulatory Compliance Technique?' Paper presented to the Australian Institute of Criminology Conference, *Current Issues in Regulation: Enforcement and Compliance*, Melbourne, 3 September 2002.

[URL: <http://www.aic.gov.au/conferences/regulation/yeung.pdf>.]

Zawawi, C. 1994 'Sources of News – Who feeds the Watchdogs?' *Australian Journalism Review*, 16 (1): 67-71.

Zimmerman, J. 2001 'The effects of bureaucratization on corruption, deviant and unethical behaviour in organizations', *Journal of Managerial Issues* 13 (1): 119-133.

Zinn, C. 2000 'Australian Radiologists Face Prosecution for Fraud', *British Medical Journal* 320:140.

Zubkoff, M. (ed.) 1976 *Health: A Victim or Cause of Inflation?* New York: Milbank Memorial Fund by Prodist.

Appendices

Appendix A :

Media attention to medical fraud and overservicing –

25 press articles up to 1981

Peter Samuel, "The Big Medibank Muck-Up" *The Bulletin* 27 September 1975: 14-19

Stuart Simson, "Medibank Under the Microscope" *Australian Financial Review* 12 January 1976: 1

"AMA wants to end Medibank bulk-billing" *The Australian* 2 February 1976: 3

Philip Cornfield, "Medibank: Clamp-down on Cheats" *The Australian* 3 February 1976: 7

David Marr, "The Gold Fleece in the Bush" *The Bulletin* 20 February 1976: 21-22

"Minister Warns Doctors: Watch will be Kept on Claims" *Illawarra Mercury* 27 May 1976: 4

"Government Wants Check on Doctors' Work" *Sydney Morning Herald* 1 June 1976: 3

"Five Doctors facing Charges of Fraud" *Illawarra Mercury* 3 June 1976: 2

Martin Beesley, "Medibank White-anted" *The Australian* 17 December 1976: 5

David Broadbent, "Kickbacks fact of Life, says doctor" *The Age* 12 February 1977: 5

Ron Hicks, "Medical Racket Doctors Liable to 2 Years Jail" *The Australian* 12 February 1977: 3

Editorial "Pathological Profiteering" *The Age* 14 February 1977: 9

Janet Hawley, "How the Kick-back Racket Works – by a Pathologist" *The Australian* 17 February 1977: 1 & 2

"Medi 'could save \$30m: too many tests'" *The Age* 26 March 1977: 3

David Armstrong, "How to Stop Doctor Frauds" *The Bulletin* 9 July 1977: 44

Ron Hicks, "Doctor's Incomes Soar to \$70,000 a Year" *The Australian* 4 November 1977: 3

"Doctor Remanded as \$50,000 Medi Fraud Check Starts" *The Australian* 8 December 1977: 3

"Medibank Fraud \$1m fictitious family claim plan alleged" *Sydney Morning Herald* 17 December 1977: 4

Ron Hicks, "Do Australians Pay too Much for their medical care?" *The Australian* 30 December 1977: 9

Editorial "Prevention and Cure" *The Canberra Times*: 25 February 1978

Shane O'Connor, "Multi-Million \$ Fraud in Bulk Billing" *The Sunday Mail* 22 October 1978: 1

Simon Balderstone, '\$900,000 'rip-offs' recovered' *The Age* 6 October 1979: 1

John Jesser, "Doctors Criticize Claim Rejections", *The Canberra Times* 16 March 1980: 6.

David Hickie, Patients' Guide to Medical Rip-Offs" *The National Times*: 17-23 May 1981:

Robin Bromley, "Medical Scandal: Secret Report Exposes Doctors' Rip-Off" *The Bulletin* 11 August 1981: 22-23

Appendix B

Media attention on medical fraud – 1982

Jill Margo, 'Visiting doctor's warning' *Sydney Morning Herald* 2 February 1982: 9

'UK doctor warns locums of risks' *The Age* 2 February 1982: 5

'\$100m a year health fraud, says AMA' *The Advertiser* 4 February 1982: 1

Mark Metherell, 'Bulk-billing opened medical till to the unscrupulous' *The Age* 4 February 1982: 4

Michelle Grattan, 'Clamp on health: AMA says \$100m milked each year', *The Age* 4 February 1982: 1

'How some plunder the system' *The Age* 4 February 1982: 1

Deborah Snow, 'Canberra to bar payments to fraudulent doctors', *Australian Financial Review* 4 February 1982: 3

Jenni Hewett and Jill Margo, 'Government to crack down on cheating doctors' *Sydney Morning Herald* 4 February 1982: 3

Editorial, 'A bitter pill for the AMA' *Daily Telegraph* 4 February 1982: 10

Tom Isles, 'Health levy back in ALP plan' *The Canberra Times* 4 February 1982: 1

Norm Lipson and Jane Dargaville, '\$100 Million Medi Swindle: A little crook? So is one doctor in thirty' *Daily Telegraph* 4 February 1982: 1

'Medical fraud lower on Qld' *The Courier-Mail* 4 February 1982: 1

'AMA says 900 doctors cheat' *The Illawarra Mercury* 4 February 1982: 3

'Doctors bleeding public of \$100m a year – AMA' *The Hobart Mercury* 4 February 1982: 1

'Many doctors 'not aware' of overservicing' *The Advertiser* 5 February 1982: 6

Rod Wise, 'Back to Medibank is Labor health plan' *Australian Financial Review* 5 February 1982: 7

Editorial 'Health care and abuse' *The Canberra Times* 5 February 1982: 2

Commentary - Paul Kelly 'Bill Hayden the strong man just doesn't look like one' *Sydney Morning Herald* 5 February 1982: 7

Sue Cook, 'System tempts some doctors to cheat, says GPs' *The Australian* 5 February 1982: 3

Editorial 'The \$100 million Medifraud' *The Age* 5 February 1982: 13

Nine Letters to the Editor on medical fraud *The Age* 5 February 1982: 12

Editorial 'Our health rip-off' *The Hobart Mercury* 5 February 1982: 6

Stuart McLean, 'Labor frames health deal' *Daily Telegraph* 5 February 1982: 2

Stuart McLean, '\$100m is 'only the tip' of the medical fraud iceberg' *Daily Telegraph* 5 February 1982: 5

Mark Metherell, 'Medi fraud areas isolated' *The Age* 5 February 1982: 7

Deborah Snow, 'ALP plan brings medifraud claims' *Australian Financial Review* 5 February 1982: 7

Mark Metherell, 'Fee structure unfair, says doctor' *The Age* 6 February 1982: 3

Prudence Anderson, 'Here's how doctors are cheating' *The Sun-Herald* 7 February 1982: 3

'New medical-frauds action planned' *The Canberra Times* 7 February 1982: 1

'Crooked GP frauds brazen' *The Sunday Mail* 7 February 1982: 26

Editorial 'Carrots are better medicine than clubs' *Australian Financial Review* 8 February 1982: 10

'Frauds may top \$200m: document on doctors leaked' *The Advertiser* 8 February 1982: 3

Jenni Hewett, 'Fraud check urged on 2,500 doctors' *Sydney Morning Herald* 8 February 1982: 1 & 30

Editorial 'Fraud in the surgery' *Sydney Morning Herald* 8 February 1982: 6

Philip McIntosh, 'Health funds harassing patients: psychiatrist' *The Age* 8 February 1982: 5

Ian Davis, '2500 doctors cheated, says report' *The Age* 8 February 1982: 5

Fia Cumming, 'Leaked report tells of massive medical fraud' *Daily Telegraph* 8 February 1982: 2

'Doctor fraud: 2500 accused' *The Courier Mail* 8 February 1982: 1

Dr. R. P. Palmer, Letter to the Editor 'Medical fraud – the many absurdities' *The Courier-Mail* 8 February 1982: 4

'Doctor frauds worse than revealed by AMA chief' *The Hobart Mercury* 8 February 1982: 1

Doug Spencer interviews Dr. Neil Blewett re: 900 doctors involved in fraud ABC Radio AM, 8 February 1982

Richard Carlton 'Doctors' billing fraud alleged: The 'fraud and overpayment detection' method of investigation and difficulties of detection' Interview with Dr. Chris Selby Smith, Department of Health and Detective Ray Cooper, Australian Federal Police ABC-TV *Nationwide*, 8 February 1982

'Doctor frauds to surface – Blewett' *The Advertiser* 9 February 1982: 9

'Doctor tells just how the rip-off works' *The Courier-Mail* 9 February 1982: 1

Editorial 'The Ethics of Doctors' *The Courier-Mail* 9 February 1982: 4

'Labor pledge on medical rip-off' *The Courier-Mail* 9 February 1982: 9

Commentary - Claude Forell 'Malpractice needs a remedy', *The Age* 10 February 1982: 13

'NSW may start checks on doctors' *The Age* 10 February 1982: 16

'Only 51 convicted since 1975, says Newman' *The Australian* 10 February 1982: 1

Mike Steketee, 'Doctors face a check-up' *Sydney Morning Herald* 10 February 1982: 1

Wallace Brown 'Medifraud costing us \$100m year' *The Courier-Mail* 10 February 1982: 1

'Revelation on those cheating doctors' *The Mercury* 10 February 1982: 1

'Doctors to face fees scrutiny' *The Illawarra Mercury* 10 February 1982: 3

Prof. T. Brophy (Pres. Qld branch AMA), Letter to the Editor *The Courier-Mail* 11 February 1982: 4

Laura Veltman, 'Medibank is 'almost bankrupt' *Sydney Morning Herald* 12 February 1982: 9

Letter to the Editor 'Patients should pay direct' *Sydney Morning Herald* 11 February 1982: 6

Commentary - Ross Gittens 'A health system that spreads the doctors' disease' *Sydney Morning Herald* 11 February 1982: 7

'Doctor fraud "morally disgusting"' *The Mercury* 11 February 1982: 2

'State medical tribunal may be expanded' *Sydney Morning Herald* 12 February 1982: 9

'Victoria sets up doctor watchdog' *The Canberra Times* 15 February 1982: 3

Peter Arnold, Letter to the Editor 'Doctors face rebate muddle' *Sydney Morning Herald* 15 February 1982: 6

H. L. Soper, (NSW spokesman for the General Practitioners Society in Australia) Letter to the Editor 'Labor disaster' *Sydney Morning Herald* 15 February 1982: 6

Dr. B. Chan, Letter to the Editor, 'Doctors: Blame lies with the system' *The Courier-Mail* 15 February 1982: 4

Commentary - Maximillian Walsh, 'Rogue doctors hard to pin down' *The Bulletin* 16 February 1982: 26

'Delays on medifraud attacked' *Daily Telegraph* 17 February 1982: 14

Three Letters to the Editor 'Doctors in a corrupt society' *Sydney Morning Herald* 18 February 1982: 6

'Struck-off doctor appeals to the High Court' *Sydney Morning Herald* 18 February 1982: 9

Peter Grimshaw, 'Doctors' big surgery con exposed' *Daily Telegraph* 19 February 1982: 3

'Medifraud costing 'hundreds of millions tax' *Daily Telegraph* 23 February 1982: 5

Bob Chisholm, 'Doctors accused over waste' *Daily Telegraph* 23 February 1982: 3

Sue Cook, 'Medical fraud squad move: doctors, ALP wary of new government plan' *The Australian* 25 February 1982: 3

Ian Scott, Letter to the Editor 'Health system has many victims' *Sydney Morning Herald* 26 February 1982: 6

P. J. Gibney, Letter to the Editor, 'Medifraud solution' *The Bulletin* 2 March 1982: 12

Robin Bromley, 'AMA heads off criticism on private hospitals' *The Bulletin* 2 March 1982: 27

'New move to end medical fraud' *Sydney Morning Herald* 13 March 1982: 7

G. J. Hannigan, Letter to the Editor, 'The Feds move in', *The Bulletin* 16 March 1982: 17

'Doctor's fee for drug script \$200, court told' *Sydney Morning Herald* 23 March 1982: 3

Tom Ormonde, 'Tough new laws to fight medical fraud', *The Age* 23 March 1982: 4

Tony O'Leary, 'Medical rip-off: doctors to be named' *The Sun*, 23 March 1982: 7

Laura Veltman, 'Bid to toughen up on medi cheats' *The Australian* 25 March 1982: 1

Laura Veltman, 'Cheating doctors warned of tax check' *The Australian* 25 March 1982: 5

'Doctors face tougher penalties' *Sydney Morning Herald* 26 March 1982: 10

Deborah Snow, 'Hayden stresses medical frauds' *Australian Financial Review* 29 March 1982: 5

Laura Veltman and Sue Cook, 'Doctors 'ripped off \$300m': Hayden hits at failure to stop medical frauds' *The Australian* 29 March 1982: 3

'Confidentiality risk in medical fraud bill' *Sydney Morning Herald* 29 March 1982: 11

Michael Gordon, 'AMA urges caution on fraud laws', *The Age* 29 March 1982: 3

V. W. O'Keefe, 'Attacks on doctors', *The Bulletin* 30 March 1982: 17

Laura Veltman, 'Top level inquiry into medical fraud' *The Australian* 30 March 1982: 3

'Overservice by many doctors' – poll' *The Sun* 3 April 1982

Thee Letters to the Editor 'Doctors and overservicing' *Sydney Morning Herald* 10 April 1982: 12

'Health department files subpoenaed: fraud probe' *Australian Financial Review* 26 April 1982: 8

Tom Ormonde, 'Changes hit medi-fraud fight: PS man', *The Age* 2 July 1982: 3

'Department was naïve on medifraud, says MP', *The Age* 15 July 1982: 5

Karen Milliner, 'Fraud, overservicing blow to image of medical profession' *The Canberra Times* 21 July 1982: 13

Greg Turnbull 'Liberals ask doctors for cash to fight ALP 'threat', *Sydney Morning Herald* 24 July 1982: 3

'Lack of 'clear policy' in medifraud investigation', *The Canberra Times* 28 July 1982: 9

'How clever doctors fool the Health Department' *Sydney Morning Herald* 28 July 1982: 3

'Medi-fraud 'big fish' main target' *The Australian* 28 July 1982: 2

Paul Lynch, 'Doctors in 'substantial medi-frauds' *The Australian* 6 August 1982: 3

'Union health fund decision this week: Carlton' *The Age* 9 August 1982: 3

Mark Metherell, 'AMA chief: get rid of 'biased' MP', *The Age* 28 August 1982: 5

Christine Herd, 'AMA wants fraud probe MP sacked' *The Australian* 30 August 1982: 18

'Medibank wants summary proof for fraud penalty' *The Australian* 2 September 1982: 2

Sue Cook, 'Doctors 'denied legal protection' *The Australian* 3 September 1982: 2

'Failure to prosecute health fraud alleged' *The Canberra Times* 9 September 1982: 17

Michael Smith, 'Medifraud cover-up suspected' *The Age* 11 September 1982: 1

Michael Smith, 'Medifraud: a tale of political failure' *The Age* 13 September 1982: 1 & 3

Michelle Grattan, 'When a Minister takes the blame' *The Age* 13 September 1982: 13

Jenni Hewitt, 'Medifraud: Minister calls for quick report', *Sydney Morning Herald* 13 September 1982: 3

Peter Cave, 'Report on medifraud', AM ABC Radio, 13 September 1982

Tom Ormonde, 'Medifraud report to be speeded up', *The Age* 14 September 1982: 1

Commentary - Claude Forell, 'Time for medical reappraisal', *The Age* 15 September 1982: 15

'Health management criticised', *The Canberra Times* 15 September 1982: 10

Editorial 'Medifraud calls for wide review' *The Age* 16 September 1982: 13

Editorial 'Medical frauds' *Sydney Morning Herald* 17 September 1982: 6

Paul Kelly, 'Medifraud – the wait for 'hard evidence' *Sydney Morning Herald* 17 September 1982: 1

'Doctors accused of \$12m a month ripoff', *Daily Telegraph*, 17 September 1982: 4

Commentary - Paul Kelly, 'Medifraud set to take off where tax frauds left off', *Sydney Morning Herald* 17 September 1982: 7

'Medifraud task force planned' *Sydney Morning Herald* 18 September 1982: 3

Paul Molloy, 'Doctors lash out at 'medical vandalism'', *Sydney Morning Herald* 20 September 1982: 9

'AMA says minister a medical vandal' *The Canberra Times*, 20 September 1982: 3

Commentary – Michelle Grattan, 'Health Department tale of ineptness' *The Age* 20 September 1982: 9

B. W. Ross, Letter to the Editor 'When a cold is not a cold', *Sydney Morning Herald* 21 September 1982: 6

Editorial, 'Action on medifraud', *Sydney Morning Herald* 21 September 1982: 6

'Review of ALP procedure on medifraud sought', *The Canberra Times*, 22 September 1982: 12

Deborah Snow, 'AMA concedes fault in training of doctors', *Australian Financial Review* 22 September 1982: 2

Jenni Hewitt, 'AMA blames government for delay in medifraud action', *Sydney Morning Herald* 22 September 1982: 9

Pam Bornhorst, 'State to inquire into fraud by doctors', *The Australian* 23 September 1982: 3

'Carlton attacked on medical fraud', *The Australian* 24 September 1982: 4

'Belated response on medifraud' *The Canberra Times*, 24 September 1982: 10

Letter to the Editor, Jim Carlton, Federal Minister for Health, 'Give doctors a fair go' *Sydney Morning Herald* 24 September 1982: 6

Letter to the Editor, Jodhi Menon NSW spokesman GPSA, *Sydney Morning Herald* 24 September 1982: 6

Letter to the Editor 'A 'Hello' cost patient \$30' *Sydney Morning Herald* 1 October 1982: 7

Letter to the Editor Jodhi Menon 'Doctor's reputation should be vindicated' *Sydney Morning Herald* 2 October 1982: 12

'How honest are we?' *Sun-Herald* 3 October 1982: 4, 5 & 6

Richard Guilliatt, 'New auditing techniques keep watch on doctors' *The Age* 4 October 1982: 3

Philip McIntosh, 'Specialist attacks medifraud checks' *The Age* 5 October 1982: 4

'Doctor gets jail for fraud' *The Age* 5 October 1982: 4

Laura Veltman, 'Doctors' group slams 'crooks' *The Australian* 7 October 1982: 2

Laura Veltman, 'Optometrists' fees up soon' *The Australian* 7 October 1982: 2

Stephen Mills, 'Federal police short, so theft inquiries are curbed' *The Age* 13 October 1982: 4

'AFP 'hampered' in medifraud hunt' *The Canberra Times* 13 October 1982: 3

Commentary - Jenni Hewett, 'Medifraud: the \$100m coincidence' *Sydney Morning Herald* 13 October 1982: 7

'Husband, wife on charges of medifraud' *The Age* 14 October 1982: 10

Paul Molloy, 'Doctors need a strong disciplinary body, GPs told' *Sydney Morning Herald* 19 October 1982: 14

Ian Davis, 'MPs denied documents on medifraud' *The Age* 20 October 1982: 4

Deborah Snow, 'Medifraud inquiry baulked by privilege claim' *Australian Financial Review* 20 October 1982: 5

Jenni Hewett, 'Minister defies MPs' order for documents' *Sydney Morning Herald* 20 October 1982: 3

'Medifraud committee is refused documents' *The Canberra Times* 20 October 1982: 1

'Challenge to medifraud privilege bid' *The Age* 21 October 1982: 5

'Row over medical inquiry papers' *The Australian* 21 October 1982: 4

Deborah Snow, 'Medifraud probe challenge on disputed files' *Australian Financial Review* 21 October 1982: 4

Jenni Hewett, 'Privilege won't bar accounts committee' *Sydney Morning Herald* 21 October 1982: 12

Helen O'Neil interviews David Connolly regarding the refusal to grant access to the parliamentary committee on health department files on medical fraud. AM ABC Radio 21 October 1982

Ellen Peterson, 'Medifraud' papers to be released' *The Australian* 22 October 1982: 4

Linda Adamson, Australian Council of Social Service, Letter to the Editor, 'Medical bulk-billing the best system' *Sydney Morning Herald* 22 October 1982: 6

Ian Davis, 'Canberra frees medi documents' *The Age* 22 October 1982: 1

Ian Davis 'MPs find medical frauds not investigated' *The Age* 27 October 1982: 3

'Howells knows of 'no crime' in Department of Health' *The Canberra Times* 27 October 1982: 14

'No criminality in Health Department' *The Australian* 27 October 1982: 4

Deborah Snow, 'Staff shortage claim in medical fraud inquiry' *Australian Financial Review* 27 October 1982: 4

Helen O'Neil reports on the final stage of a report into medical fraud AM ABC Radio 27 October 1982

'Medifraud facts 'withheld' *The Canberra Times* 28 October 1982: 1

'Task force 'option' for medifraud *The Canberra Times* 28 October 1982: 9

'Fraud doctor readmitted' *The Australian* 28 October 1982: 2

'Medifraud facts cut from report, says Health officer' *Sydney Morning Herald* 28 October 1982: 1

Ian Davis and Michael Gordon, 'Medi inquiry told of PS corruption' *The Age* 28 October 1982: 1

'Medifraud facts 'withheld' *The Canberra Times* 28 October 1982: 1

'Medifraud probe hears new corruption charge' *Australian Financial Review* 29 October 1982: 16

Ellen Peterson, 'Medifraud trap closes' *The Australian* 2 November 1982: 1

'Crooked doctors' cash flow cut off' *The Daily Telegraph* 2 November 1982: 3

Philip McIntosh, 'Doctors band together to foil patients' claims: Opit' *The Age* 3 November 1982: 18

Tom Ormonde, 'Hunt puts blame on others for medifraud inaction' *The Age* 11 November 1982: 1 & 17

Tom Ormonde, 'Canberra not soft on medifraud: MacKellar' *The Age* 12 November 1982: 5

Tom Ormonde, 'Health official defends deletions' *The Age* 12 November 1982: 5

'MacKellar 'hit medifraud hard' *The Australian* 12 November 1982: 2

Deborah Snow, 'MacKellar quizzed on depth of Medifraud briefings' *Australian Financial Review* 12 November 1982:

Deborah Snow, 'Hunt denies inaction at medifraud inquiry' *Australian Financial Review* 12 November 1982: 26

'Medifraud details kept from Minister' *Sydney Morning Herald* 12 November 1982: 12

'Medifraud report cuts defended' *The Advertiser* 12 November 1982: 6

Tom Ormonde, 'Health chief may quit early' *The Age* 15 November 1982: 3

Deborah Snow, 'Room at the top in Health Department with retirements' *Australian Financial Review* 16 November 1982: 3

'Director-General of Health to step down' *The Advertiser* 16 November 1982: 12

Tom Ormonde, 'Flying squad' may police medifraud' *The Age* 17 November 1982: 1 & 6

Tom Ormonde, 'New health head is named: first non-doctor' *The Age* 24 November 1982: 5

Greg Turnbull, 'Health gets a new head' *Sydney Morning Herald* 24 November 1982: 10

Jack Waterford, 'Willett to succeed Howells as Health Director-General' *The Canberra Times* 24 November 1982: 31

Helen O'Neil reports on response of the parliamentary committee on medical fraud AM ABC Radio 10 December 1982

Kerrie Weil speaks to Hal Soper of the General Practitioners' Society about medical fraud *AM ABC Radio* 10 December 1982

Ellen Peterson, 'Police to probe doctor 'cover-up' *The Australian* 10 December 1982: 3

Tom Ormonde, 'Medifraud Rap For PS' *The Age* 10 December 1982: 1

Tom Ormonde, 'Health rip-offs: a case of collective failure' *The Age* 10 December 1982: 10

Ian Davis, 'Attack not fair: Minister' *The Age* 10 December 1982: 10

'Ingenious abuses of system' *The Age* 10 December 1982: 10

Deborah Snow, 'Medifraud: Grave charges against Health Department' *Australian Financial Review* 10 December 1982: 1 & 8

'Medifrauds crunch urged' *The Illawarra Mercury* 10 December 1982: 3

'Doctor suspended' *The Illawarra Mercury* 10 December 1982: 3

'Blitz on medifraud urged' *The Advertiser* 10 December 1982: 3

Jenni Hewett, 'Health chief hits back on medifraud' *Sydney Morning Herald* 11 December 1982: 5

'Doctor flew to NZ under false name – police: Port GP denies medifraud' *The Illawarra Mercury* 10 December 1982: 1

'Doctors criticise inquiry findings' *The Illawarra Mercury* 11 December 1982: 6

Jenni Hewett, 'Challenge to AMA's role in discipline of doctors' *Sydney Morning Herald* 14 December 1982: 3