SPECIAL REPORT

BILLIONS DOWN THE DRAIN

MEDICARE FRAUD AND NON-COMPLIANCE AND ITS IMPACT ON AUSTRALIA'S HEALTHCARE SYSTEM

CONTENTS

Prepared by the Health Services Union

"From an outsider's perspective, Medicare does not appear to be committed to meeting its obligations to its key stakeholders: the government, health funds, clinicians or patients. Its compliance processes do not meet industry standards in data monitoring and audit"

- Dr Jonathon Ryan, 2024[11]

1. EXECUTIVE SUMMARY

Apathy is Costing Taxpayers Billions:
Medicare fraud and non-compliance costs Australia an estimated $1.5 billion to $10 billion annually due to systemic failures. Money that should be strengthening the public healthcare system for all Australians.

Fraudulent and Non-Compliant Practices Enabled by Weak Oversight:
Weak oversight, structural loopholes and a lack of accountability in billing practices allow fraudulent and non-compliant claims to go undetected. Widespread abuse of public funding is further enabled by outdated, reactive fraud detection methods and a heavy reliance on tip-offs instead of proactive audits.

Neglect and Complacency:
Unlike many international counterparts, Australia has failed to make a serious investment in a robust system to detect and combat Medicare fraud and non-compliance. While the US and UK have dedicated healthcare fraud units, Australia's approach remains outdated and ineffective. Australia's Medicare's detection system has not kept pace with a changing technological landscape, compared to other sectors like financial institutions and tax authorities, which use real-time, proactive, AI-driven monitoring.

Reform Undermined by Self-Serving Organisations:
The AMA's response to Medicare fraud and non-compliance is characterised by deflection, weak evidence, and resistance to oversight, putting financial interests and control ahead of meaningful systemic reform.

An Entrenched Culture of Maximising Profit From Medicare Billing:
One in two surveyed healthcare workers report pressure to maximise profit from Medicare billing, while 93% believe current fraud and non-compliance prevention measures are failing. Practices such as upcoding, overservicing, and rule-bending are widespread, especially in medical imaging and pathology.

Silenced by Fear:
More than 93% of healthcare workers are afraid to report Medicare billing fraud and non-compliance in their workplace due to fears of retaliation. This culture of fear discourages reporting, allowing fraudulent and non-compliant practices and regulatory violations to persist unchecked.

A Call for Immediate Action:
Without stronger enforcement, Ai-driven fraud and non-compliance detection, and a move away from self-regulation and fee-for-service models, Medicare remains vulnerable to exploitation, putting the very integrity of Australia's healthcare system in jeopardy.

Medicare fraud and non-compliance is costing Australian taxpayers between **$1.5 billion and $10 billion annually.**

2. INTRODUCTION

Medicare Billing Fraud and Non-Compliance
In the 2023-24 financial year, the Australian Government allocated $29.8 billion to medical benefits.[1]* Yet, a significant portion of this Medicare Benefit Schedule (MBS) billing, amounting to billions of dollars every year, is lost to fraudulent and non-compliant billing; a systemic failure that has persisted despite repeated inquiries and independent reviews.

Multiple reviews of Medicare have highlighted the extent to which current systems of monitoring, detection and oversight – governed by legislative frameworks – are woefully inadequate. Without significant reform, these vulnerabilities leave the system open to substantial levels of fraud and misuse.

Within this report, we summarise the findings from various investigations conducted since 2012, critically examining the effectiveness of measures implemented to address these issues. We also identify actions required to safeguard the future integrity of the Medicare system. Importantly, the report highlights how certain organisations, driven by relentless self-interest, have attempted to obscure the commentary surrounding Medicare related fraud and non-compliance by propagating misinformation designed to create uncertainty and inaction.

This report is published as a final response to the Special Commission of Inquiry into Healthcare Funding in NSW. Any examination of the sustainability of healthcare in Australia must confront the billions of dollars lost to Medicare-related fraud and non-compliance. Moreover, we hope this report sparks discussion and drives genuine inquiry and reform at the Commonwealth level.

Members of the Health Services Union (HSU), who are deeply embedded in the healthcare system, offer unique insights into the prevalence of Medicare fraud and non-compliance. Their insights expose not only the mechanisms behind fraud and non-compliance but also the systemic deficiencies that allow them to persist undetected. To be clear, this report does not argue that most medical practitioners engage in fraudulent billing - far from it. Every day, our members work alongside ethical, community-minded, and hardworking medical practitioners who are vital to the health and well-being of our society. However, Medicare's governance and accountability structures must be strengthened – and those who seek to maintain the status quo must be challenged. The sustainability and integrity of our Medicare system depend on it.

Real-Time Fraud and Non-Compliance Loss Tracker:

- Annual Loss: **$1.5 billion to $3 billion**
- Daily Loss: **$4.1 million to $8.2 million**
- Monthly Loss: **$125 million to $250 million**
- Hourly Loss: **$171,000 to $342,000**
- Weekly Loss: **$28.8 million to $57.6 million**
- Per Minute: **$2,850 to $5,700**

**Total amount based on medical benefits allocation, and does not include allocations for private health insurance, Child Dental Benefits Schedule and Pharmaceutical benefits and services*

Fraud and Non-Compliance: A Distinction Without a Difference?

The legal and regulatory discourse surrounding fraud and non-compliance is riddled with ambiguity; perhaps deliberately so. Intent is commonly used to draw a distinction between fraud and non-compliance. But this distinction is neither legally nor conceptually watertight.

The Commonwealth defines fraud as "dishonestly obtaining a benefit, or causing a loss, by deception or other means." [2] This implies an element of intent. In contrast, non-compliance is typically understood as a failure to meet regulatory obligations, often without intent. [3] However, intent is not always a necessary component of fraudulent conduct. Legal frameworks, including the Commonwealth Criminal Code, recognise that a person can be criminally responsible for an offence even if they are mistaken about, or ignorant of, the existence or content of an Act that directly or indirectly creates the offence. [i] [4]

A central question emerges: when does gross non-compliance cross into fraud? If fraud involves improperly obtaining financial benefits, and non-compliance results in the same outcome, the legal distinction between the two may collapse. A failure to comply with Medicare billing laws, whether due to deliberate deception, wilful blindness, or reckless disregard, results in public money being wrongfully acquired. In that sense, non-compliance may not simply lead to fraud; it may be fraud. Medical practitioners and healthcare providers have an ethical and legal duty to act in the best interests of their patients – not only in medical care but also in their stewardship of publicly funded resources.

Historically, the language of non-compliance has created a grey zone, allowing improper claims to be treated as regulatory infractions rather than criminal conduct. But if the result is the same, public funds lost, misused, or wrongly claimed, then the distinction between fraud and non-compliance is more about rhetoric than reality. This report argues that it is time to strip away the definitional smokescreen: wrongful acquisition of public money is, in effect, defrauding the public. The law may already recognise this reality. Policy must now follow.

[i] The Criminal Code outlines different types of fraudulent conduct, reinforcing the notion that serious non-compliance can, in some cases, be considered as fraud. Section 134.2(1) criminalises obtaining a financial advantage through deception, while Section 135.1(1) addresses dishonesty in gaining a benefit. Further, Sections 135.1(3) and 135.1(5) extend liability to dishonesty that causes a loss, whether to an individual or an entity.

GLOSSARY

AFP	Australian Federal Police
AI	Artificial Intelligence
AMA	Australian Medical Association
ATO	Australian Taxation Office
CMS	Centers for Medicare and Medicaid Services
DoHAC	Department of Health and Aged Care
FBI	Federal Bureau of Investigations
GP	General Practitioner Specialist
HSU	Health Services Union
MBS	Medicare Benefit Schedule
NDIS	National Disability Insurance Scheme
NHS	National Health Service
NSHFCA	NHS Counter Fraud Authority
Phillip Review	Independent Review of Medicare Integrity and Compliance (2023) – Dr Pradeep Philip
PSR	Professional Services Review
RACGP	Royal Australian College of General Practitioners

3. INCIDENCE AND SCALE OF MEDICARE BILLING FRAUD AND NON-COMPLIANCE

The True Cost of Medicare Fraud and Non-Compliance: A System Open to Exploitation

"From the beginning, there were inadequate safeguards in a scheme based on the honour system. In no other area of public expenditure where recipients have significant control has so little attention been paid to audit." – Dr Andrew Webber, 2012 [5]

More than a decade after this warning about Medicare's vulnerabilities, Australia's universal healthcare system remains alarmingly exposed to fraud and non-compliance. Weak oversight, outdated auditing methods, and a prevailing reliance on an honour-based system have created a multi-billion-dollar problem, one that continues to drain public healthcare funding with little transparency or accountability.

In 2012, Dr Webber, then Director of the Professional Services Review (PSR) [ii], warned that Medicare's billing system and structure made it particularly susceptible to abuse. He pointed to a system where billing operates largely on trust, allowing providers to self-manage with minimal scrutiny. Crucially, he noted that some medical businesses measure success by the volume of claims rather than the quality of care - an incentive structure that directly fuels exploitation. As Dr Webber has noted, too many *"unscrupulous"* practitioners have turned certain MBS codes into a financial *"bonanza"* - with corporate owners setting quotas for claims *"irrespective of clinical need."* [5]

Fast forward to today, and those same warnings remain equally relevant and have only intensified. Based on 2022-2023 data, estimates quantify that Medicare fraud and non-compliance cost Australian taxpayers between $1.5 billion and $10 billion annually - an undeniably alarming figure. A 2023 independent review commissioned by Federal Health Minister, the Hon. Mark Butler, and undertaken by Dr Pradeep Philip, Head of Deloitte Access Economics Australia, reinforced Dr Webber's concerns, revealing that weak governance, ineffective legislation, and outdated audit processes continue to allow fraud and non-compliance to thrive. [3]

To put Australia's problem in perspective, the UK's National Health Service (NHS) estimates annual fraud losses of approximately £1.3 billion ($2.6 billion AUD), despite having stricter compliance measures in place. [6] In the United States, fraud in Medicare and Medicaid is aggressively pursued, with authorities recovering billions each year through whistleblower actions and federal investigations. [7] Unlike Australia, both nations acknowledge the issue and invest heavily in detection, a point we will examine in a succeeding chapter of this report.

A critical failing in Australia is the persistent refusal to quantify the full scale of the problem. The debated $10 billion estimate has not and cannot be definitively disproven, because there is no effective system to measure fraud and non-compliant billing in the first place. [3] Dr Philip confirms *"there is real potential for the problem to scale to the order of magnitude in Dr Faux' analysis* [$10 billion] *should effective controls, systems and education not be put in place".*[3] Based on analysis of the available independent data, a clear consensus has emerged - billions of taxpayer dollars are being siphoned from Medicare, undermining healthcare access and robbing patients of essential services. [8] [5] [9] [10]Without urgent reforms, Australia's Medicare system will remain a soft target for exploitation; one where the true cost of fraud and non-compliance is likely far worse than we know.

[ii] The Professional Services Review (PSR) is peer-review led panel responsible for investigating suspected cases of inappropriate practice and enforcing sanctions, based on referrals from delegates of the Chief Executive Medicare.

Medicare Fraud estimates range from $1.5 billion to $10 billion and expected to rise to $1.9 billion - $11.1 billion if left unchecked

Source	Estimate equivalent rate of Fraud/non-compliance	MBS non-compliance implication	
		2023/24 FY	2026/27 FY
What is wrong with Medicare? (Webber, 2012)	8 -12%	$2.4 – $3.6 billion	$3.0 - $4.5 billion
Independent Review of Medicare Integrity and Compliance (Philip, 2023)	5% - 10%	$1.5 – $3.0 billion	$1.9 - $3.7 billion
(McKinsey as quoted by the Australian National Audit Office, 2020)	6%	$1.8 billion	$2.2 billion
(Faux as quoted by Philip, 2023)	30%	$10.0 billion	$11.1 billion
(Flynn as quoted by Faux, 2021)	10% - 25%	$3.0 - $7.5 billion	$3.7 - $9.3 billion

A typical GP will use only a fraction of the 6,000 available billing codes, relevant to their own specialties. Publicly available standard GP MBS reference sheet would include the following: [23]

PROCEDURES AND CONSULTATIONS	ITEM NUMBER
Routine Hours Consultation	
- In the Surgery	3, 23, 36, 44, 123
- Aged Care Facility	90001, 90020, 90035, 90043, 90051, 90054
- Home/Hospital	4, 24, 37, 47, 124
After Hours Consultations	
- In the Surgery	5000, 5020, 5040, 5060, 5071
- Aged Care Facility	5010, 5028, 5049, 5067, 5077
- Home/Hospital	5003, 5023, 5043, 5063, 5076
- Urgent	585, 599
Health Assessments	699, 701, 703, 705, 707, 715
Chronic Disease/Complex Care	721, 723, 732, 70997, 70987, 139, 729, 731, 900, 903
Women's Health	73806, 16500, 16591, 16407, 14206, 30062, 35503
Mental Health	2700, 2701, 2715, 2717, 2712, 2713, 90250 – 90253, 90264, 930, 933, 935, 937, 943, 945
Diagnostic Procedures	11505, 11506, 11707, 11607, 73812, 73826
Minor Procedures	30071, 30072, 30192, 30196, 30202, 30064, 30061, 30216, 30219, 41500, 30026, 30032, 30029, 30035, 47904, 47915, 47916, 32147, 32072, 30003

4. HOW AND WHY FRAUD AND NON-COMPLIANCE HAPPENS

Why Fraud and Non-Compliance Happens - A System Ripe for Exploitation

"From an outsider's perspective, Medicare does not appear to be committed to meeting its obligations to its key stakeholders: the government, health funds, clinicians or patients. Its compliance processes do not meet industry standards in data monitoring and audit" - Dr Ryan, 2024 [11]

Medicare fraud and non-compliance occur not due to complexity but because of weak oversight, structural loopholes, and a lack of accountability. Some argue that fraud and non-compliance are inevitable in a system with nearly 6,000 billable items, but, in general, medical practitioners only need to master a small fraction relevant to their specialty. [3] [8] [12] Ample resources from MBS FAQs, Services Australia guidelines, and Department of Health and Aged Care (DoHAC) directives, offer clear billing instructions. [13] [14] [15] It is clear the issue isn't complexity, but a reluctance to manage administrative tasks, which are often seen as an imposition or 'burden.' [12] A recent Royal Australian College of General Practitioners (RACGP) survey found 'administrative burden' to be a leading complaint and frustration of General Practice Specialists (GPs) - we argue that's just part of the profession. [16]

A litany of public interest journalism and investigative reports suggests more sinister motives are behind widespread and opportunistic Medicare fraud and non-compliance. Too many practitioners treat Medicare as an unlimited funding source, structuring their operations around maximising claims rather than responsible spending of public funds or optimising patient care. [17] [18] [19] [20] [21] The multi-billion-dollar chronic pain industry is dubbed a 'cash cow', lining the pockets of medical practitioners engaging in over-treatment and questionable billing. [17] Dr Ryan, a cardiothoracic surgeon, described how conspiring medical practitioners, at a medical conference in 2015, enthusiastically proclaimed '*I have a present for you ..... 45503*' – referring to a misused Medicare billing item that nearly doubled rebates for a routine heart procedure amongst the profession. Ryan goes on to criticise his colleagues, stating, *"there are clinicians who claim more than they are entitled to because they believe the MBS undervalues the work that they do"*. [11]

Dr Webber also presents a salient point that with the growing commercialisation of healthcare - profit drives healthcare, and inefficiency and exploitation more easily follows. [5] A Medical Journal of Australia report renews warnings that rising private equity investment in Australian healthcare is likely to drive up costs and lower care quality, mirroring US trends. Between 2017 and 2022, venture capital firms acquired 256 GP practices across Australia, a process that is rapidly accelerating and threatening the centrality of universality. [22]

Private equity investments in Australian healthcare have been accelerating in recent years

Individual acquisitions 2017 - 2022 [22]

How Fraud and Non-Compliance Happens – Self Regulation Lends Itself to Exploitation

Weak oversight and automated billing make fraudulent and non-compliant claims easy to submit with negligible risk of detection. For example, in instances of bulk-billing, when a patient receives a medical service, a billing code is selected and submitted to Medicare, and the medical practitioner or service claims the patient's rebate. The patient, the legal beneficiary, has no authority to verify the codes used. In general, the patient receives limited or no explanation of what was billed, whether extra services were added, or if the consultation length reported was accurate. Even if they check their claims history, vague descriptions offer little clarity, and there is no scrutiny before payments are made. Lacking patient oversight, fraudulent and non-compliant claims remain unchecked. Previously, patients submitted their own Medicare claims, creating a layer of accountability. A 1999 medical report forewarned that full automation without oversight posed a fraud risk, yet the warning was never heeded. [24]

Analysis conducted by the HSU of Australia's PSR case outcomes and case notes exposes major flaws in Medicare billing, including medical practitioners charging for services never provided. GP Management Plans and Team Care Arrangements are especially prone to misuse, with some items claimed without genuine clinical input or chronic disease management for patients who do not have a chronic illness. Upcoding is a common fraud tactic, with medical practitioners inflating consultation times to increase reimbursements. Other concerning patterns show financially driven clinical decisions, including splitting procedures across multiple days to maximise claims and performing unnecessary procedures solely to increase Medicare reimbursements per patient. [25]

Without real-time and whole-of-system monitoring, fraud and non-compliance flourish in Medicare. As most Australians remain unaware of what's billed in their name, the system remains acutely susceptible to abuse and exploitation. The Philip Review found Medicare's billing design, combined with weak oversight, made it unfit for purpose and enabled fraud and non-compliance to persevere. He noted that past reforms, including the MBS Continuous Review[iii] and the evolution of payment systems[iv], had only increased complexity without strengthening integrity. His conclusion was blunt: nothing short of a system-wide overhaul will protect Medicare from exploitation, and notably, that *"there must also be a commitment by all stakeholders to change".*[3]

HSU's analysis of Australia's PSR case outcomes show [56]:

65% of PSR case outcomes in 2024 involved instances of **upcoding, while 38%** involved incorrect use of **GP management plan and/or team care arrangement** item numbers

[iii] MBS continuous review is an ongoing review of Medicare items by relevant stakeholders, implementing changes to items including deletion, combination and amendments to descriptors.
[iv] Digital and manual claiming channels have evolved to 14 individual channels, created for specific care settings.

5. WEAKNESS OF OVERSIGHT

Flawed Oversight – A System Built to Miss Fraud and Non-Compliance

The PSR is responsible for safeguarding Medicare but struggles with limited human and technological resources, restricted investigative power, and competing priorities. At the same time, the DoHAC maintains that it combats fraud and non-compliance through data matching and audits, identifying unusual billing patterns and automatically referring 80/20 rule[v] breaches to the PSR. [26] However, by any best-practice compliance and detection standard, both processes are deeply flawed. The risk detection is weak and ineffective, and fraud and non-compliant behaviour are entrenched in certain specialties. Further, only a small fraction of Medicare payments are reviewed, and just 10% of flagged cases face any form of investigation. [57] Astonishingly, 40% of PSR cases stem from tip-offs rather than proactive audits, a damning indictment of the inadequacy of the current audit process. [27]

To a significant extent, the automated billing system places the burden of fraud and non-compliance detection on patients, requiring them to proactively check their MyGov accounts - an arduous and convoluted task that many will not perform, nor should it be their responsibility. Meanwhile, peer oversight is virtually non-existent, as medical colleagues have no or very little visibility into each other's billing practices nor a need to police their peers' billing practices. The PSR primarily investigates statistical outliers, yet some fraudulent and non-compliant billing patterns are so widespread that they slip through undetected – they have become normalised and accepted. [11] It is concerning how easily such manipulation goes unchecked as *"permissive cultural attitudes facilitate the spread of non-compliant Medicare billing practices within craft groups".* [11]

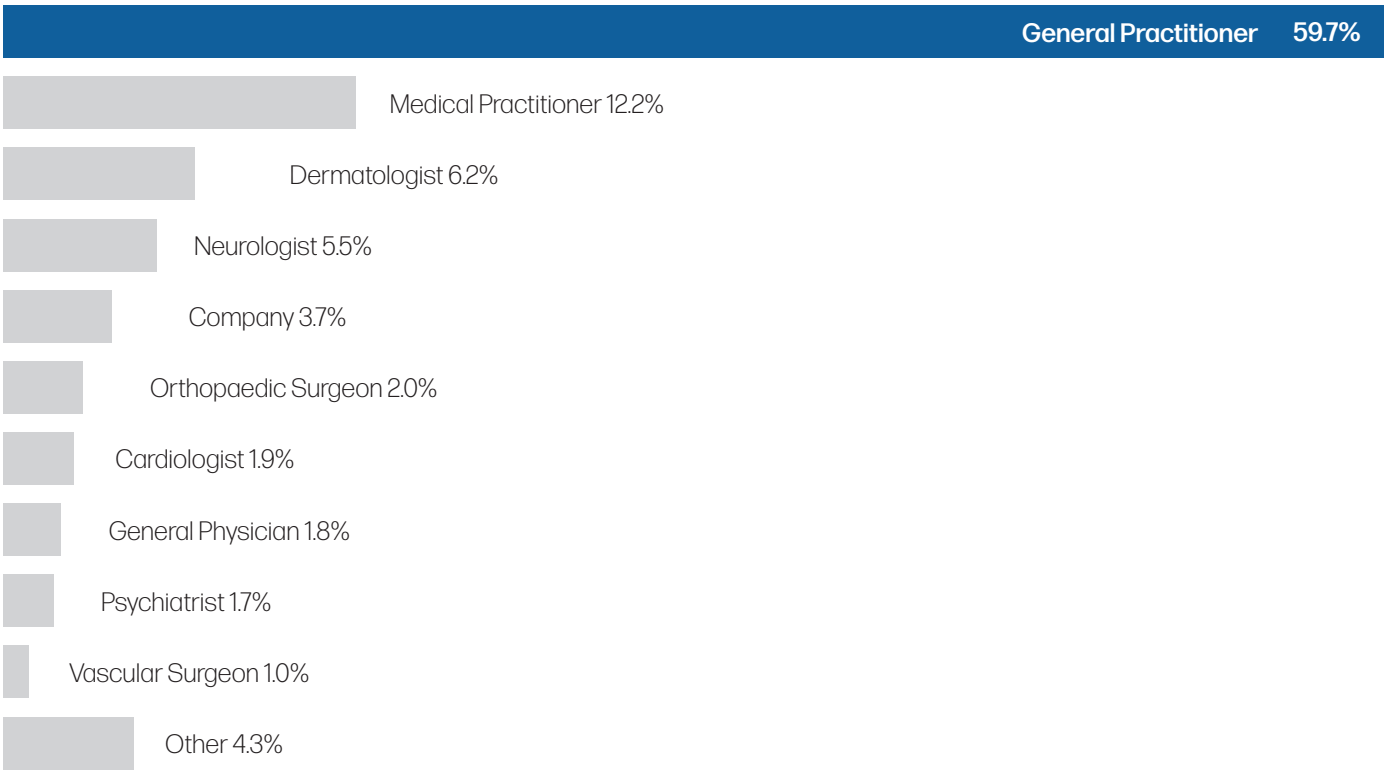
The PSR: Outdated, Ineffective, and Unfit for Purpose

GPs are disproportionately referred to the PSR for investigation, despite their comparative Medicare expenditure. The 80/20 rule, designed to flag high patient volumes, is enforced more stringently on GPs than on specialists. [8] [25] This is particularly concerning given that non-GP attendances account for nearly 70% of all MBS claims, yet do not face the same level of scrutiny. This discrepancy suggests that the PSR either assumes non-GP billers are less likely to engage in fraudulent or non-compliant billing, or, as our internal analysis confirms, it simply does not investigate them adequately. [28]

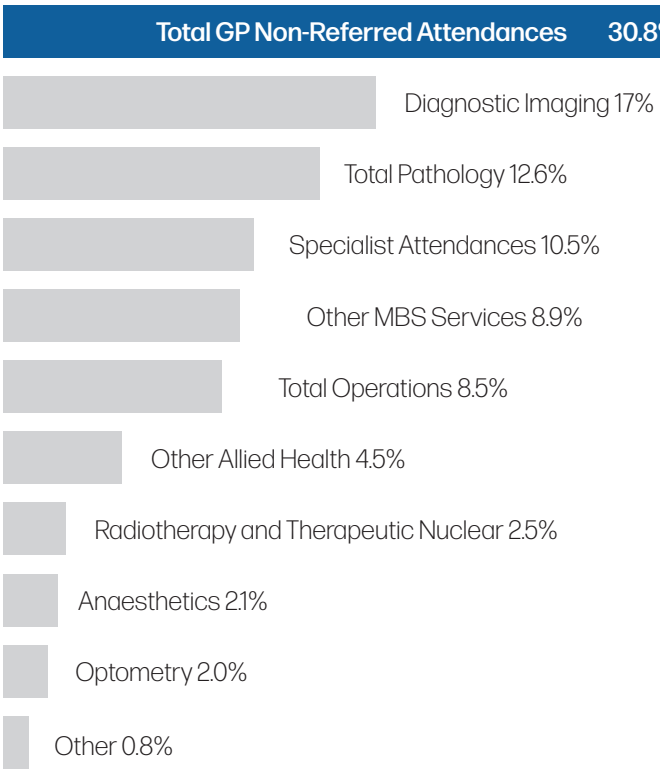
[v] *The 80/20 rule is a prescribing pattern of service in which a practitioner cannot render 80 or more services per day in any 20 days within a 12-month period.*

GPs are overrepresented in PSR investigations relative to Medicare expenditure

Percentage of MBS repayments from PSR investigations by profession (2024) [56]



Percentage of MBS expenditure by professional groups (2024) [29]



A 2020 report from the Australian National Audit Office (ANAO) found that Medicare's non-compliance detection systems lacked the technological sophistication of other regulatory bodies, finding that the DoHAC approach to health provider compliance was only "partially effective." [10] The absence of real-time oversight leaves the system vulnerable to exploitation, allowing billions in questionable claims to flow unchecked. AI tools could identify unusual billing combinations, flag emerging fraud tactics, and block claims outside a provider's scope - capabilities that are now standard in financial and tax regulation but conspicuously absent in Medicare oversight. [30] [31] [32]

Medicare's oversight mechanisms remain outdated, failing to curb fraudulent and non-compliant billing entrenched in certain specialties. The reliance on statistical outliers and tip-offs is insufficient. Effective risk detection must go beyond superficial anomalies to identify broader patterns of systemic misuse. Despite billions flowing through Medicare annually, it lacks real-time monitoring.

In contrast, banks, insurers, and tax authorities employ sophisticated AI-driven fraud detection systems to monitor irregularities in real time. Financial institutions utilise machine learning to analyse spending behaviours, detect anomalies, and flag suspicious transactions instantly. For example, the biggest bank in the United States, JPMorgan Chase, has integrated AI extensively across its transaction and detection operations, enhancing productivity and efficiency.[33] Similarly, the Australian Taxation Office (ATO) has a number of AI-driven fraud detection systems to combat $2.5 billion in fraudulent claims, $45 billion in unpaid taxes, and millions in unpaid superannuation. [34] [35] Meanwhile, DoHAC persists with rudimentary analytics, relying on outdated statistical models rather than modern fraud detection methodologies. Medicare compliance oversight, in its current form, is not just outdated but ineffective.

If fraud detection in banking, insurance, and taxation operated on the same lagging principles, the financial system would be in chaos.

Response to Review: Inaction, Evasion, and the Illusion of Reform

A 2020–21 audit found DoHAC lacked a risk-based approach, prompting a revised compliance model to improve oversight. [10] [3] Medicare billing fraud and non-compliance gained greater attention in 2022 after Dr Margaret Faux's thesis became widely discussed in policy circles, leading to the DoHAC commissioned Philip review. [3][8]

A separate 2022 review of Section 92 of the *Health Insurance Act 1973* saw the Australian Medical Association (AMA) attempt to retain influence over PSR appointments, including the PSR Director, but it was ultimately unsuccessful. [27] The Philip Review led to legislative reforms under the Health Insurance Amendment Bill 2023 (Professional Services Review Scheme), removing the AMA's veto power, adding two Associate Directors, and expanding proactive education initiatives. [42] [43]

The 2023–24 Federal Budget allocated $29.8 million to implement the Philip Review's recommendations, with another $18.1 million committed in 2024–25. [10] However, key vulnerabilities remain unaddressed, including governance, legislation, and real-time monitoring of Medicare claims. While the AMA's latest attempt to control the PSR failed, the amendments have produced no discernible impact on fraud and non-compliance levels. This raises the question of whether the government's soft approach was a calculated effort to placate the AMA while sidestepping substantive reform, effectively kicking the issue down the road. Meanwhile, another audit by the Australian National Audit Office is being considered, at the time of this publication, to assess the government's response; whether this leads to real reform or yet another cycle of delay remains to be seen. [58]

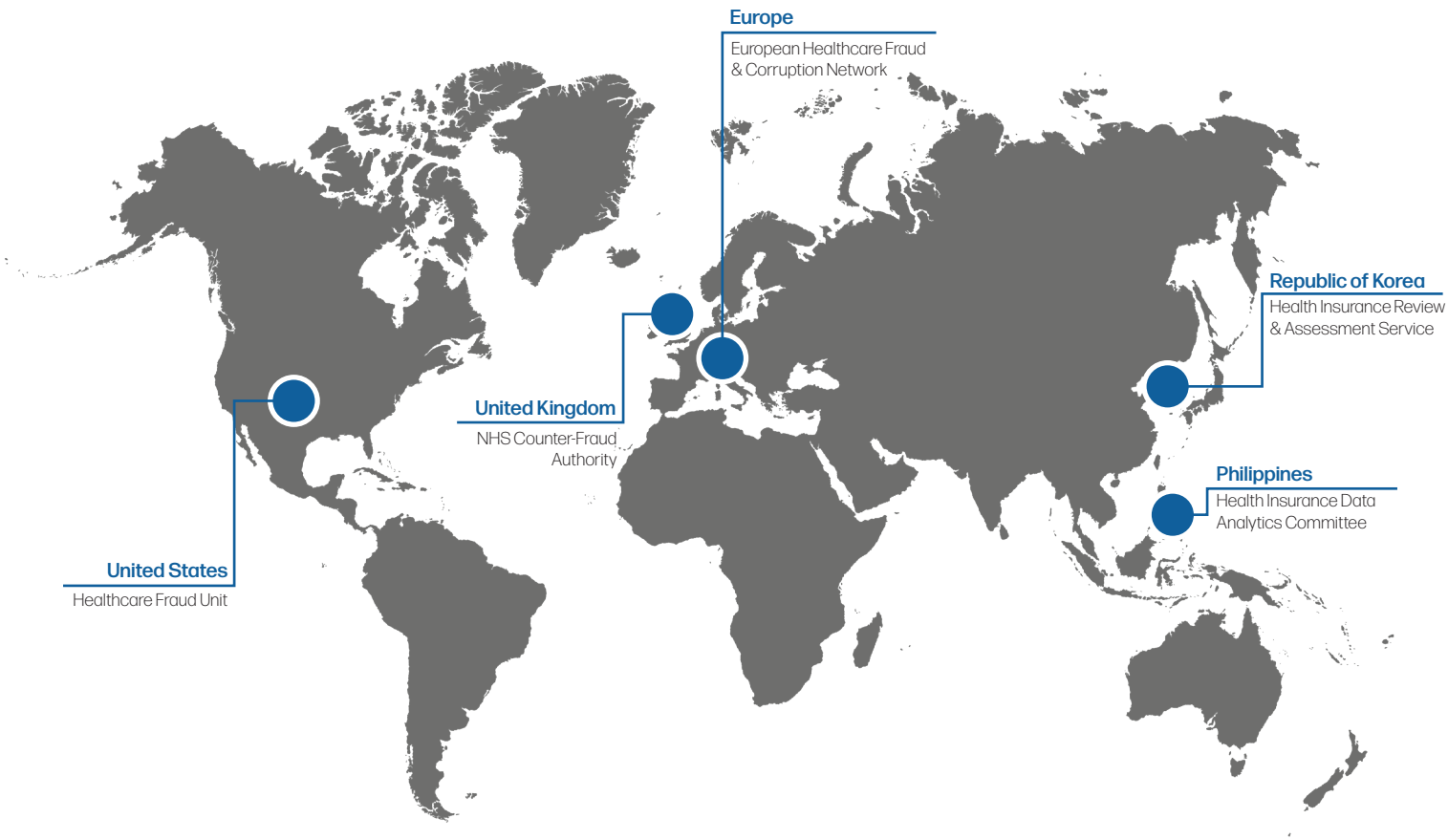
How Do We Compare?

The Federal Bureau of Investigations (FBI) in the United States estimates 3 - 10% of Medicare transactions involve fraud, which prompted the establishment of a Healthcare Fraud Unit within the Department of Justice. [30] [31] [36] In addition, the Centers for Medicare and Medicaid Services (CMS) actively release datasets to aid in identifying fraud, waste, and abuse within the system, ensuring that fraud prevention is integrated into broader enforcement strategies. [30] [31]

In the United Kingdom (UK), a 2011 independent report estimated that the NHS was losing £5 - 7 billion ($10 - 14 billion AUD) annually to fraud, a finding that gained traction in 2014 and led to the creation of the NHS Counter Fraud Authority (NHSCFA). [37] [38] [39] [40]

A key issue identified was inconsistent data collection, a challenge being faced by Australia's Medicare system [37]. Following the NHSCFA's establishment, measures including real-time transaction monitoring and improved inter-agency collaboration were introduced, significantly reducing fraud risk and demonstrating the effectiveness of structured, AI and data-driven prevention strategies. [6]

In Australia, fraud prevention efforts remain limited. While the AFP leads the NDIS Fraud Fusion Taskforce, a multi-agency initiative with the ATO, Services Australia, and the Australian Criminal Intelligence Commission, there is no equivalent taskforce targeting Medicare fraud. [41] Although the taskforce has suggested its framework could apply to other payment systems, little progress has been made in extending its scope to Medicare.



6. OPPORTUNITY COSTS: ECONOMIC IMPACTS OF MEDICARE BILLING FRAUD AND NON-COMPLIANCE

Medicare fraud and non-compliance in Australia isn't just a financial drain; it's a high-stakes market failure, where perverse economic incentives fuel unethical behaviour, distorting resource allocation and pushing the healthcare system towards chronic and embedded inefficiency. Fraudulent and non-compliant billing diverts billions annually from legitimate healthcare needs, hitting both government budgets and taxpayers with unnecessary costs.

From a public finance perspective, this misallocation of funds creates a deadweight loss, where taxpayer dollars vanish into unproductive, often illegal activities rather than being channelled into critical healthcare investments, including cutting-edge medical infrastructure, preventative care, and a robust healthcare workforce. The result? Policymakers are left in a lose-lose scenario: either inject more public funds into an already leaking system or slash costs in ways that reduce access to care, disproportionately affecting lower-income and vulnerable Australians.

Fraudulent and non-compliant billing doesn't simply create isolated economic loss, it changes provider behaviour and fuels opportunism, allowing providers to exploit the system by inflating claims with minimal fear of detection. This entrenched rent-seeking behaviour skews competitive market dynamics, rewarding those who game the system while leaving ethical medical practitioners, who are in the majority, at a disadvantage. Over time, this breeds a principal-agent problem, where healthcare providers and practitioners (the agents) increasingly act in self-interest, rather than prioritising the needs of the system and its patients.

Beyond the immediate economic leakage, Medicare fraud and non-compliance shred allocative efficiency by funnelling resources into excessive procedures rather than essential, high-value interventions. This kind of supplier-induced demand risks turning the system into a profit-driven machine, rewarding unnecessary treatments at the expense of patient-centred care. Noted economist Victor R Fuchs warned that conventional health policies often inadvertently amplify perverse economic incentives and entrench inefficiency – further stating that *"the most tempting targets - 'waste,' 'fraud,' and 'abuse' - "have proven remarkably resistant to attack".* [44] [45] Similarly, researchers Amitabh Chandra and Douglas Staiger highlight how allocative inefficiencies across hospitals sap the potential benefits of medical treatments. [46]

On a broader scale, systemic fraud and non-compliance erode public trust, weakening the social contract that underpins the principles of universal healthcare. As confidence in Medicare declines, so too does public support for taxation-based funding, accelerating a shift toward policy drift and potential privatisation, an outcome that would only widen healthcare inequality. Meanwhile, fraud investigations and compliance efforts eat up even more government resources, diverting attention from structural reforms that could, and should, drive efficiency and improve patient outcomes.

Addressing Medicare fraud and non-compliance isn't just about plugging budget holes, it's an economic necessity. Without tougher enforcement, sharper compliance tools, and stronger deterrents, Australia risks a healthcare system riddled with inefficiencies, bleeding taxpayer money while leaving patients behind. Given the escalating sophistication of fraudulent schemes, proactive intervention is the only way to break the cycle, before inefficiency breeds even more non-compliance, further straining public finances. The longer these perverse incentives remain unchecked, the harder and costlier it will be to restore Medicare's economic integrity.

What $2 billion funds within the Australian healthcare system: [1]

South Australia National Health Reform Agreement

$2.05 billion

What $1 billion funds within the Australian healthcare system: [1]

Urgent Care Clinics	$58.5 million
Additional Adult Mental Health Centres (12 centres)	$48.0 million
Strengthening Mental Health & Suicide Prevention Services	$72.2 million
Specialist Dementia Care	$9.9 million
Better Palliative Care in Aged Care Homes	$10.7 million
Multidisciplinary Outreach Care	$10.3 million
New Comprehensive Cancer Centres (3 cities)	$294.5 million
National Immunisation Program	$33.0 million
More Affordable Public Dental Care for Adults	$107.8 million
Affordable Breast Cancer Treatment (2,600 courses)	$252.5 million
Stronger First Nations Health Services	$63.1 million
Improved Access to Cervical Cancer Screening Services	$2.8 million
Expansion of Clinical Trials	$1.5 million
Rural Training for Junior Medical practitioners to Support Local Communities	$35.5 million
TOTAL	**$1 BILLION**

NSW's share would fund more than **3,750 extra allied health staff** in NSW Health[vi]

[vi] *Based on if $1.5 billion is lost nationally. $450 million as NSW's share of federal health funding calculated off typical share of around 30% of total federal budget, based on current budget estimate papers. Cost of allied health professionals based on an average wage of $100,000 plus super and allowancespapers. Cost of allied health professionals based on average wage of $100,000 plus super and allowances.*

7. WHAT FRAUD AND NON-COMPLIANCE REVEALS ABOUT THE AUSTRALIAN HEALTHCARE SYSTEM

The AMA's Defence of Medicare Fraud and Non-Compliance Is Nothing New - And That's the Problem

"The AMA has been happy to obtain concessions from the government, but then has been unable to respond with binding commitments from the medical profession" – Prime Minister Bob Hawke, 1984[50]

The AMA has responded to allegations of Medicare fraud with the same tired arguments it has relied on for decades; arguments that collapse under scrutiny. For too long, the AMA and other medical representative bodies have positioned themselves as defenders of public healthcare while simultaneously resisting oversight and regulation.[47] [48] [49] The reality is that their primary concern is preserving the status quo that benefits their members.

The Illusion of Professional Purity

A central pillar of the AMA's defence is the idea that every medical practitioner is ethical, and hardworking and would never engage in fraudulent or non-compliant billing practices. But this assumption ignores a fundamental truth - medical practitioners, like workers and professionals in any industry, respond to financial incentives. The notion that the medical profession is uniquely immune to exploitation and misconduct is outdated and dangerous.

The AMA insists that Medicare fraud and non-compliance is a minor issue, a case of a few bad actors rather than systemic failure. Yet, as this report has highlighted, every major independent review over the past decade confirms that billions are lost to Medicare fraud and non-compliant billing annually. If fraud were truly insignificant, how does the system continue to haemorrhage billions? Even if only a small fraction of medical practitioners are engaged in fraudulent or noncompliant billing, the consequence to the healthcare system is enormous.

More importantly, in any other industry, if an individual or business overbilled by $500,000 frequently and systemically, it would very likely be considered fraud. No other profession, perhaps with the historical exception of the finance sector, has been allowed to set its own rules and self-regulate to the extent that medical practitioners and the AMA do. This lack of accountability has created an environment where billions in public funds can be misused with minimal or no consequences.

The AMA's Deflection Tactics

The AMA's response to Medicare fraud and non-compliance follows a predictable pattern: downplay, deflect, and obstruct. Instead of engaging with the substance of the allegations, it leans on misleading studies and appeals to complexity.

One of its primary defences is that the MBS is simply too complicated for medical practitioners to navigate correctly. As the AMA has claimed, *"The vast majority* [of non-compliance] *is due to the complexity of Medicare and the difficulties of matching best practice medical care with a complex MBS".*[51] This argument is as condescending as it is absurd. Are we to believe that the same professionals who perform intricate surgeries and diagnose rare conditions cannot comprehend a billing system? Complexity might explain minor errors, but it does not justify systemic overbilling that costs taxpayers billions.

Other medical representative bodies are no better, a recent RACGP report even suggested that decreasing regulation was a workforce retention strategy, essentially arguing that making it easier to rort the system keeps medical practitioners happy. [16]

Another frequently cited claim is that medical practitioners undercharge more often than they over charge. This argument is based largely on the University of Sydney's "Under or over? General practitioner charging of Medicare" study, which the AMA and RACGP have used to suggest that Medicare benefits from medical practitioner generosity. [47]

Yet the study is riddled with flaws and bias. With only 21 citations, a third of which are opinion pieces authored by vested interests, it does not put any *'kybosh'* on accusations of fraud and non-compliance. [52] Indeed, it relies on self-reported data - essentially asking medical practitioners to admit if they've overbilled. It also uses outdated records from 2013–2016 and makes questionable assumptions about consultation time equating to billing legitimacy.

The methodology lacks rigour, and the conclusions appear to be shaped by predetermined narratives rather than by objective academic analysis. It reads as if the authors undertook the work with a specific outcome in mind, rather than to critically examine the issue at hand. More importantly, it ignores the basic reality that deliberate fraud and non-compliance is not the same as occasional underbilling due to administrative error. As our original critique, why would anyone self-incriminate?

The recent December 2024 article "Questionable evidence and argumentation regarding alleged misuse of Medicare" presents itself as a critique of Dr Ryan's recent analysis of Medicare misuse.[53] In reality, it is yet another example of AMA deflection hidden in a single-page rebuttal that makes no new contribution to the evidence base, contains no original data, and fails to meet even the most minimal academic standards.

The authors cite just four sources, including an AMA press release, and rely heavily on vague assertions. They accuse Ryan of extrapolation and flawed logic, yet provide no counter-analysis, no empirical evidence, and no meaningful engagement with the substance of his work. Their own footnote concedes what the rest of the piece confirms: "no new data were generated or analysed during this study."

Even more troubling is the selective treatment of foundational research by Dr Margaret Faux and Dr Pradeep Philip. The article cherry-picks isolated lines while ignoring both authors' central conclusions: that large-scale Medicare non-compliance and Fraud exists, are deeply embedded, and involve clinicians. Suppressing this context is not scholarly disagreement. It's academic sleight of hand.

Ryan's paper, by contrast, presents new data drawn from first-hand experience as a cardiothoracic surgeon. His findings are grounded in both evidence and lived clinical reality, a perspective the response seems eager to dismiss. This is

In 2009, the AMA's power was evident when its former head blocked then-Federal Health Minister, the Hon. Nicola Roxon, from cutting excessive cataract surgery fees.[55] Roxon sought to curb payments for the procedure, but fierce medical lobby opposition watered down the cuts under the guise of maintaining affordability for patients. Dr Webber countered that these fees were originally set when cataract surgery was more complex and required a week-long hospital stay. With modern advancements reducing it to a 20-minute day procedure, he argued a significant fee reduction was justified. [5] **This wasn't about protecting patients—it was about protecting revenue streams.**

professional gaslighting: ignoring inconvenient truths, marginalising whistleblowers, and substituting deflection for debate. Academic disagreement is vital. But it must be grounded in rigour, not reflex. The issues Ryan raises deserve serious, transparent, evidence-led responses, not editorial posturing in the guise of critique.

A Broken Power Dynamic

The disproportionate influence of the AMA in shaping health policy has allowed this culture of resistance to oversight to persist. Australia's healthcare workforce is composed of a vast array of health workers - allied health professionals, hospital staff and nurses - yet medical practitioners, through organisations like the AMA, maintain outsized control over funding and regulation. The AMA's 2025 "Modernising Medicare" campaign exemplifies this imbalance: its primary focus is on increasing medical practitioner rebates, with little mention of systemic reforms that would benefit the broader healthcare workforce or improve patient outcomes. [54]

Time for Meaningful Reform

Medicare operates largely on an honour system, with minimal oversight. The AMA's insistence that fraud and non-compliance concerns are exaggerated is an attempt to preserve that lack of scrutiny. But blind trust is not a governance strategy. A system that leaks billions each year is a system that demands reform. Stronger audits, independent oversight, and a reduced role for self-interested medical lobby groups are essential.

If healthcare was truly patient-centred, we wouldn't have an AMA that resists compliance measures. We wouldn't have a government scared to challenge entrenched medical interests. The fact that Medicare fraud and non-compliance continues at this scale isn't just an indictment of individual medical practitioners, it's a symptom of a deeply imbalanced system. The AMA's tired responses to Medicare fraud and non-compliance are not new; it is the same defensive rhetoric it has deployed for decades. What has changed, however, is that the scale of fraud and non-compliance is now undeniable. The question is not whether we should act, but why we have allowed this to continue for so long.

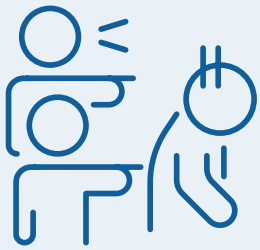
8. MEMBER STORIES AND EVIDENCE

Driven by member feedback, HSU conducted a survey on Medicare fraud, workforce pressures, and oversight concerns. A sample of 110 health workers from NSW public and private sectors, including those in billing, finance, and compliance, were surveyed.

Concerning Insights from Health Workers

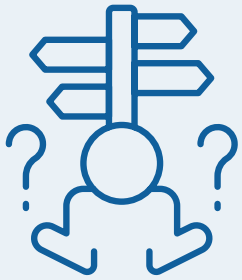
Survey responses reveal patterns of upcoding, deliberate rule circumvention, overservicing, and outright fraudulent claims. The most at-risk areas were medical imaging and pathology.

Responses show:



Pressure to Maximise Profit from Medicare Funding

- Among those for whom the issue if relevant in their workplace, **50%** of respondents have faced explicit or implicit pressure to maximise profit



Reporting Concerns & Protections

- Only **17%** understand how to report Medicare fraud
- Fewer than **7%** feel protected from employer retaliation
- Many respondents **preferred anonymity** due to fear of retribution

Widespread Issues

- **1 in 3** healthcare workers have witnessed or suspected improper billing
- **74%** believe billing pressures negatively impact patient care

Upcoding: Falsifying Billing to Maximise Claims

"Doctors not being present to see patients, but still billing* [as if they were present] *for procedures"

- Medical practitioners inflating service durations to claim higher rebates, such as billing 30-minute consults as hour-long sessions, or charging for extended consultations that lasted only minutes when performed by telehealth.
- In laboratories, unnecessary procedures were reportedly routinely added to test requests to increase Medicare claims, and visiting medical practitioners were said to be only performing their rounds later in the day to claim higher after-hours rates for the consults.

Deliberate Circumvention: Bending the Billing Rules for Financial Gain

"Interventional procedures are billed using an item code which reflects that a radiologist was present and a consultation occurred, when in fact the radiologist is reporting the procedure remotely and a GP performed the procedure"

- Medical practitioners delaying patient care in order to claim a higher rebate.
- Manipulating billing codes to claim a higher benefit, such as falsely stating that a specialist was present for certain procedures.
- Fragmenting procedures across multiple days; not for clinical reasons, but to increase billing. Particularly disadvantaging rural patients making several trips unnecessarily.

Overservicing: Maximising Profits not Care

***"Adding Axilla* [ultrasound] *to every breast* [ultrasound]"**

- Conducting unnecessary tests and procedures purely because they are billable, such as excessive imaging referrals and adding unjustified scans to existing tests
- Self-generated imaging referrals
- Surgeons pushing surgical interventions, for which they stand to benefit from financially, before trialling best practice, cost efficient conservative options through allied health

Blatant Violations: Unscrupulous Agents Rorting System Vulnerabilities

"Resubmitting claims with* [falsified] *dates of service in order to be paid from Medicare"

- Billing for procedures they did not personally perform
- Falsifying document to claim Medicare payments when not eligible

These findings expose flaws in Medicare's oversight, with less than 7% believe existing safeguards effectively prevent fraud and non-compliance. This cross section of healthcare is underrepresented in the PSR case outcomes, but these results indicate that Medicare fraud and non-compliance outside GP practice is underreported under current systems.

Survey responses reveal a complex web of financial, structural, and managerial pressures driving Medicare billing manipulation. While some cite resource constraints, others point to profit-driven motives that compromise patient care. Private practice, with minimal oversight, is particularly vulnerable to the incidence of fraud and non-compliance having an exponential capacity. Survey responses identify, in rural areas, general practitioner visiting medical officers are reportedly prioritising revenue over patient care, further raising ethical concerns.

Uncertainty remains over whether aggressive billing stems from survival or greed. Survey responses highlight direct pressure from medical practitioners, managers, and executives to manipulate billing, with workers questioning whether ethical practice can prevail when financial incentives drive decision-making for medical practitioners and private companies. Key concerns include medical practitioners linking billing practices to their own salaries; pressuring staff to maximise patient numbers to secure higher earnings, pathology management prioritising financial targets, and senior administrators focusing on cash flow over care.

9. RECOMMENDATIONS

Legislative Overhaul of the DoHAC Medicare Compliance Approach

Introduce mandatory real-time reporting for high-risk billing categories. Legislative amendments should redefine fraud and non-compliance to eliminate legal loopholes and include wilful ignorance. Expand the scope of investigations to investigate a broader range of wrongful billings and allocate greater resources to strengthen enforcement.

AI-Driven Medicare Monitoring and Real-Time Fraud and Non-Compliance Detection

Leverage Australia's best practice counter fraud initiatives to enhance and deploy an AI-powered fraud detection system that continuously analyses billing patterns, identifies anomalies, and flags high-risk claims in real time. This system should enable the soft blocking of suspicious billing claims and seamlessly integrate with the ATO and Services Australia. Led by multiple agencies, including the Australian Federal Police, it will facilitate cross-referencing of income and billing data, strengthening early fraud detection and prevention.

Patient Billing Transparency and Verification

Launch the Medicare Bill Transparency Initiative to notify patients via an accessible electronic alert when claims are made in their name during the Medicare billing processing. This initiative enhances accountability in the billing processand better enables patients who wish anonymously to identify and flag incorrect claims.

Independent Medicare Integrity Commission (MIC)

Establish an independent watchdog with powers to conduct forensic audits, issue penalties, and investigate systemic fraud within Medicare. Unlike the historical and current functioning of the PSR, the MIC should be free from conflicts of interest and have enforcement capabilities comparable to the Australian Securities and Investments Commission (ASIC), ensuring robust accountability measures.

Modernising Healthcare Funding for Better Outcomes

Government should develop new funding mechanisms for healthcare that move away from fee-for-service towards outcome-based or capitation-based payments. As highlighted in the Commonwealth Government's Strengthening Medicare report, primary care funding should also transition to support multidisciplinary, team-based care in the community, with an expanded role for allied health professionals, paramedics, and nurses.

10. CONCLUSION

Medicare fraud and non-compliance have routinely been treated as an inconvenient afterthought, while billions of taxpayer dollars are siphoned away from patient care by those who exploit a flawed system. Every dollar lost to fraud and non-compliance is a dollar taken from hospitals, vital health services, and the most vulnerable Australians who rely on Medicare for essential health services.

What has been presented in this report is more than a minor financial scandal. The Commonwealth Government's recent reform agenda is incomplete, and the AMA's deflection tactics only enable systemic neglect over accountability, corporate interests over patient care, and convenience over transparency. While other nations strengthen and modernise their public healthcare systems, Australia moves slowly on a growing crisis.

At the same time, it is crucial to acknowledge that the vast majority of medical practitioners are ethical, hardworking, and deeply committed to their communities - HSU members work alongside them every single day. Together, health workers and medical practitioners dedicate their lives to upholding the integrity of our healthcare system. But the integrity of the majority alone cannot stop the haemorrhaging of public funds. That is why this report provides clear recommendations based on best-practice monitoring and detection; to ensure every taxpayer dollar is directed where it belongs: patient care. We outline what is occurring, how it is occurring, and why it is occurring.

While the government invests heavily in tackling fraud within the NDIS and national taxation system, Medicare, Australia's most essential national public health program, remains alarmingly unprotected. This raises urgent questions. If fraud and non-compliance in other sectors warrants immediate action, why is Medicare left so vulnerable? Is this mere negligence, or are powerful interests actively obstructing reform to protect their financial gain? Australia deserves a Medicare system that works for the people and for healthcare workers - with every dollar going to patient care. Isn't that the whole point?

REFERENCES

[1] The Commonwealth of Australia, "Budget Paper No.3, Federal Financial Relations 2024-25," 2024.

[2] Attorney-General's Department, "The Commonwealth Fraud and Corruption Control Framework," Australian Government, 2024.

[3] P. Philip, "Independent Review of Medicare Integrity and Compliance," Australian Government Department of Health and Aged Care, 2023.

[4] Australian Government, Attorney-General's Department, "The Commonwealth Criminal Code: A Guide for Practitioners, Division 9: Circumstances Involving Mistake or Ignorance," 2024.

[5] T. D. Webber, "What is wrong with Medicare?," Medical Journal of Australia, vol. 196, no. 1, 2012.

[6] NHS Counter Fraud Authority, "Strategic Intelligence Assessment," 2024.

[7] U.S Department of Justice, "Justice Department Charges Dozens for $1.2 Billion in Health Care Fraud," July 2024.

[8] M. Faux, "Claiming and Compliance under the Medicare Benefits Schedule: A Critical Examination of Medical Practitioner Experiences, Perceptions, Attitudes and Knowledge," University of Technology, Sydney, Faculty of Health, 2021.

[9] The Commonwealth of Australia, "Budget Paper No.1, Federal Budget Strategy and outlook 20024-25," 2024.

[10] Australian National Audit Office, "Auditor-General Report No.17 2020–21: Managing Health Provider Compliance," 2020.

[11] J. B. Ryan, "Lessons from the 'legitimate' misuse of Medicare Benefits Schedule Item 45503," Australian Health Review, vol. 48, no. 3, pp. 254-258, 2024.

[12] Australian Government Department of Health and Aged Care, "MBS Online, Medicare Benefit Schedule," 2025.

[13] Australian Government Department of Health and Aged Care, "MBS Online, AskMBS Email Advice Service," 2023.

[14] Australian Government, Services Australia, "Billing Rules for Procedure".

[15] Australian Government Department of Health and Aged Care, "How to comply with Medicare obligations".

[16] The Royal Australian College of General Practitioners, "General Practice: Health of the Nation," RACGP, East Melbourne, Vic, 2024.

[17] A. Ferguson, "Fraud, waste and abuse: How some medical practitionerss are exploiting Medicare and turning patients into 'cash cows'," ABC News, May 1, 2024.

[18]A. Branley, "Health department records show some pathology companies rorted Medicare during COVID pandemic, expert says," ABC News, July 16, 2024.

[19] M. Cunningham, "Whistleblower alleges widespread fraud by dozens of 'double-dipping' specialist medical practitionerss, sparking probes," The Age, Nov 15, 2024.

[20] C. Houston, "Medical practitioners avoids jail despite $318,000 Medicare fraud," The Age, Oct 17, 2023.

[21] R. Lindsay and S. J. Vincent, "Medicare item number statistics in relation to fraud," Clinical and Experimental Optometry, vol. 105, no. 4, pp. 435-437, 2022.

[22] L. V. Berquist, "Private equity investment in health care delivery, Australia, 2008-2022," The Medical Journal of Australia, vol. 220, no. 7, pp. 368-371, 2024.

[23] Australian Medical practitioners, "MBS Quick Guide," 2024.

[24] R. Smith, "Electronic Medicare fraud: current & future risk, Trends & issues in crime and criminal justice no. 114," Australian Institute of Criminology, Canberra, 1991.

[25] Australian Government Professional Services Review, "PSR Case Outcomes".

[26] Australian Government, Department of Health and Aged Care, "Practitioner review program, for practitioners – review by a delegate of the Chief Executive Medicare.".

[27] R. Creyke and D. Dhupelia, "Report on Review of Section 92 of the Health Insurance ACT 1973 (Cth)," Department of Health and Aged Care, 2022.

[28] iSeeGP, "Why Does PSR Target Small Infractions While Ignoring Multi-Million Dollar Alleged Medicare Fraud?," Feb, 2025

[29] Australian Government Department, Department of Health and Aged Care, "Medicare annual statistics – State and territory (2009–10 to 2023-24)," 2024.

[30] J. M. Johnson and T. M. Khoshgoftaae, "Data-Centric AI for Healthcare Fraud Detection," SN Computer Science, vol. 4, p. 389, 2023.

[31] M. Herland, T. M. Khoshgoftaar and R. A. Bauder, "Big Data fraud detection using multiple medicare data sources," Journal of Big Data, vol. 5, p. 29, 2018.

[32] J. T. Hancock, H. Wang, T. M. Khoshgoftaar and Q. Liang, "Data reduction techniques for highly imbalanced medicare Big Data," Journal of Big Data, vol. 11, no. 8, 2024.

[33] A. Saeedy, "The Rise of Artificial Intelligence at JPMorgan," The Wall Street Journal, Feb, 2025

[34] T. Bennett, "ATO captures billions of dollars from tax cheats with AI," Financial Review, Aug, 2023.

[35] Australian National Audit Office, "Governance of Artificial Intelligence at the Australian Taxation Office," 2025.

[36] U.S. Department of Justice, Criminal Division, "Healthcare Fraud Unit".

[37] J. Gee, M. Button and G. Brooks, The financial cost of fraud: what data from around the world shows, Milton Keynes: MacIntyre Hudson, 2009.

[38] BBC News, "NHS fraud and error 'costing the UK £7bn a year'," Mar, 2014

[39] K. Dutta, "NHS fraud 'equal to its entire budget for cancer treatment'," Independent, Mar, 2014.

[40] NHS Counter Fraud Authority, "Fighting Fraud in the NHS," 2018.

[41] Australian Government, Services Australia, "Fraud fusion Taskforce".

[42] Australian Government Professional Services Review, "PSR Panel Newsletter - January 2025.".

[43] Australian Government Professional Services Review, "PSR Newsletter - September 2023".

[44] V. R. Fuchs, "Three "Inconvenient Truths" about Health Care" The New England Journal of Medicine, vol. 359, no.17 1749-1751, 2008.

[45] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Board on Global Health; Committee on Improving the Quality of Health Care Globally., "The Critical Health Impacts of Corruption," in Crossing the Global Quality Chasm: Improving Health Care Worldwide, Washington (DC), National Academies Press (US), 2018.

[46] A. Chandra and D. O. Staiger, "Identifying Sources of Inefficiency in Healthcare," The Quarterly Journal of Economics, vol. 135, no. 2, pp. 785-843, 2020.

[47] C. Harrison, J. Gordon, J. Henderson, G. C. Miller and H. Britt, "Under or over? General practitioner charging of Medicare," Australian Journal of General Practice, vol. 52, no. 4, pp. 220-224, 2023.

[48] N. Coatsworth, "Don't protest too loudly, medical practitionerss - we do have a Medicare crisis," The Sydney Morning Herald, Oct 19, 2022.

[49] T. Kirby, "Australia rocked by Medicare fraud and wastage allegations," The Lancet, vol. 400, no. 10362, 2022.

[50] R. Hawke, "Speech by the Prime Minister, Health and Research Employees' Association," Sydney, 1984.

[51] Australian Medical Association, "Compliance review vindicates medical practitionerss, dismissing claims of widespread rorting," April, 2023.

[52] Australian Medical Association, "University of Sydney research puts the kybosh on Medicare fraud claims," April, 2023.

[53] Looi JCL et al. (2024) Questionable evidence and argumentation regarding alleged misuse of Medicare. Australian Health Review 48(4), 484–485. doi:10.1071/AH24168

[54] Australian Medical Association, "AMA's plan to Modernise Medicare: Policy Brief," 2025.

[55] ABC News, "Cataract rebate dispute resolved," Jan, 2010.

[56] Professional Services Review, "Case out comes, Jan 2024-Dec 2024," Australian Government.

[57] The Royal Australian College of General Practitioners, "Navigating Medicare and the PSR," 2024.

[58] Australian National Audit Office, "Managing Health Provider Compliance – follow on".

AUTHORISED BY Gerard Hayes AM, HSU Secretary, NSW/ACT/QLD

PREPARED BY Dr Dustin Halse & Dr Laura O'Connor