HEALTH LEGISLATION AMENDMENT BILL 2005

THE INQUIRY

1.1 The Health Legislation Amendment Bill 2005 (the Bill) was introduced into the House of Representatives on 14 September 2005. On 5 October 2005, the Senate, on the recommendation of the Selection of Bills Committee (Report No. 11 of 2005), referred the provisions of the Bill to the Committee for report.

1.2 In recommending the reference of the Bill to the Committee, the Selection of Bills Committee provided the following issues for consideration.

To examine the provisions of the Bill relating to new powers to set conditions, limitations and restrictions on the circumstances in which Medicare benefits will be payable for health services; in particular to:

a) consider the evidence that these powers are necessary;

b) identify if the Bill provides sufficient mechanisms to ensure that decisions to impose conditions, limitations and restrictions are made in line with scientific evidence;

c) determine the need for appropriate structures to guarantee consumer and expert consultation in the decision making process; and

d) examine the need for appeals mechanisms to prevent arbitrary application of the power.

1.3 The Committee considered the Bill at a public hearing on 13 October 2005. Details of the public hearing are referred to in Appendix 2. The Committee received 33 submissions relating to the Bill and these are listed at Appendix 1. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca

THE BILL

1.4 The purpose of the Bill is threefold, namely:

- Schedule 1 of the Bill amends the *National Health Act 1953* to extend until 30 June 2006 the existing arrangements for approving pharmacists to supply medicines subsidised under the Pharmaceutical Benefits Scheme (PBS);
- Schedule 2 of the Bill amends the *National Health Act 1953* to clarify that dependents of contributors to private health funds are covered as well as the contributors themselves; and

- Schedule 3 of the Bill proposes two amendments to the *Health Insurance Act 1973*. The first amendment clarifies the powers to set conditions, limitations and restrictions on items in the Medicare tables, and the second amendment inserts a new power to allow the Minister to determine that Medicare benefits are not payable for certain services rendered in specified circumstances.[1]

1.5 None of the amendments proposed in the three Schedules is expected to have a direct financial impact.[2]

ISSUES

Schedule 1

1.6 Most witnesses supported the amendment to extend the existing arrangements by six months, including the Australian Divisions of General Practice (ADGP), and the Queensland and South Australian Governments.[3] Women's Health Victoria (WHV) and the Women's Centre for Health Matters (WCHM) advised that they 'do not oppose' the amendment.[4]

1.7 Only the Australian Consumers' Association (ACA) voiced an objection. The ACA stated:

> The ACA is strongly opposed to the continuation of the provision which allows the Australian Community Pharmacy Authority (ACPA) to set location rules. This encourages anti-competitive practices between pharmacies and results in higher prices and fewer options for Australian consumers.[5]

1.8 In the second reading speech the Parliamentary Secretary to the Minister for Health and Ageing explained that 'extension of the existing arrangements until the end of 30 June 2006 will enable the government, in consultation with the Pharmacy Guild of Australia, to carefully consider the findings and recommendations of the review in relation to the pharmacy location rules and the role of the ACPA'.[6]

---

1 Parliamentary Secretary to the Minister for Health and Ageing, Second Reading Speech, 14.9.05.

2 Explanatory Memorandum, p.2.

3 *Submission* 29, p.2 (ADGP); *Submission* 32, p.1 (Queensland Government), and *Submission* 33, p.1 (South Australian Government).

4 *Submission* 8, p.1 (WHV); *Submission* 18, p.1 (WCHM).

5 *Submission* 20, p.2 (ACA).

6 Parliamentary Secretary to the Minister for Health and Ageing, Second Reading Speech, 14.9.05.

Schedule 2

1.9 Schedule 2 proposes amendments to ensure that both contributors and their dependents are covered by private insurance policies. Witnesses were supportive of the proposed amendment. Women's Health Victoria (WHV) stated:

> We support the proposed amendments in Schedule 2 to ensure that where appropriate cover is purchased, that both the contributors to private health insurance funds, and their dependents, receive insurance coverage.[7]

1.10 The Queensland Government commented:

> Clarification of the provisions of the private health insurance as covering both contributors and their dependents appears an appropriate path to follow.[8]

Schedule 3

1.11 Schedule 3 proposes two changes to provisions within the *Health Insurance Act 1973* relating to the conditions under which Medicare benefits are payable.

1.12 The first set of proposed changes (contained in items 1 – 4) clarify the scope of existing powers in the Health Insurance Act to specify particular conditions under which benefits for certain medical, pathology and diagnostic imaging benefits are payable.

1.13 The second set of changes included in Schedule 3 (contained in item 5) proposes the insertion of a new power in the Health Insurance Act to allow the Minister to determine, by legislative instrument, that Medicare benefits are not payable for certain services provided in specified circumstances.

Schedule 3, Items 1 – 4

1.14 The Health Insurance Act currently allows for the regulations under which the Medicare tables are made to set out rules for the interpretation of the tables. The Parliamentary Secretary stated:

> It has been a long standing practice to specify, in the Medicare tables, conditions that must be met for Medicare benefits to be payable for health services. The amendments remove any doubt as to the validity of such conditions in the tables.[9]

---

7 *Submission* 8, p.1 (WHV).

8 *Submission* 32, p.1 (Queensland Government).

9 Parliamentary Secretary to the Minister for Health and Ageing, Second Reading Speech, 14.9.05.

1.15 The National Association of Practicing Psychiatrists (NAPP) raised concerns in relation to the amendment and sought clarification of what would be gained 'by seeking more power'.[10]

1.16 The Department noted that the Office of Legislative Drafting and Publications had suggested that 'it would be more appropriate for the Act to be amended to clarify that these Tables may set conditions, limitations or restrictions on the circumstances in which Medicare benefits are payable for health services and to make clear the regulation making power of the Act'.[11]

Schedule 3, Item 5

1.17 Submissions and witnesses raised concerns about the amendment proposed by Item 5 as it was argued that the proposed new power would enable the Minister to exclude certain services from Medicare benefits.

1.18 The Australian Medical Association (AMA) noted that such an amendment would represent an increase in the Minister's power and stated:

> This amendment would give the Minister a broad power to make a determination to the effect that a Medicare Item in the Schedule shall not be used for the purpose specified in the determination.[12]

1.19 The AMA commented that it was not aware of any major problem in the operation of Medicare which justified the introduction of this new power. It argued that:

> The Minister can remove or amend an item already. The Minister can ask the medical profession to cease using an item for a certain purpose.[13]

The AMA concluded that '…it is just not a problem'.[14]

1.20 The Medical Industry Association of Australia (MIAA) noted that it had not been consulted by DoHA in relation to this Bill. It stated that it was not aware that 'code drift' was a significant issue and doubted that the proposed amendment was the appropriate solution. The MIAA commented that it 'does not support the inappropriate use of MBS items and accepts that there are procedural issues which must be honoured in respect to what is best for patients'.[15]

1.21 The Australian Women's Health Network (AWHN) expressed concern that under the proposed arrangements the Minister would be able to make determinations

---

10 *Submission* 27, p.2 (NAPP).

11 *Submission* 25, p.5 (DoHA).

12 *Submission* 15, p. 2 (AMA).

13 *Submission* 15, p. 2 (AMA).

14 *Committee Hansard*, 13.10.05, p.3 (AMA).

15 *Submission* 16, p.1 (MIAA).

without the benefit of the expert advice of the Medical Services Advisory Committee. The Network commented that it was 'concerned to ensure that extensive consultation will take place in relation to the services and procedures reimbursable under Medicare and insists that decisions must be made on the basis of the best scientific advice available, not simply Ministerial prerogative'.[16]

1.22 The Tasmanian Medicare Action Group (TMAG) raised concerns about the proposed extension of Ministerial power.[17] The Hobart Women's Health Centre (HWHC) and Women's Health Victoria (WHV) expressed concern at the impact this amendment could have on women's health as it 'would allow the restriction of certain essential, medically appropriate and safe medical procedures which may be considered by the government as unacceptable'. WHV went on to comment:

> Equity in access to health services, including abortion, should be facilitated by Medicare. Withdraw of Medicare rebates for abortions will not prevent women from having abortions but rather ensure that, like an increasing number of health care services that were previously universal, abortions are available only to those who can afford private health care.[18]

1.23 The Queensland Government objected to the proposed amendment and argued 'any removal of Medicare benefits for a type of medical procedure could shift demand for that service from the private to the public health sector'.[19]

1.24 The Australian Divisions of General Practice (ADGP) gave qualified support for the amendment, and stated:

> Although this relates primarily to Medicare claims on new medical technologies before 'safety' and 'value for money' have been satisfactorily considered by government, caution should be applied in its utilisation. A determination made without due consultation with the health profession, particularly where it relates to general practice, may impact significantly on the community.[20]

1.25 Four submissions, all from individuals, supported the amendment, generally on the basis that they believed that procedures such as abortion should not receive a Medicare benefit and they supported the Minister's right to exclude such services.[21]

1.26 The Department stated that the proposed amendment is designed to enable the Minister to respond more immediately when concerns about possible misuse of MBS items arise.[22] The Department indicated that:

---

16 *Submission* 19, pp. 5-6 (AWHN); see also *Submission 31*, (Public Health Association of Australia).

17 *Submission* 3, p.1 (TMAG).

18 *Submission* 8, p.2 (WHV); see also *Committee Hansard*, 13.10.05, p. 7 (WHV).

19 *Submission* 32, p.2 (Queensland Government).

20 *Submission* 29, p.2 (ADGP).

21 *Submissions* 2, 21, 22 and 24.

> Some medical practitioners use existing Medicare Benefits Schedule (MBS) items for new technologies or procedures which were never envisaged when the items were created and which may not yet be proven to be safe, effective or cost effective through the Medical Services Advisory Committee (MSAC) process. With rapid advances in medical technology, it is difficult to anticipate and exclude such medical technologies from being claimed, until they are proven to be safe and effective.[23]

1.27 The proposed amendment will provide 'more flexibility and responsiveness around the introduction of new technologies'. DoHA also indicated that there are mechanisms in place to assess new technologies as new medical technologies or procedures must be assessed by the Medical Services Advisory Committee (MSAC) before they are publicly funded under Medicare. The MSAC advises the Minister on whether new medical services should be publicly funded based on an assessment of their safety, effectiveness and cost effectiveness, using the best available evidence. DoHA went on to state:

> The rationale for the proposed legislative change is to preserve the evidence based approach to the use of MBS items. The proposed amendment will provide the Minister with a power to exclude medical procedures from Medicare funding until the scientific evidence has been gathered. [24]

1.28 The Department also noted that the Minister already has powers in regard to specific items. DoHA explained that twice a year the General Medical Services Table is amended. Items may be revised, added to or removed. The Bill gives flexibility in the interim periods as information from the Health Insurance Commission about specific cases had indicated 'a spike in utilisation of items that had not had much activity at all'. The Department noted that 'suddenly there was an unexplained spike in utilisation that equated to a new technology that was in the process of going through MSAC but was sneaking onto the schedule and then sneaking into practice without having that cost-effectiveness analysis concluded'.[25]

1.29 On 14 October 2005 it was reported that the Minister was reconsidering whether this amendment was necessary and that discussions were being held with the AMA.[26] Subsequently, on 2 November, the House of Representatives passed amendments to the Bill to omit Schedule 3, Item 5.

---

22 *Submission* 25, p.5 (DoHA).

23 *Submission* 25, p.5 (DoHA).

24 *Submission* 25, p.6 (DoHA).

25 *Committee Hansard*, 13.10.05, p. 15 (DoHA).

26 *The Australian Financial Review*, 14.10.05 'Abbot gives up rebate power'.

Recommendation

The Committee reports to the Senate that it has considered the Health Legislation Amendment Bill 2005. The Committee notes the amendments to the Bill made by the House of Representatives and recommends that the Bill be passed as amended.

Senator Gary Humphries
Chairman

November 2005