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# Health Legislation Amendment Bill (No 2) 2001

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# Health Legislation Amendment Bill (No 2) 2001

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# Health Legislation Amendment Bill (No 2) 2001

**Date Introduced:** 5 April 2001

**House:** House of Representatives

**Portfolio:** Health and Aged Care

**Commencement:** On Royal Assent. A few items have a retrospective commencement, and these will be indicated in the text below.

## Purpose

The Bill contains amendments in a number of separate areas of health legislation, chiefly:

- appointments to the board of the Australian Institute of Health and Welfare
- changing the name of the Health Ethics Committee of the Australian Institute of Health and Welfare
- the recognition of specialist medical practitioners
- payment of Medicare benefits where cheques made out to general practitioners are not presented within a specified period of time, and
- minor changes to the 30 per cent rebate on private health insurance scheme.

## Background

As the amendments have no central theme, the background to each set of amendments is discussed below in the Main Provisions section.

## Main Provisions

### *Australian Institute of Health and Welfare Act 1987*

**Proposed Schedule 1** amends the *Australian Institute of Health and Welfare Act 1987*('the AIHW Act').

The Australian Institute of Health and Welfare (AIHW) is established under the AIHW Act. It conducts health-related and welfare-related research, including gathering information, producing statistics, and publishing reports. The AIHW may also make recommendations to the Minister on the prevention and treatment of diseases, and the improvement and promotion of health and health awareness.

#### Appointment of Board members

Currently, the Board of the AIHW consists of fifteen members. The first eleven are the Chairperson of the AIHW, the Director of the AIHW, a member of the staff of the AIHW, a member nominated by the Australian Health Ministers' Advisory Council, a member nominated by the Standing Committee of Social Welfare Administrators, a representative of the State Housing Departments, the Australian Statistician, the Secretary to the Department of Health and Aged Care, and three other members nominated by the Minister. The last four are:

- a person who has knowledge of the needs of consumers of health services
- a person who has knowledge of the needs of consumers of welfare services
- a person who has knowledge of the needs of consumers of housing assistance services, and
- a person who has expertise in research into public health issues.

Each of these four persons is nominated by the Minister after recommendation by a relevant representative or peak body.[1]

Under the Bill, the first eleven Board members will not change. The last four members with specific expertise will also not be altered. However, the bodies that can recommend a nomination to the Minister are proposed to be prescribed by regulation rather than listed in the Schedule to the AIHW Act (**items 1 and 2 of Schedule 1**). Further, the Minister will not be required to nominate a person recommended by the bodies prescribed in the regulations, but may depart from their recommendations.

The Minister for Employment Services, in his second reading speech, states that this 'will ensure a greater flexibility in the appointments'.[2] It will also ensure greater ministerial control over appointments to the AIHW. Currently, the Minister may only appoint as these four members persons whose nomination has been recommended by a relevant body.

Under the Bill, the Minister will have to seek recommendations but will not be required to nominate a person who has been recommended.

These changes will apply only to appointments made after the Bill commences (**item 4 of Schedule 1**).

### Ethics committee name change

The AIHW currently has an ethics committee known as the 'Health Ethics Committee of the Australian Institute of Health and Welfare'. This title omits reference to the AIHW's welfare-related responsibilities, which the AIHW has had since 1992.[3] Accordingly, the Bill proposes to rename it the 'Australian Institute of Health and Welfare Ethics Committee' (**items 5 and 6 of Schedule 1**). No changes to the functions or composition of the ethics committee are proposed.

**Item 9 of Schedule 1** reappoints each current member of the Health Ethics Committee to the new Australian Institute of Health and Welfare Ethics Committee. The appointments will continue until the date when the current member's term would be due to expire if the ethics committee had not undergone a name change. This provision is technically required because the change of the ethics committee's name would otherwise require a wholly new committee to be appointed.

### Confidentiality

It is a criminal offence under the AIHW Act for any person to disclose confidential information or documents obtained by the AIHW.[4] However, disclosure is permitted if it will not identify the information subject, or if the ethics committee gives written permission. The ethics committee may currently give permission only in relation to 'health-related information and statistics'.[5] **Item 8 of Schedule 1** proposes that permission may relate also to 'welfare-related information and statistics'. This amendment reflects the AIHW's dual functions relating to health and to welfare.

## *Health Insurance Act 1973*

**Proposed Schedule 2** amends the *Health Insurance Act 1973* (the HI Act), in relation to the recognition of specialists and 'pay doctor via claimant' Medicare rebate cheques.

### Recognition of specialist medical practitioners

The Bill proposes to 'simplify the process for recognising medical practitioners as specialists' in order to generate 'administrative efficiencies'.[6] Currently, a medical practitioner may be recognised as a specialist by applying in writing to the Minister and paying the prescribed fee. If the medical practitioner meets the criteria, the Minister may issue a determination that he or she is a recognised specialist. Alternatively, the Minister

may refer the question whether a medical practitioner should be recognised as a specialist to the Specialist Recognition Advisory Committee in the relevant State or Territory.[7]

Under the Bill, the relevant specialist organisation may simply give a notice to the Managing Director of the Health Insurance Commission (HIC) that a particular person is qualified as a specialist (**proposed new section 3D**). However, this only applies to medical practitioners who have qualified after completing a course of study and becoming fellows of the relevant specialist organisation.

Applicants who claim to qualify because they are registered as specialists under a State or Territory law will not have access to any simplified procedure. They will continue to have to apply to the Minister for recognition (**proposed subsection 3DB(1)**). Applicants who claim to qualify after completing a course of study and becoming fellows will also have the option of applying to the Minister for recognition (**proposed subsection 3DB(2)**). In practice, this procedure would be unlikely to be used unless the relevant specialist organisation failed to give a notice relating to a particular person.

The criteria for recognition as a specialist remain unchanged, as does the date from which recognition as a specialist takes effect. Existing regulations prescribing relevant specialist organisations, qualifications and application fees will continue in effect (**item 6 of Schedule 2**).

However, the circumstances in which recognition as a specialist may cease are expanded under the Bill. Currently, under the HI Act, recognition ceases only if a specialist ceases to practice in or to be domiciled in Australia. The Bill proposes that recognition will also cease if the medical practitioner requests this (**proposed paragraph 3DA(3)(b) and subsection 3DC(4))**. Significantly, where recognition was granted by a notice from the relevant specialist organisation to the HIC, it can be revoked by the relevant specialist organisation giving another notice to the HIC stating that the medical practitioner no longer meets the criteria for the specialty (**proposed paragraph 3DA(3)(a)**).

### Direct payment of Medicare benefits to doctors

This Bill also proposes a change to the way Medicare benefits are payable. At present, Medicare benefits are payable to the person who incurs the medical expense (that is, the patient). There are various methods by which Medicare benefits may be paid, including cash in hand and electronic transfer into the patient's bank account. Where the patient has not paid the account, he or she is not entitled to the Medicare benefit, but may be given on request a cheque made out to the practitioner who rendered the medical service. Although referred to as 'pay doctor via claimant' cheques, they may in fact be issued for certain other professional services, including diagnostic imaging, rendered by a medical practitioner, dentist, optometrist, or pathologist.[8]

In some cases, the patient does not forward the cheque to the practitioner in a timely manner, leaving medical professionals with long delays or ultimately bad debts for medical services already provided. **Item 7 of Schedule 3** will allow the HIC to pay

Medicare benefits directly to general practitioners where 'pay doctor via claimant' cheques are not presented within 90 days of issue. These payments may be made by electronic transmission directly into the medical practitioner's bank account, or by other means. This amendment will apply to cheques given to the patient after 1 July 2001, or after Royal Assent to this Bill if that date is later than 1 July 2001 (**item 8 of Schedule 3**).

Once the Medicare benefit has been paid directly to the general practitioner, the patient's request for a 'pay doctor via claimant' cheque is taken to have been 'withdrawn', and the patient is not entitled to subsequently request another cheque for the same services (**proposed subsection 20(4)**). Clearly, removing the right to request another cheque is necessary to prevent double dipping. However, it is not clear what effect the withdrawal of the initial request will have, as the cheque will have already been issued by the HIC. The provision does not have the effect of cancelling the cheque which has already been issued and given to the patient. The Medicare Benefits Branch of the Department of Health and Aged Care has advised that the HIC will have an administrative system in place which will automatically cancel the 'pay doctor via claimant' cheques 90 days after issue and pay the general practitioner directly at that time.[9]

Importantly, this amendment will only permit payments directly to general practitioners, not to other medical practitioners, dentists, optometrists, or pathologists providing professional services. No explanation is given in the *Explanatory Memorandum* or the second reading speech as to why this is. In 1999, the Government made a commitment to general practitioners to investigate the problem of unpresented cheques.[10] One of the recommendations of the Pay Doctor Cheque Working Group was that 'pay doctor via claimant' cheques be cancelled 90 days after issue and be re-issued to the general practitioner.[11] However, as such cheques may also be issued for other professional services, the problem could conceivably arise also in relation to medical services rendered by any medical practitioner, dentist, optometrist, or pathologist. Even if these other professions experience problems with unpresented cheques only occasionally, it would nevertheless be of benefit to express the amendment in general terms, rather than restricting it to general practitioners.

## *Private Health Insurance Incentives Act 1998*

**Proposed Schedule 3** amends the *Private Health Insurance Incentives Act 1998* (the PHII Act). The PHII Act establishes the 30 per cent rebate on private health insurance. There are two schemes for the operation of the rebate:

- the incentive payments scheme, under which a person pays the private health insurance premium up front, then seeks reimbursement of the rebate amount from the HIC, and
- the premiums reduction scheme, under which a person pays a reduced private health insurance premium and the health fund then seeks reimbursement of the rebate amount from the HIC.

### Low claims and late claims

Under current arrangements, health funds must submit their claims for reimbursement within seven days after the end of the month.[12] Where claims for reimbursement are made after this period, or a health fund submits a claim for less than the full amount and later wishes to recover the difference, there is no statutory entitlement to recover the amounts from the HIC. Rather, the only recourse is to seek an 'act of grace' payment, which is entirely within the discretion of the Minister for Finance and Administration.[13]

The Bill proposes that health funds may apply to the Managing Director of the HIC for additional reimbursement where:

- they initially claimed an amount below the full amount of the reduction in premiums (**proposed section 15-21**), or
- the claim is lodged later than the seven day notification period (**proposed section 15-22**).

Applications for late or low claims must contain an explanation for the reason the claim was initially submitted for less than the full amount, or was submitted late (**proposed subsections 15-23(3) and (4)**). Claims may be made up to three years after the month in which the entitlement to reimbursement arose (**proposed subsection 15-23(2)**). Presumably, this will allow health funds to now apply for claims back to the commencement of the rebate scheme.

The Managing Director of the HIC must consider whether, having regard to the explanation given, it would be reasonable to pay the additional amounts sought (**proposed subsection 15-24(1)**). The Managing Director has discretion to pay all or only part of the additional amount sought, or not to pay any additional amount, depending on what he or she considers would be reasonable. If the Managing Director does not give notice of his or her decision within three months, he or she is taken to have decided to grant the application for an additional payment (**proposed subsection 15-24(5)**). Health funds have a right to request the HIC to reconsider a decision not to grant additional payments sought (**item 2 of Schedule 3**).

### Premium reductions

Calculation of the premium reduction under the premium reductions scheme is amended to make it consistent with the amount of the reduction available under the incentive payments scheme.[14] Currently, under section 4-10, the reduction available under the incentive payments scheme is either:

- 30 per cent of the premium, if the private health insurance policy is not a registered or registrable one, or
- the greater of 30 per cent of the premium and the incentive amount,[15] if the private health insurance policy is registered or registrable.

Only 'appropriate' private health insurance policies are eligible to be registered by the HIC.[16] Those people who are eligible to apply for registration of a policy are those who are personally covered by the policy, or who have taken out a policy solely for their dependant children, or for whom the policy is a fringe benefit of employment.[17]

However, under the premium reductions scheme, the amount of the reduction is the greater of 30 per cent of the premium and the incentive amount, regardless of whether the policy is registered or registrable. With the amendments made to section 12-5 by **items 7, 8, 9 and 10 of Schedule 3**, this will continue to be the case only for private health insurance policies which are registered or registrable. Policies which are not registered or registrable will be eligible only for a 30 per cent reduction of the premium. This will bring the calculation of the reduction under the premium reductions scheme into line with the incentive payments scheme.

These amendments are backdated to 15 December 1998, the date on which the PHII Act commenced.

## Concluding Comments

Most of the amendments proposed in the Bill are of a minor or technical nature. Issues worthy of consideration, as discussed above, include:

- the increase in ministerial control over some appointments to the AIHW, at the expense of representative and peak bodies
- that specialists who become recognised as specialists after a notice is given to the HIC by the relevant specialist organisation are vulnerable to have their recognition revoked by the specialist organisation if, in its opinion, they cease to meet the criteria for the relevant specialty, and
- that payments made directly to doctors by the HIC if a 'pay doctor via claimant cheque' is not presented within 90 days only apply to general practitioners, not other medical professionals.

## Endnotes

1 The designated representative bodies are listed in the Schedule to the *Australian Institute of Health and Welfare Act 1987*. Currently, they are the Australian Council of Social Service, the Australian Hospital Association, Australian Medical Association, Australian Pensioners' and Superannuants' Federation, Australian Private Hospitals' Association, Brotherhood of St

Laurence, Catholic Social Welfare Commission, Consumers' Health Forum of Australia, National Shelter, and Public Health Association of Australia.

2 Mal Brough, Minister for Employment Services, Second Reading Speech on the Health Legislation Amendment Bill (No 2) 2001, House of Representatives, *Hansard*, p. 26535, 5 April 2001.

3 When subsections 5(1AA) and 5(1A) of the *Australian Institute of Health and Welfare Act 1987* were inserted by the *Australian Institute of Health Amendment Act 1992*.

4 Section 29 of the *Australian Institute of Health and Welfare Act 1987*.

5 Subsections 29(2A) and (2B) of the *Australian Institute of Health and Welfare Act 1987*.

6 Mal Brough, Minister for Employment Services, Second Reading Speech on the Health Legislation Amendment Bill (No 2) 2001, House of Representatives, *Hansard*, p. 26535, 5 April 2001.

7 Paragraphs 3D(1)(c) or (d) of the *Health Insurance Act 1973*.

8 Definition of 'professional service' in subsection 3(1) of the *Health Insurance Act 1973*.

9 E-mail correspondence with the Department of the Parliamentary Library, 4 May 2001.

10 The current *Memorandum of Understanding* between the Commonwealth and the Royal Australian College of General Practitioners, the Rural Doctors Association of Australia and the Australian Divisions of General Practice, effective from 1 July 1999-30 June 2002, clause 13 commits to the establishment of a working group to report by 1 January 2000 on the issue of 'pay doctor via claimant' cheques.

11 General Practice Financing Group, Final Minutes of Meeting, Wednesday 1 March 2000, http://www.health.gov.au/haf/mou/gpfg1mar.htm (accessed 26 April 2001).

12 Section 15-10 of the *Private Health Insurance Incentives Act 1998* and definition of 'notification period' in section 20-5.

13 Section 33 of the *Financial Management and Accountability Act 1997*. See also Department of Finance and Administration, *Act of Grace Payments*, http://www.dofa.gov.au/publications/act_of_grace_payments.html (accessed 30 April 2001).

14 See section 4-10 of the *Private Health Insurance Incentives Act 1998*.

15 The incentive amount is a fixed amount set by section 20-10 of the *Private Health Insurance Incentives Act 1998*. The amount varies according to the number of people covered by the policy, and whether the policy provides hospital, ancillary or hospital and ancillary cover.

16 These are policies which provide hospital cover, ancillary cover or combined cover for Australian residents and certain other persons, such as Australian diplomatic staff and their families overseas: see definition of 'appropriate private health insurance policy' in section 20-5 of the *Private Health Insurance Incentives Act 1998*and 'eligible person' in sections 3, 6 and 7 of the *Health Insurance Act 1973*.

17 Section 11-10 of the *Private Health Insurance Incentives Act 1998.*