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Bills Digest

No. 48 2000–01

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ISSN 1328-8091

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Published by the Department of the Parliamentary Library, 2000

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National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Bill 2000

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10 October 2000

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National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Bill 2000

Date Introduced: 6 September 2000

House: House of Representatives

Portfolio: Health and Aged Care

Commencement: On Royal Assent

Purpose

To amend the *National Health Act 1953* to require the inclusion of medicare numbers on prescriptions for pharmaceuticals under the Pharmaceutical Benefits Scheme.

Background

The purpose of the Pharmaceutical Benefits Scheme (PBS) is to provide the Australian community with reliable and affordable access to necessary and cost effective medicines. The PBS has been in operation for 50 years with benefits first being made available from 1 June 1948. It has evolved into a scheme which from 1 February 1999 covers 559 drug substances (generic drugs), available in 1,354 forms and strengths (items) and marketed as 1,992 different drug products (brands).

To access pharmaceutical benefits under the PBS, general patients (non-cardholders) must pay the first $20.60 (from 1 January 2000) for each prescription item. Concessional patients who hold a health card (pensioners, beneficiaries and people with low incomes) must pay $3.30 (from 1 January 2000) per prescription item. Individuals and families are protected from large overall expenses for PBS listed medicines by safety nets. For general patients, once the eligible expenditure of a person and/or their immediate family exceeds $631.20 in a calendar year, the patient copayment per item decreases from $20.60 to the concessional copayment rate of $3.30.[1] For concessional patients (cardholders), the $3.30 copayment per prescription item is removed once their total eligible expenditure exceeds $171.60 within a calendar year.[2]

On average, about 82% of the cost of subsidised (ie PBS) drugs is paid for by the Commonwealth.[3] In 1998-99, the PBS dealt with 138.98 million benefit prescriptions,[4] an increase of 3% over 1997-98, compared to about 45 million non-PBS subsidised prescriptions. So, three quarters of all prescriptions dispensed in 1998-99 attracted a PBS subsidy. There has been an average 12.6% annual increase in government expenditure on the PBS between 1994-95 and 1999-2000. The cost to the government of the PBS in 1998-99 was over $3 billion, with nearly 80% of these costs being associated with concessional benefit prescriptions.[5]

Eligibility for PBS benefits is restricted to Australian residents and visitors from those countries with which Australia has a Reciprocal Health Care Agreement. Currently, those countries are the UK (incl. Northern Ireland), Ireland, New Zealand, Malta, Italy, Sweden, the Netherlands and Finland.

Concerns about two forms of unentitled use of the PBS motivate the current Bill: access to PBS subsidised drugs by tourists, overseas visitors, and those with non-resident status; and also the case of "doctor-shopping", where consumers present prescriptions from different doctors to different pharmacists for the same drugs, for the purposes of obtaining large quantities for recreational drug use or commercial export. There are statutory limits on how often a person can receive pharmaceutical benefits for the same drug within a certain period. The Health Insurance Commission (HIC) estimates that in 1998-99, the number of people who engaged in doctor shopping may be around 8,500.[6] With the average cost to the government per PBS prescription in 1998-99 being $21.68, if all these people engaged in doctor shopping just once, it would cost the government over $184,000, on average. The quality of Australian pharmaceuticals is high, and the HIC also holds that some doctor-shopping activity is associated with the overseas diversion of PBS subsidised medicines.[7]

Currently, there are inherent difficulties in pharmacists determining the entitlement status of customers. Pharmacists will routinely ask customers if they have a concession card, and if they don't, they are assumed to be entitled as general patients. Unless there is some salient reason to think otherwise, customers are not usually further questioned, and pharmacists may also be reluctant to enquire as to a person's residence status. Also, there is no requirement for those who are not on a concession card to produce identification to have access to PBS subsidised drugs. The name and address details supplied on a prescription (or a concession card) are not always a reliable means of determining entitlement, either. The cited address may be out of date, for instance, and it may not match those kept by the HIC (or the latter may be out of date). In such cases, the HIC will question whether the pharmacist should be reimbursed the subsidised amount. The pharmacist, however, will not have been in a position to identify a possible discrepancy in the details.[8] Recent HIC audits reveal a significant (and increasing) degree of insufficient or incorrect information recorded on prescription forms. In 1997-98, 45% of audited PBS prescription forms had incorrect or insufficient patient detail (with 4% having no date of supply). This increased to 72% in 1998-99, (with 8% not showing a date of supply).[9] Doctor-shopping is also often not transparent to pharmacists. Because it involves the same

person visiting a range of pharmacists, each single pharmacist will not usually be in a position to identify over-frequent purchase of a particular drug by that person.

The requirement proposed in this Bill to provide a customer's medicare number with PBS purchases (and its provision to the HIC by the pharmacist with the prescription information) is intended to allow pharmacists to more reliably identify unentitled non-residents (who should not have a medicare number). A unique number assigned to each person, will also enable the HIC to monitor more accurately the incidence of doctor-shopping.[10] And, in addition to the costs this will eventually save the PBS, there will also be potential savings in medicare costs. This is because, to avoid detection, doctor shoppers sometimes will not claim the PBS entitlement (and will therefore not impose costs on the PBS). However, in doctor-shopping, they may incur medicare costs through visiting a large number of different doctors to obtain prescriptions.[11] By capturing the medicare number on a general prescription, the HIC will have the facility for detecting such action more reliably.

The current bill concerns one of three approaches being developed by the Federal Government to introduce online health records. The other two initiatives are the *Better Medication Management System* (BMMS), and *Health Connect*. It is understood that each will require new or amending legislation.

BMMS will enable the creation of an on-line electronic patient medication record which links prescriptions written by different doctors and dispensed by different pharmacies. The medicare number will be the mechanism for linking records to a particular individual. The purpose of this system is to minimise the incidence of medication misadventure where a person is prescribed on different occasions drugs which in combination would interact dangerously.[12] It is also designed to be of use in emergency settings, and also to further minimise doctor-shopping.

The Health Connect initiative, which is only at the proposal stage and is intended to be rolled out in the longer term, is a national electronic network which will enable doctors, hospitals and pharmacists to access the health records of patients who opt into the system. The key aims of Health Connect are to enable easier access to health records, the reduction of medical misadventures and dangerous drug interactions, and the improvement in coordination of care by different health professionals. These movements in networked medication and medical records are in keeping with similar initiatives in the UK, for instance, where NHS-net – a dedicated national health scheme network service linking information in primary and secondary care – is expected to be working by 2002.[13]

Main Provisions

Schedule 1

Items 1 to 5 insert various definitions of terms into existing **subsection 84(1). Section 84** is the interpretation section for Part VII of the Act, which deals with pharmaceutical benefits. The terms proposed to be added are:

- 'communicated prescription' (**item 1**). This is simply a prescription written by medical practitioner ('doctor') or dental practitioner ('dentist') and presented or otherwise passed on to an approved pharmacist ('supplier')

- 'expiry date' (**item 2**). This is the expiry date on a medicare card. If there is no date on the card, the Health Minister may specify an expiry date

- 'medicare card' (**item 3**). This includes a card issued by the HIC and a card or other authorisation issued under the *Veterans Entitlements Act 1986* as evidence of the holder's eligibility for benefits under the Repatriation Pharmaceutical Benefits Scheme

- 'medicare number' (**item 4**). The definition also covers a set of numbers applicable to a person who is eligible to have a medicare card but for some reason does not - for example, foreigners visiting Australia who are covered by certain reciprocal health care agreements (such as English citizens), and

- 'special number' (**item 5**). Special numbers are intended to apply to persons who are entitled to pharmaceutical benefits but do not have a medicare card or whose medicare number will not be known or available at the time of supply of pharmaceutical benefits. A special number can also given to a class of people, rather than one number per person. According to the Explanatory Memorandum,[14] such classes may include 'persons who are not legally competent, persons requiring emergency treatment, and foreigners persons covered by reciprocal health care agreements but are not entitled to a medicare card (for example, Irish and New Zealand citizens).

Item 6 adds **new subsections 84(8) to (10). New subsections 84(8) and 84(9**) allow a person to supply their medicare card details to another person (such as a pharmacist) by producing the card, or writing it down, or by simply telling them what it is.

Item 7 repeals section 86 and inserts **new sections 86 to 86E**. **New section 86** specifies that only an 'eligible person'[15] being treated by a doctor or dentist is entitled to receive pharmaceutical benefits under the Act. The current form of section 86 does not appear to impose any direct residency or like eligibility requirements before a person can receive such benefits.

New section 86A prohibits a supplier from dispensing pharmaceuticals (at the pharmaceutical benefit rate) in respect of a person if they have 'reason to believe' that person is out of Australia at that time. This presumably applies where an agent of the

person presents a prescription for filling. There is no guidance on whether the supplier must ask an agent the whereabouts of the person in question. There also appears to be no penalty for a contravention of this provision.

New section 86B gives the supplier a **discretionary power** to request that the person presenting a prescription provide a medicare number and expiry date if he or she is seeking a pharmaceutical benefit. The provider may do so whether or not the prescription has a medicare number on it and whether or not he or she already has a number stored in his or her records. If the person provides a number and/or expiry date, the supplier may check this against his or her records and against the medicare number recorded on the prescription. He or she may write the medicare number on the prescription, including changing the number already written on it by the doctor or dentist if he or she considers the new number is 'more reliable'.[16]

New section 86C applies from **1 January 2001**. From this date, rather than having a discretionary power under **new section 86B**, a supplier ***must*** ask for a medicare number where it is not endorsed on a prescription ***and*** the supplier does not have the person's number stored in his or her records. In this situation, if the person presenting prescription declines to give the number, he or she is not eligible to receive the pharmaceutical from the supplier at the benefit rate, but must pay the full price and then seek the appropriate refund from the local Medicare office or the HIC.

New section 86D allows suppliers to record and retain medicare numbers and expiry dates, but only where that has been authorised by the person providing the number or date. **New paragraph 86D(1)(b)** provides that the supplier must be satisfied that the person providing the number or date is the person to whom the number corresponds, or is the person's legal guardian, or another person capable of giving an authorisation.[17] The authorisation may come directly from a person presenting the prescription or may come via a doctor's or dentist's prescription, **new subsection 86D(2)**.[18] However, a person is not required to authorise the recording and retention of his or her their number, **new subsection 86D(3).**

New subsection 86D(4) sets out the obligations of a supplier who has recorded medicare card details. These must be protected 'by such security safeguards as it is reasonable in the circumstances to take': **new paragraph 86D(4)(a).** The supplier also has obligations regarding persons having access to these details in the normal course of business, such as staff who deal with prescriptions. Suppliers must do 'everything reasonably within [their] power…to prevent unauthorised use or disclosure of information contained in that record': **new paragraph 86D(4)(b)**. This presumably means appropriate staff training and handling procedures.[19] Penalties for unauthorised use or disclosure are included in **new section 135AAA** - see **item 11**.

New section 86E gives the Health Minister the power to prescribe classes of persons for whom special numbers (see item 5) are available. **New subsection 86E(2)** sets out classes that may be so prescribed as including persons who are not legally competent, persons

requiring emergency treatment, and foreign persons covered by reciprocal health care agreements but who are not entitled to a medicare card.[20] However, the Minister may also prescribe other classes. The Minister may also prescribe what things the supplier must be satisfied of before supplying pharmaceutical benefits on the basis that a person falls within a particular class, and the procedure the supplier should follow in such cases: **new subsection 86E(3)**.

Item 8 inserts a **new subsection 88(3A)**. This gives a doctor or dentist a discretionary power to request from the person for whom he or she is are writing or communicating a prescription a medicare number and expiry date (assuming the patient is seeking to pay the benefit rate rather than the full rate when getting the prescription filled by a pharmacist). A person so requested does not have to provide his or her medicare details or authorise the doctor or dentist to inform an approved supplier of such a number for the purpose of recording and retaining it in the supplier's records: **new subsection 88(3C)**.

Item 9 inserts a **new section 88AA**. This section is similar in purpose to section 86D (power of suppliers to record and retain medicare numbers and expiry dates) but applies to doctors and dentists instead of pharmacists. In particular, doctors and dentists have the same duty of care relating to safeguarding the security of these details.

Item 10 inserts **new subsections 99(7) to (9).** These come into force from **1 July 2001**. **New subsection 99(7)** states that a supplier will not entitled to be paid by the Commonwealth for the supply of pharmaceutical benefits to a person unless:

- the prescription filled by the supplier contains a medicare number, or special number, as a number applicable to the person to whom the prescription relates, and
- if this number is a medicare number, it is the same as the medicare number held in the records of the HIC as a number applicable to that person.

However, **new subsection 99(8)** modifies the effect of **new subsection 99(7).** It provides that where the sole reason for the non-correspondence of number and name is that the medicare number on the prescription has expired not more than 60 days[21] before the time the pharmaceuticals were supplied, the approved supplier is entitled to payment. According to the Explanatory Memorandum, this provision has been included because in most situations where a medicare number and name do not correspond, it is simply because a person's medicare card has expired and a new card has not yet been obtained for some reason.

Item 11 inserts **new section 135AAA** which sets out the privacy requirements for doctors, dentists and approved suppliers in relation to medicare numbers and expiry dates provided for the purposes of obtaining pharmaceutical benefits.[22] The privacy requirements apply only where a medicare number / expiry date is provided for defined sole purposes. In relation to a doctor or dentist, these are (**new subsection 135AAA(1):**

- to enable the person to write or communicate a prescription for the supply of a pharmaceutical benefit; and / or
- to enable the medicare number or medicare number and date to be recorded and retained by the person to facilitate the writing of those prescriptions in the future.

In relation to a supplier of pharmaceuticals, these are (**new subsection 135AAA(3):**

- to enable the person to supply a pharmaceutical benefit; and / or
- to enable the medicare number, or medicare number and date, to be recorded and retained by the person in his or her records to facilitate the supply of pharmaceutical benefits in the future; and / or
- to enable the person to record and retain that medicare number, or medicare number and date, in order to complete the written version of a communicated prescription.

The penalty for making, 'directly or indirectly', an unauthorised disclosure or an unauthorised use of that number or that date is 50 penalty units[23] or 2 years gaol, or both. Any disclosure to another person or use of a medicare number or expiry date is 'unauthorised' (**new subsections 135AAA(2) and (4)**) unless it is done:

- by a doctor, dentist or supplier in the performance of the duties, or in the exercise of the powers or functions, of that person under the Act in relation to the Pharmaceutical Benefits Scheme, or
- for the purpose of enabling a person to perform functions under the *Health Insurance Commission Act 1973* in relation to the Pharmaceutical Benefits Scheme.

Note that a person is still liable for the offence after the person ceases to be a doctor, dentist or supplier.

New subsection 135AAA(5) applies similar obligations and liabilities with regard to disclosure and use of information on employees or ex-employees of doctors, dentists and suppliers.

A person who receives unauthorised information about another person's medicare number or expiry date, and directly or indirectly discloses that number or that date to any person, or otherwise makes use of that number or that date, will be guilty of an offence if the person knows or ought reasonably to know that the disclosure or use was unauthorised, **new subsection 135AAA(6)**. The penalty for this offence is 50 penalty units or 2 years gaol, or both.

However, a person or body may disclose a medicare number or expiry date to another person for a specified purpose with the express authority of the person in respect of whom that number was provided, or the person's legal guardian, or another person capable of giving an authorisation (as determined by the Minister under clauses 86D or 88AA): **new**

subsection 135AAA(7). The person receiving this information is obliged not to disclose it except for the purpose for which they received it: **new subsection 135AAA(8).** The penalty for breach this obligation is 50 penalty units or 2 years gaol, or both.

New subsection 135AAA(9) provides that, notwithstanding the various non-disclosure obligations under **new section 135AAA**, a medicare number or expiry date can still be 'communicated' to a court for the purpose of proceedings under **new section 135AAA**.

Item 12 inserts a **new subsection 135AA(5A)** which allows a pharmaceutical entitlements number (defined in item 14 below) applicable to a person to whom a claim for benefits under the Pharmaceutical Benefits Program relates, to be included in a database held by the HIC. The pharmaceutical entitlements number relates to either persons covered by a benefit entitlement card (defined in item 13 below), or persons included within a class determined by the Minister under **new subsection 86E(1)**. According to the Explanatory Memorandum, 'the amendment is of a consequential nature to allow the Health Insurance Commission to continue to store pharmaceutical benefits information. It does not disturb the effect of the current guidelines for storing information developed by the Privacy Commissioner and issued under section 135AA.'

Item 13 defines 'benefit entitlement card' to mean medicare cards (defined in **item 3)** and any concession card which demonstrates a person's eligibility for pharmaceuticals at the concessional PBS rate - ie pensioners, sickness beneficiaries and people with low incomes.[24] Section 135AA provides for the issuing of privacy guidelines by the Commonwealth Privacy Commissioner. The practical effect of the amendment is to allow such guidelines to explicitly cover the issue of benefit entitlement cards.

Item 14 inserts a further definition to **new subsection 135AA(11)** - 'pharmaceutical entitlements number'. This term includes medicare numbers (defined in **item 4)** and the number on any concession card which demonstrates a person's eligibility for pharmaceuticals at the concessional PBS rate. This amendment serves the same purpose as **item 13,** except for numbers rather than cards.

Concluding Comments

The extent of the problems that the proposed legislation seeks to address is unclear. The very fact that it is difficult for pharmacists to routinely detect which consumers are ineligible non-residents means that it is difficult to know how many of these ineligible consumers claim PBS subsidies. Also, even though doctor-shopping is an identifiable problem, the rate of doctor-shopping is already declining steadily (by an average annual rate of 15% since 1995-96) as a result of the HIC Doctor-Shopping initiative.[25] With the increased education and information that practitioners and pharmacists are now receiving, this decrease is likely to continue.

In view of the indeterminate, and probably decreasing, extent of the problems addressed by the legislation, there is some question as to how strongly it is needed. This question becomes even more prominent in the context of the relatively modest projected financial savings to the Commonwealth (an average of $16 million per annum over the next five years - only 0.55% of last year's total PBS expenditure), the extra time and administrative costs to pharmacists.[26] Nonetheless, it is important to note that regardless of the cost-benefit justification for the proposed legislation, the Commonwealth has a legitimate entitlement to pursue measures that allow it to ensure that public moneys are being properly spent. The current lack of an appropriate audit trail to trace this may well be sufficient reason in itself to call for measures such as those proposed in the current Bill.

Concerns about privacy have been expressed in connection with the measures proposed in the Bill. However, the main focus of concern appears to be the possibility that this Bill will set a precedent for use of medicare numbers in relation to the fuller electronic health records strategy. The Australian Medical Association in particular has urged caution in condoning use of medicare numbers as identifiers in this Bill, because it paves the way for their use as the 'unique patient identifier'[27] necessary for accessing patient medication history information in the BMMS, and medical record information in any future Health Connect project.[28] Having the medicare number as the unique patient identifier in the BMMS makes it easier to engage in data-matching between the PBS and medicare databases, for instance. The major concern raised with this relates to the current absence of an overarching, uniform framework for the protection of privacy which will govern all of the electronic health initiatives,[29] making it unclear what uses of data will and will not be permissible. For instance, under the proposed BMMS scheme, could a person's medication history data be used for secondary research, or policy development purposes, or commercial purposes?

Regardless of the merit of these wider concerns about the absence of a uniform privacy framework for e-health initiatives, when the focus is confined solely to the provisions and operation of the current Bill, the substance of privacy concerns is arguably limited. At most, the risk will be that pharmacists and/or HIC officers can reconstruct a consumer's medical conditions from their pharmaceutical records. While this is a legitimate concern, given that one's medical condition is significantly personal and information about it ought to be protected as a matter of privacy, pharmacists and HIC officers are already likely to have this capacity, to the extent that medical conditions can reliably be reconstructed from medication histories. Many pharmacists keep electronic records of the pharmaceuticals purchased by their customers. Perhaps the concern would be greater if records were networked between pharmacies, and *any* pharmacist could access anyone's medication history via a unique identifier. However, the present Bill does not contain any measures proposing that computer records will be networked between pharmacies.

Another, unrelated, issue arising in the Bill is that pharmacists will be liable to forego their subsidy reimbursement from the HIC if there are discrepancies in relation to the medicare number associated with any of the claims they place with the HIC. The pharmacist will be

at risk of non-reimbursement in cases of fraud, for instance, even when the pharmacist has acted in good faith and taken all reasonable care.

Endnotes

1 Patients may pay more than the copayment where a PBS item is priced above the benchmark price for different brands of the same drug, or the benchmark price for a particular therapeutic group of drugs. The Government subsidy is limited and any difference in price must be met by the patient.

2 All pensioners continue to receive a pharmaceutical allowance of $2.70 per week payable fortnightly, or $140.40 per year, to help defray their out-of-pocket pharmaceutical expenses.

3 *Australia's Health 2000*, Australian Institute of Health and Welfare.

4 *Annual Report 1998-99*, Health Insurance Commission.

5 Health Access and Financing Division, Department of Health and Aged Care, http://partners.health.gov.au/haf/branch/pbb/phbensch.htm.

6 This figure has dropped from 13240 in 1995-96, mainly as a consequence of information, education and consultation initiatives undertaken by the HIC through their Doctor Shopping Project.

7 *Annual Report 1998-99*, Health Insurance Commission, p. 85.

8 Currently, pharmacists supply PBS-subsidised drugs to customers at an initial loss to themselves. They later enter a claim for reimbursement to the HIC (which requires details of the transaction including prescription, with name and address details). If the HIC finds discrepancies or deficiencies in information supplied, they return the queried details to the pharmacist for rectification, if possible. In a significant number of cases, however, the details cannot easily be verified or rectified by the pharmacist, in which case they are at risk of not being reimbursed by the HIC for those claims.

9 *Annual Report 1998-99*, Health Insurance Commission, p. 88.

10 The HIC already monitors this, and it does this by counting the frequency of purchases by the same name (at the same address). However, because there can be discrepancies between pharmacists in the way they record eg., a person's name, (John Douglas Smith, John Smith, Douglas Smith), a series of purchases by the same person may not necessarily register as so at the HIC.

11 This possibility was described by an officer of the HIC via electronic communication.

12 At the moment, doctors in the community will generally be unaware of the medication that their patient may have been taking in hospital, and hospitals unaware of medication prescribed by their doctors. The collection of this information, and its on-line availability will reduce the incidence of contra-indicated drug use.

13 Department of Health (UK) 1999 *Information for Health: an information strategy for the modern NHS, 1998-2005* http://www.nhsia.nhs.uk/strategy/full/contents.htm.

14 Explanatory Memorandum, item 5 (no page number).

15 An 'eligible person' is defined in the *Health Insurance Act 1973* as an Australian resident or diplomatic staff and their families for which Australia has agreed to treat as an Australian resident for the purposes of entitlement to PBS.

16 The pharmacist is at risk of loss of reimbursement from the HIC if the new number is incorrect, so there is an incentive for them to take as much care as possible to verify the number on the prescription, or customer cited number, and the number in their own computer records, if they keep it.

17 Such persons are to be determined by the Minister: **new subparagraph 86D(1)(b)(iii**).

18 The doctor or dentist must have themselves been authorised to inform the supplier of the medicare number by a person to whom the number corresponds, or who is the person's legal guardian, or another person capable of giving an authorisation, **new subsection 88(3B).**

19 Note however that under guidelines issued by Pharmacy Guild, only professional pharmacists should have access to computerised records.

20 These persons may be required to produce relevant proof of entitlement, eg passport, permanent residency documentation.

21 This 60 day limit can be varied upwards or downwards by Ministerial determination: paragraph 99(8)(e). **New subsection 99(9)** provides that such determinations are disallowable instruments.

22 Existing section 135A already requires persons undertaking duties under the Act or the *Health Insurance Commission Act 1973* not to disclosure certain information except where authorised under these Acts. The Explanatory Memorandum states that 'language used in new section 135AAA is consistent with that used in existing provisions such as section 135A.' Binding privacy guidelines in relation to healthcare cards have also been developed by the Commonwealth Privacy Commissioner under section 135AA of the Act: see http://www.privacy.gov.au/pdf/p6_4_69.pdf

23 Currently $5 500, section 4AA of the *Crimes Act 1914*.

24 Subsection 84(1) of the National Health Act defines concessional beneficiary.

25 *Annual Report 1998-99*, Health Insurance Commission, p. 83.

26 Although it is difficult to estimate these, the Explanatory Memorandum suggests that the main time costs would occur through obtaining medicare numbers from customers and getting authorisation to store them. It also acknowledges some software updating may be required. There may also be some time cost involved in having to handwrite medicare numbers on the prescriptions.

27 In order to enter, access and keep track of information about a particular person's medication or medical history in an electronic database, it is necessary to have some code or identifier which can be uniquely assigned to that person. A unique patient identifier allows information about a particular person to be matched, compared and cross-referenced.

28 See Dr Kerryn Phelps, 'AMA Warns: Medicare Numbers the New "Australia Card"', 13 September 2000, http://www.domino.ama.com.au/dir0103/MediaRel.nsf/28e36caf74bf9d484a2569650021cf77/1f114d131ac434524a256959007e0c64?OpenDocument. As noted in the Main Provisions section of this Digest, the Bill includes new privacy provisions. It is likely that the BMMS legislation (not yet introduced) with also include privacy elements.

29 See, for example, "AMA push for Privacy Legislation" *Australian Doctor*, 1 September 2000, p. 7; Dr Kerryn Phelps, 'AMA Warns: Medicare Numbers the New "Australia Card"', 13 September 2000; "Medicare Database Sparks Fears for Privacy", *Sydney Morning Herald* 15 September 2000; and Kerryn Phelps, "Enhancing Privacy and Confidentiality in the World of E-health", http://www.domino.ama.com.au/Dir0103/WhosWho.nsf/cb4834a4ac5a2ba24a2564b00048928c/e8b394fe152a4d784a25694b0007efbc?OpenDocument.