



National Health Amendment (Prostheses) Bill 2004

Luke Buckmaster and Angela Pratt
Social Policy Section

Contents

Purpose.....	1
Background.....	1
Schedule 1—Changes to Coverage of Prostheses by Health Funds	1
What are prostheses?	1
History of policy	2
Basis of policy commitment	2
Figure 1: Prostheses Services and Benefits 1997–98 to 2002–03	3
Details of proposed measure.....	4
Purchaser-provider agreements	5
Implementation arrangements	6
Cost	6
Position of significant interest groups	6
Analysis and commentary.....	7
Health insurance premiums	8
Improved choice for patients.....	9
Improved administrative arrangements	10
ALP/Australian Democrat/Greens policy position/commitments	10
Schedule 2—technical amendments	10
Main Provisions	11
Schedule 1— Changes to Coverage of Prostheses by Health Funds	11

Schedule 2—technical amendments	13
Concluding Comments.....	13
Endnotes.....	15

National Health Amendment (Prostheses) Bill 2004

Date Introduced: 1 December 2004

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Sections 1 to 3 and anything else not otherwise specified commence on the Bill receiving Royal Assent, Schedule 1 commences on a single day to be fixed by Proclamation, and Schedule 2, commences (retrospectively) 1 July 2004.

Purpose

This Bill proposes to amend the *National Health Act 1953* to require registered health benefit organisations (health funds) to offer a no gap and gap permitted range of prostheses as part of hospital procedures for which a Medicare benefit is payable.

Schedule 1 of the Bill proposes to amend the *National Health Act 1953* to allow the Minister for Health and Ageing to determine in writing:

- no gap prostheses—and the benefit amount for each no gap prosthesis; and
- gap permitted prostheses—and the minimum and maximum benefit amounts for each gap permitted prosthesis.

Schedule 2 of the Bill proposes several minor consequential amendments to legislation related to private health insurance (PHI).

Background

This Bill was originally introduced on 12 August 2004 but lapsed when Parliament was prorogued on 31 August, prior to the federal election. The Bill has been reintroduced with some minor modifications, the most significant of which is a provision that enables that health funds benefit from the capacity of the public hospital system to negotiate lower prices for prostheses services.

Schedule 1—Changes to Coverage of Prostheses by Health Funds

What are prostheses?

Prostheses are artificial devices that are attached to the body as an aid, or substitute for body parts that are missing or non-functional. Prostheses include bridges, dentures, artificial parts of the face, artificial limbs, hearing aids, and implanted pacemakers.¹ The amendments to the *National Health Act 1953* proposed by Schedule 1 of this Bill relate only to *surgically implanted prostheses*—that is, prostheses which are implanted during a

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

surgical procedure performed in a hospital. These include a wide range of aids and devices, such as heart pacemakers, cochlear implants, artificial hips, screws used in joint or bone reconstructions and repairs, grommets, and vein stents.

There are currently around 9 000 prosthetic items listed on the Prostheses Schedule under the *National Health Act*.² As explained below, the cost to health funds of providing surgically implanted prostheses has grown significantly over recent years, as a result of advances in medical technology and new prostheses and prosthetic devices becoming available.

History of policy

Government plans to introduce changes to the manner in which health funds cover the cost of surgically implanted prostheses were originally announced in April 2003, as part of a range of measures aimed at improving the regulation of health funds, and introducing further competition to the PHI industry. Announcing the government's plans to make changes in this area, the then Minister for Health and Ageing, Senator Kay Patterson said that the proposed changes were aimed at reducing the costs of prostheses to the PHI industry.³ The Explanatory Memorandum accompanying the Bill further notes that the measures proposed by the Bill will offer greater choice to consumers of PHI, and be less administratively cumbersome than existing arrangements in relation to coverage of prostheses by health funds.⁴

The measures proposed by the Bill have are the product of a consultation process between the government and health funds, hospitals, state and territory governments, prostheses suppliers, consumers and other interested parties. The consultation process included a Prostheses Strategic Review Forum, held in March 2002, following which the Department of Health and Ageing sought submissions from stakeholders on possibilities for reform to the existing prostheses arrangements.⁵ The health funds and the public and private hospitals prepared a joint submission.⁶ The measures proposed by this Bill are largely based on the joint submission from the health insurers and hospitals.⁷

Basis of policy commitment

The main explanation provided by the government for proposing new PHI arrangements for prostheses is the growing cost to health funds of prostheses and medical devices over the past decade. In seeking to quantify the impact of prostheses services on health funds, the Explanatory Memorandum to the Bill notes that:

- currently prostheses benefits account for 12 per cent of total hospital benefits, up from 1.7 per cent in 1989-90
- total benefits paid by health funds for prostheses services in 2003-04 was over \$647 million—on average, a 29 per cent increase when compared with 2001-02, and

Warning:

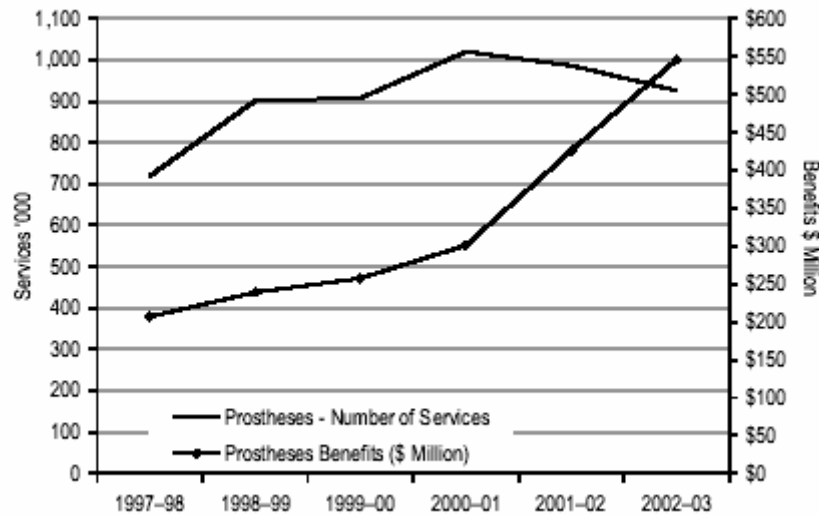
This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

- current rates of growth in prostheses costs are estimated to be resulting in 2% growth in PHI premiums each year.⁸

The increase in benefits for surgically implanted prostheses paid out by health funds over the last five years is shown in Figure 1.

Figure 1: Prostheses Services and Benefits 1997–98 to 2002–03⁹



Prostheses costs are said to be significantly connected with premium growth due to unique arrangements in place in relation to coverage of prostheses services by health funds. Under these arrangements, health funds are required to meet 100 per cent of the cost of all surgically implanted prostheses and other medical devices listed on the government's Prostheses Schedule.

The government argues that, by requiring health funds to meet the total cost of prostheses services, current arrangements do not provide sufficient incentives for containing the cost of such services. By enabling private health insurers to offer a product that may include a co-payment or gap for prosthetic items, the government hopes to promote a stronger emphasis on evidence-based assessment of safety, efficacy and cost-effectiveness, and hence on containing the cost of prostheses to the health funds.

The government also notes that current arrangements for coverage of prostheses are unique in that no other item or service covered by PHI fails to offer consumers the choice to not insure for more expensive or unproven items—that is, to offer the choice between no gap and gap permitted coverage. This measure therefore proposes to remedy this situation by enabling health funds to offer consumers the option of choosing a health insurance product that may include co-payments or gaps for prosthetic items.

Further, the government argues that current arrangements in relation to prostheses place an unreasonable administrative burden on health funds, hospitals and suppliers of prostheses,

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

given that, for example, the list of prostheses currently includes over 9,000 items. The argument is also made that current arrangements also make pricing disputes between funds, suppliers and hospitals more likely. As explained below, the Bill proposes to give the Minister the power to determine which prostheses will be covered under no gap arrangements (and what the benefit amount for no gap prostheses will be), and which prosthetic devices can be covered under gap permitted arrangements (and what the minimum and maximum benefit amounts for each gap permitted prosthesis will be).

By transferring the responsibility for price-setting of prostheses to the Minister, the measures proposed by the Bill seek to streamline the current administrative arrangements whereby health funds, hospitals and suppliers effectively have to negotiate with one another over prices and benefit arrangements. The health funds and hospitals have complained that the existing arrangements are cumbersome, impractical and inefficient.¹⁰

Details of proposed measure

As noted above, currently health funds are required to meet 100 per cent of the cost of all surgically implanted prostheses and other medical devices listed on the government's Prostheses Schedule. The Prostheses Schedule is unique within regulations related to the PHI industry in that it prescribes actual medical items that must be funded by health funds.

This Bill proposes to amend the *National Health Act 1953* to change these arrangements through introduction of a requirement for health funds to offer a no gap and gap permitted range of prostheses as part of hospital procedures for which a Medicare benefit is payable.

The Bill also proposes to amend the *National Health Act 1953* to allow the Minister for Health and Ageing to determine in writing:

- no gap prostheses—and the benefit amount for each no gap prosthesis, and
- gap permitted prostheses—and the minimum and maximum benefit amounts for each gap permitted prosthesis.

This means that the responsibility for decisions in relation to listing and benefit levels for prostheses items that health funds will be required to cover will rest with the Minister.

Nevertheless, as the Minister for Health and Ageing, Mr Abbott, explained in his Second Reading Speech for this Bill, when making such determinations, the Minister 'may take into account advice from experts in the field of prostheses and in the health insurance industry'.¹¹ This provision will be supported by an existing advisory structure, featuring a Prostheses and Devices Committee comprising clinicians and representatives of health funds, prostheses suppliers, hospitals and consumers.¹² Ministerial determinations made under this Bill will be legislative instruments.

Additional important details of this proposed measure include:

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

- health funds will still be permitted to provide cover for prostheses not listed on the no gap or gap permitted prostheses determination,
- health funds will still be permitted to provide cover for prostheses under their tables of ancillary health benefits,
- health funds and public hospitals will be allowed to agree on a benefit amount below the benefit amount for a no gap prosthesis or below the minimum benefit amount for a gap permitted prosthesis. This provision recognises that health funds benefit from the capacity of the public hospital system to negotiate lower prices for prostheses services, and
- health funds will still be required to offer at least one hospital cover policy covering *all* episodes of hospital treatment, including prostheses services (under paragraph (bd), Schedule 1 of the *National Health Act 1953*). At the same time, health fund members will retain the ability to choose to pay lower premiums for lesser coverage.

Purchaser-provider agreements

The Bill also proposes to insert a new section into the *National Health Act 1953* relating to prostheses benefits under hospital purchaser-provider agreements (HPPA).¹³ This refers to agreements between health funds and hospitals or day facilities over benefits paid for a particular medical procedure. The Bill proposes to specify that arrangements for payment for no gap and gap permitted prostheses where these are provided as part of an episode of treatment covered by a HPPA:

- are aligned with the benefit amounts determined by the Minister (see above); and
- are structured such that they either cover the full cost of treatment (no gap coverage) or restrict the amount of out-of-pocket expense to the patient to a specified level (gap permitted coverage).¹⁴

These arrangements will apply to HPPAs that are in place both immediately before and after the commencement of this Bill.

The Bill also proposes to amend Schedule 1 of the *National Health Act 1953* to require health funds to provide cover for prostheses in relation to in-hospital procedures on the MBS where the treatment is *not* covered by a HPPA. As with the proposed arrangements for prostheses provided under HPPAs, this amendment also specifies benefit amounts for no gap and gap permitted prostheses cover.¹⁵ It also provides that prostheses benefits in such situations will be calculated differently for a public hospital than for a private hospital or a day hospital facility. This appears to be in recognition of the fact that, as noted above, health funds benefit from the capacity of the public hospital system to negotiate lower prices for prostheses services.

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

Implementation arrangements

The provisions proposed in Schedule 1 are due to commence on a single day to be fixed by Proclamation. However, if any of the provision(s) do not commence within the period of 9 months beginning on the day which the Bill receives the Royal Assent, they commence on the first day at the end of that period. This provides health funds with a period of nine months from the day on which the Bill receives Royal Assent, in which to implement the provisions of Schedule 1. The original version of the Bill provided for a period of six months before the Act would commence in the absence of proclamation. The Explanatory Memorandum accompanying this Bill states that the revised implementation timeframe is to ensure that sufficient time is allowed for ‘industry’ (meaning health funds, prostheses suppliers and hospitals) to ‘make arrangements to adjust to the prostheses arrangements’.¹⁶

Cost

The government expects that the new prostheses arrangements will result in a reduction in pressure on private health fund premiums and hence in the growth of government outlays on the 30 per cent Private Health Insurance Rebate (PHIR). The Explanatory Memorandum estimates savings from the measure at \$4.3 million in 2005-06 and \$20.6 million in 2006-07, though detailed costings were not provided.¹⁷

It should be noted that any such costing would need to include a range of complex factors including estimates of:

- the future cost of prostheses services to health funds had the measure not been introduced,
- the impact of the measure on the future cost of prostheses services to health funds, and
- the future cost of PHI premiums.

In the absence of more information about how the government’s costings for the measures proposed by the Bill were arrived at, it is not possible to provide detailed commentary on the government’s costing of this measure.

Position of significant interest groups

The changes to arrangements for private health insurance coverage of surgically implanted prostheses proposed by this Bill have had a mixed response from significant industry groups.

There appears to have been consensus within the health sector for some time that the arrangements under which private health insurance for surgically implanted prostheses is currently provided—whereby surgically implanted prostheses are covered under ‘no gap’ arrangements, or, in other words, health funds meet 100 per cent of the cost of surgically implanted prostheses—are unsatisfactory. As discussed above, the rising costs of providing prostheses have placed upward pressure on private health insurance premiums.

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

Further, hospitals and health funds have argued that the current administrative arrangements through which benefits are negotiated between health funds and hospitals, and through which various prostheses are classified for the purposes of determining benefits, are cumbersome, impractical, administratively onerous, and inefficient.¹⁸

Subsequently, as noted above, in 2002 the Australian Health Insurance Association (AHIA—the representative group for the private health insurance funds) and public and private hospitals prepared a joint submission to the Department of Health and Ageing on the need for reform of prostheses arrangements.¹⁹ The changes to health insurance coverage of surgically implanted prostheses proposed by this Bill are largely based on the proposals contained in the health insurers' and hospitals' submission. Accordingly, these groups have been supportive of the changes proposed by the Bill. AHIA Chief Executive Officer Russell Schneider, for example, argues that the proposed changes will be beneficial in that they will 'force manufacturers to lower their prices because doctors would be more likely to use the gap-free device'.²⁰ In other words, according to Mr Schneider, doctors (and patients) will be more likely to choose no gap prostheses wherever possible (because these will be cheaper for the patient), and the competitiveness of the no gap 'market' will subsequently keep prices down. Thus, Mr Schneider argues that the changes proposed by the Bill will be favourable to private health insurance consumers. On the other hand, however, the Australian Consumers' Association has expressed concern that patients may feel pressured into choosing the more expensive, gap permitted items.²¹

The Medical Industry Association of Australia, which represents the suppliers of prostheses, has cautiously welcomed the proposed new arrangements for prostheses coverage as 'constructive and practical' reform of the existing arrangements.²² Like the health insurers and the hospitals, the Medical Industry Association took the view that reform of prostheses arrangements was necessary, and worked with the government and other stakeholders on proposals for new arrangements.²³ Further, the Medical Industry Association points out that 'increasing utilisation of prostheses delivers cost savings to the health care sector, as growth in the use of prostheses and other innovative medical technologies has clear links to faster surgical recovery times, shorter hospital bed stays, improved quality of life and increased productivity'.²⁴

However, the Medical Industry Association has also expressed misgivings about the effect of the new arrangements on patients, as the new arrangements will mean the introduction of patient out-of-pocket costs for some surgically implanted prostheses.²⁵ The Australian Consumers' Association, while acknowledging the spiralling costs of prostheses to health insurance funds,²⁶ has previously expressed similar concerns.²⁷ The issue of out-of-pocket costs is discussed further below.

Analysis and commentary

The government has advanced three main arguments in support of the measures proposed by Schedule 1 of this Bill:

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

- that the measures will make a ‘significant contribution towards reducing pressure on health insurance premiums’, and subsequently, the growth in government outlays on the 30 per cent PHIR rebate
- that the measures will improve choice (between different levels of prostheses cover) for patients, and
- that the measures contained in the Bill will improve the efficiency and practicality of the current arrangements under which private health insurance funds provide coverage for surgically implanted prostheses.

Health insurance premiums

As noted above, according to the Explanatory Memorandum which accompanied the Bill, prostheses benefits account for approximately 12 per cent of the total hospital benefits paid out by health insurance funds each year (up from less than 2 per cent 15 years ago), and the current rates of growth in prostheses costs are estimated to be contributing significantly towards increases in costs of health insurance premiums.²⁸ Accordingly, by providing health insurance funds with the option of providing both gap *and* no gap cover for surgically implanted prostheses, to bring coverage of surgically implanted prostheses into line with other medical procedures which private health insurance provides cover for (as opposed to no gap cover being compulsory, and health funds effectively having to pay 100 per cent of the costs of surgically implanted prostheses, as is currently the case), the government anticipates that pressure on health insurance premiums will be reduced.

It is difficult to estimate the likely impact of the measures proposed by the Bill on future premium prices, because until the measures come into effect, it will not be possible to assess their impact on the cost to health funds of providing prostheses services (since, for example, at this stage it is not known which prostheses will come under the no gap arrangements, and for which prostheses there will be a gap permitted, and what the applicable benefits will be). Further, even if the measures proposed by the Bill result in a reduction in the cost to health funds of providing prostheses services, whether this will result in a *reduction* in premiums, or even moderate future premium increases, is a different question. This is because there are myriad factors which determine the cost of health insurance premiums: the cost to health funds of surgically implanted prostheses are but one (albeit a significant one over recent years). Accordingly, claims that the measures proposed by the Bill will result in a reduction in private health insurance premiums need to be treated with caution.

The government’s projections of savings to expenditure on the 30 per cent PHI rebate from the measures proposed by the Bill (of \$4.3 million in 2005-06 and \$20.6 million in 2006-07) support the view that any moderations of premiums as a result of the measures proposed by the Bill will be extremely minor: the government currently spends approximately \$2.5 billion on the 30 per cent PHI rebate. The projected saving of \$4.3 million represents a saving of *less than* half of one per cent (\$4.3 million is approximately 0.2 per cent of \$2.5 billion) to current expenditure on the PHI rebate.

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

Improved choice for patients

One of the key arguments advanced by the government in support of the measures contained in the Bill is that it will allow for greater flexibility for the health funds in their coverage of surgically implanted prostheses, and subsequently, this will provide for greater choice for patients as they will have the ability to choose between different levels of prostheses cover (they will have the choice of a no gap product, but will also have the option of more expensive items with a co-payment). The aim of providing greater choice in prostheses cover is in line with the government's general commitment to providing choice through private health.

It is certainly the case that the measures proposed by the Bill will provide patients with choice about prostheses cover presently unavailable to them: under the current arrangements where all surgically implanted prostheses are covered under no gap arrangements, patients do not have the choice of paying a co-payment for a more expensive prosthesis. However, it is important to point out that greater 'choice' comes at a cost: that is, in the form of out-of-pocket costs for surgically implanted prostheses where hitherto there have been none. According to the Explanatory Memorandum, the majority of prostheses would remain at no gap. The government also argues that the introduction of patient co-payments for some prostheses will be mitigated by the concomitant alleviation of pressure on private health insurance premiums.²⁹

However, the Medical Industry Association points out that it will not be possible to estimate what the out-of-pocket costs associated with the new arrangements will be, because at this stage it is not clear what the gap costs will be, and to which particular prostheses they will apply.³⁰ Moreover, as noted above, it is extremely difficult to predict with any degree of precision what the likely impact of the measures on health insurance premiums will be.

A further concern is that the introduction of gap permitted prostheses might lead to differential access to prostheses services, based on ability to pay. This is because, for the first time ever, the more expensive prostheses will only be available to those patients who can afford to pay the associated out-of-pocket costs. It therefore might be argued that the measures proposed by the Bill represent the introduction of a two-tiered system of access to prostheses services. On the other hand, it is important to note that, as discussed above, the measures proposed by the Bill simply bring private health insurance coverage of prostheses into line with other services and procedures covered by health insurance (where there is already the option of gap permitted or no gap cover). It might further be argued in response, however, that in other cases where the option of no gap or gap permitted coverage is available, this does not represent the choice between different levels of *quality* of care; whereas this could be argued to be the case in the choice of no gap or gap permitted prostheses (where, for example, the no gap prosthesis might be adequate, but of a lesser standard than the gap permitted prosthesis in the same category).

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

Improved administrative arrangements

The measures proposed by the Bill seek to improve the administrative arrangements via which prostheses benefits are negotiated between hospitals and health funds, and the arrangements through which prostheses are supplied to hospitals, by transferring responsibility for prostheses price-setting to the Minister (who will be able to draw on the advice of the Prostheses and Devices Committee,³¹ and a series of clinical advisory groups, in determining which prostheses will come under the gap and no gap arrangements).

The administrative arrangements proposed by the Bill through which prostheses services will be managed appear to be more streamlined, efficient, and transparent than the existing arrangements (under which hospitals, health funds, and suppliers negotiate over prices and benefit arrangements, often in an ad hoc manner). As noted above, the health funds, hospitals and suppliers have complained about the inefficient and cumbersome nature of the existing arrangements, and subsequently they have expressed support for the measures proposed by the Bill.

ALP/Australian Democrat/Greens policy position/commitments

The Australian Labor Party has disputed many of the government's arguments in support of the measures proposed by this Bill. Shadow Health Minister Julia Gillard argues that the measures proposed by the Bill are likely to result in substantial out-of-pocket costs for surgically implanted prostheses; that the measures proposed by the Bill will result in *less*, rather than more, choice for patients, since health funds will only be required to cover the full cost of one type of prosthesis in each category under 'no gap' arrangements (and subsequently it is likely that 'only the oldest and cheapest products will be fully covered'); and, that there is no guarantee under the proposed new arrangements for evaluating new prosthetic devices that 'new technologies will be considered as they become available'. Further, Ms Gillard disputes the government's and the health insurers' claims that the measures proposed by the Bill will result in reductions in health insurance premiums.³²

As far as we are aware, the Australian Democrats, the Australian Greens, and independent members and senators have not announced positions on the measures proposed by the Bill.

Schedule 2—technical amendments

Schedule 2 of the Bill proposes three minor consequential amendments to legislation covering PHI.

The need for these amendments arises from their not being included in changes to the *National Health Act 1953* made earlier in 2004 under the *Health Legislation Amendment (Private Health Insurance Reform) Act 2004 (Reform Act)*.

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

The first of these proposed amendments relates to the regulations concerning notification of **rule changes** by health funds. The section of the *National Health Act 1953* that specifies the form for notifying rule changes by health funds was altered by the *Reform Act*. This Bill contains a savings provision which provides that a form approved by the Minister prior to the *Reform Act* continues in force as if approved under the new relevant section of the Act.

In order to avoid any potential confusion about the validity of rule change notifications made on or from 1 July 2004, the amendment is proposed to commence retrospectively from 1 July 2004.

Schedule 2 also proposes an amendment to provisions concerning **loyalty bonus schemes**. The proposed change is essentially to rectify a problem with the numbering of the relevant section.

In order to avoid any potential confusion about the validity of loyalty bonus schemes on or from 1 July 2004, the amendment is proposed to commence retrospectively from 1 July 2004.

Finally, the Bill also proposes to amend the *National Health Act 1953* by changing an incorrectly numbered cross-reference in the note to Schedule 1. This proposed change has no legal effect or impact.

Main Provisions

Schedule 1— Changes to Coverage of Prostheses by Health Funds

Item 1 and **item 2** propose to insert new definitions of gap permitted and no gap prostheses, respectively, into the *National Health Act*. Gap permitted and no gap prostheses will be determined by the Minister (see **item 5**).

Item 3 and **item 4** propose to insert a new section (5F) and new subsection (67(4)), respectively, into the *National Health Act* which make clear that any references to hospital treatment or episodes of hospital treatment within the *National Health Act* and the *Health Insurance Act 1973* include references to prostheses provided as part of the hospital treatment. The proposed new section and subsection are designed to remove any confusion about whether health funds can provide benefits for surgically implanted prostheses provided as part of an episode of hospital care.

Item 5 proposes to insert new subsections into the *National Health Act* to allow the Minister to determine the prostheses that are no gap prostheses and those that are gap permitted, and the relevant benefit amounts. Determination issued under the provisions proposed by **item 5** would be disallowable instruments.

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

Item 6 proposes to insert the words “goods and” after the word “related” into subparagraph 73BD(2)(b)(i). This is intended to ensure that a HPPA must require the hospital or day facility must provide, in the event of an episode of hospital treatment, a single account covering all hospital services and related goods and services (**including any prostheses** provided as part of the episode of treatment).

Item 7 proposes to insert a new section 73BDAAA that contains provisions relating to no gap and gap permitted prostheses payments under HPPAs:

- **Subsection (1)** sets out the conditions under which the section applies.
- **Subsection (2)** provides that the method for determining the amount to be paid by the health fund to the hospital or day facility is set out in the table in subsection 73BDAAA(2).
- **Subsection (3)** excludes benefits covered by this section from paragraphs (d) and (e) of Schedule 1. This is because, where it applies, section 73BDAAA sets or caps the benefit payable for no gap and gap permitted prostheses.
- **Subsection 4** ensures that the patient does not face any out of pocket expenses for a no gap prosthesis provided as part of the episode of hospital treatment. This subsection applies only if subsection 73BDAAA(1) applies.
- **Subsection 5** ensures that a patient has no out of pocket expenses for a gap permitted prosthesis which exceeds the ‘gap’. It also ensures that, should the health fund pay more than the minimum benefit amount for a gap permitted prosthesis, the patient does not have any out of pocket expenses that exceed the resulting smaller gap (the difference between the higher amount paid by the health fund and the maximum benefit amount). This subsection applies only if subsection 73BDAAA(1) applies.
- **Subsection 6** provides that HPPAs entered into by health funds must contain the terms required by subsections (4) and (5). This subsection applies only to HPPAs made after the commencement of section 73BDAAA: item 8(2) due to the fact that the requirement in subsection 6 applies at the point of entry into a HPPA.

Item 8 proposes two application provisions:

- **Item 8(1)** provides that section 73BDAAA of the Act applies to hospital purchaser-provider agreements made after the commencement of the Schedule..
- **Item 8(2)** provides that section 73BDAAA (other than subsection 73BDAAA(6)) also applies to HPPAs made before the commencement of the Schedule, but only if the agreement is in force immediately before that commencement.

Item 9 proposes to amend paragraph (bi) of Schedule 1, by substituting “conditions set out in paragraphs (bl), (bm) and” for “condition set out in paragraph”. Paragraph (bi) sets the minimum benefit payable by health funds for episodes of hospital treatment not covered by a HPPA, in situations of emergency.

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

The purpose of this amendment is to require health funds to apply, in relation to payment of benefit for no gap and gap permitted prostheses, the new conditions of registration relating to these types of cover set out in paragraphs (bl) and (bm).

Item 10 proposes an amendment to paragraph (bj) of Schedule 1, by substituting “conditions set out in paragraphs (bl), (bm) and” for “condition set out in paragraph”. Paragraph (bj) provides for the Minister to set out the minimum benefit payable by health funds for episodes of hospital treatment not covered by a HPPA, otherwise than in situations of emergency.

The purpose of this is to require health funds to apply, in relation to payment of benefit for no gap and gap permitted prostheses, the new conditions of registration relating to these types of cover set out in paragraphs (bl) and (bm).

Item 11 proposes to insert two new conditions of registration for health funds after paragraph (bk) of Schedule 1:

- **Paragraph (bl)** specifies the conditions (types of cover) under which paragraph (bl) applies to a prosthesis.
- **Paragraph (bm)** provides that if paragraph (bl) applies to a prosthesis:
 - each applicable benefits arrangement of the health fund must provide for benefits to be payable in respect of the prosthesis; and
 - the amount of benefit payable by the health fund in respect of the prosthesis is determined by using the table in paragraph (bm).

Schedule 2—technical amendments

Item 1 proposes to amend the *Health Legislation Amendment (Private Health Insurance Reform) Act 2004* to insert a savings provision related to notification of rule changes by health funds.

Item 2 proposes to amend the *National Health Act* to change an incorrectly numbered cross-reference in the note to Schedule 1. This proposed change has no legal effect or impact.

Item 3 proposes to amend the *National Health Act* to change an incorrectly numbered reference to provisions related to loyalty bonus schemes.

Concluding Comments

As discussed above, there appears to be consensus among relevant groups in the health sector—that is, among health insurers, hospitals, suppliers of prostheses, and consumer advocates—about the need for reform of existing arrangements for the provision of private health insurance benefits for surgically implanted prostheses. The process of consultation regarding reform of existing arrangements has centred on two key issues: first, the existing administrative arrangements for the supply, negotiation, and payment of benefits for,

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

surgically implanted prostheses; and second, the fiscal sustainability of the current system, under which *all* surgically implanted prostheses are covered by no gap arrangements, for the health insurance industry.

The measures proposed by Schedule 1 of this Bill address the first set of concerns through the introduction of new price-setting arrangements for surgically implanted prostheses. Currently, the price of, and benefits payable for, are negotiated between hospitals, suppliers, and health funds, often on an ad hoc basis. The hospitals, suppliers and health funds have complained about the inefficient and impractical nature of these arrangements. Under the measures proposed by this Bill, responsibility for price-setting will be transferred to the Minister, who will determine which prostheses will be covered by no gap and gap permitted arrangements, and what the relevant benefits for prostheses in each of these categories will be. The Minister will be advised by a committee—the Prostheses and Devices Committee, the membership of which includes clinicians, industry representatives, and consumer advocates—in this role.

The new administrative arrangements for private health insurance coverage of surgically implanted prostheses proposed by this Bill appear to be more streamlined, efficient, and transparent than the existing system. The proposed measures have the support of relevant stakeholders in the health sector—that is, hospitals, suppliers, and health funds.

The measures proposed by Schedule 1 of the Bill in response to the second set of concerns—the fiscal responsibility of the current arrangements for the health insurance industry—have been more controversial. Currently, all prostheses which are surgically implanted during an episode of hospital care and covered by private health insurance, are covered under no gap arrangements; that is, the health fund pays for 100 per cent of the cost of the prosthesis. The cost to health funds of providing cover for surgically implanted prostheses has increased considerably over recent years, both in real terms, and as a proportion of total benefits paid out. Subsequently, the existing arrangements for prostheses, whereby all surgically implanted prostheses are covered at no gap, have been identified as a significant driver of increases in private health insurance premiums. The Bill proposes to address these issues by introducing gap permitted cover for some prostheses, to bring prostheses coverage into line with health insurance coverage of most other medical services (where both gap and no gap cover is available).

Consumer groups, the Medical Industry Association, and the Australian Labor Party have all expressed concern about the effects on patients of the introduction of a co-payment system for prostheses. For example, consumer groups have argue that the proposals contained in the Bill will result in a system of differential access to prostheses, based on ability to pay. It is important to note that under the measures proposed by the Bill, there will be a no gap prosthesis available for every relevant item on the Medicare Benefits Schedule for which health insurance benefits are payable. In other words, no patient will ever be *forced* to pay a co-payment because a no gap prosthesis is not available. However, until the proposed new system is implemented—and the Minister determines which prostheses will continue to be provided at no gap, which are provided under gap permitted

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

arrangements, and what the relevant benefit levels will be—it is impossible to assess what the likely levels, and prevalence, of patient co-payments under the new system will be.

The government and some industry groups such as the health funds argue that the effects of the introduction of co-payments will be mitigated by reduced pressure on private health insurance premiums, which will result from the health funds no longer having to provide cover for all surgically implanted prostheses at no gap. However, the claim that the measures proposed by Schedule 1 of this Bill will result in reduced pressure on private health insurance premiums—or even in reductions in premium prices—need to be treated with considerable caution. There are a range of factors which influence private health insurance premiums, of which coverage of prostheses are but one. Even if the measures proposed by this Bill were to moderate the cost to health funds of providing coverage for surgically implanted prostheses, other factors are still likely to result in health insurance premiums increasing in the future.

Endnotes

- 1 'prosthesis', *Concise Medical Dictionary*, Oxford University Press, 2002, available via *Oxford Reference Online*, see: <http://www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t60.e8296> (accessed 7 December 2004).
- 2 The Prostheses Schedule exists by virtue of a determination issued by the Minister under paragraph (bj), Schedule 1 of the *National Health Act*.
- 3 Hon. K. Patterson, *Stage Two reforms drive private health fund efficiency*, Media Release, Minister for Health and Ageing, 3 April 2003.
- 4 Explanatory Memorandum, *National Health Amendment (Prostheses) Bill 2004*, House of Representatives, Parliament of the Commonwealth of Australia, 2004, p. 1.
- 5 *ibid.* pp. 8-9.
- 6 *Future Directions of Prosthesis Reform*, Joint Submission from the Australian Health Insurers, Private, and Public Hospitals, 17 May 2002, see: <http://www.apha.org.au/get/2375386587> (accessed 7 December 2004).
- 7 Explanatory Memorandum, *op. cit.*, p. 9.
- 8 *ibid.*

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

- 9 Private Health Insurance Administration Council (PHIAC), *Operations of the Registered Health Benefits Organisations—Annual Report 2002–03*, PHIAC, Canberra, 2003, p.31, see: http://www.phiac.gov.au/publications/ar_registered_health/82pa.pdf (accessed 8 December 2004).
- 10 *ibid.*, p. 8. See also: Australian Private Hospitals Association, *Submission by the Australian Private Hospitals Association to the Inter-Departmental Review of the Commonwealth Government’s Regulatory Framework for Private Health Insurance*, 10 May 2002, see: <http://www.apha.org.au/get/2376721192> (accessed 7 December 2004).
- 11 The Hon. T. Abbott, ‘National Health Amendment (Prostheses) Bill 2004—Second Reading Speech’, *House of Representatives Hansard*, 1 December 2004.
- 12 Details of the membership of this committee were released by the Minister earlier this year: see The Hon. Tony Abbott MP, *New ministerial advisory committee for prostheses*, Media Release, 14 July 2004.
- 13 The proposed new section is 73BDAAA.
- 14 For more details see the Explanatory Memorandum, *op. cit.*, p. 2.
- 15 *ibid.*
- 16 *ibid.*, p. 11.
- 17 *ibid.*, p. 3.
- 18 *ibid.*, p.8; see also: Australian Private Hospitals Association, *op. cit.*
- 19 *Future Directions of Prosthesis Reform*, *op. cit.*
- 20 Sue Dunlevy, ‘Critical operations to cost and arm and leg’, *Daily Telegraph*, 1 December 2004, p.5.
- 21 ‘The health fund hip-hop’, *Choice*, December 2003, p.15, see: <http://www.choice.com.au/viewArticle.aspx?id=104073&catId=100233&tid=100008&p=1> (accessed 7 December 2004).
- 22 Medical Industry Association of Australia, *Cautious support of prostheses reforms*, Media Release, 1 December 2004, see: <http://www.miaa.org.au/pdf/Release11204.pdf> (accessed 7 December 2004).
- 23 Medical Industry Association of Australia, *Medical Industry working with government on prostheses reform*, Media Release, 14 July 2004, see: http://www.miaa.org.au/pdf/Release_1407.pdf (accessed 7 December 2004).

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.

- 24 Medical Industry Association of Australia, *Cautious support of prostheses reforms*, op. cit.
- 25 *ibid.*
- 26 Australian Consumers' Association, *Submission to the regulatory review of private health insurance*, see: <http://www.choice.com.au/files/fl10730.pdf> (accessed 7 December 2004).
- 27 'The health fund hip-hop', op. cit.
- 28 Explanatory Memorandum, op. cit., p.8.
- 29 *ibid.*
- 30 Medical Industry Association of Australia, *Cautious support of prostheses reforms*, op. cit. Note that information supplied by the Department of Health and Ageing during Senate Estimates hearings last year indicates that the no gap and gap permitted arrangements will not apply immediately to all categories of prostheses: the process of determining no gap and gap permitted prostheses will initially be conducted on five categories of prostheses, including hip replacements, knee replacements, stents, pacemakers, and intraocular lenses (Senate Community Affairs Legislation Committee, Estimates Hearings—Health and Ageing Portfolio, 5 November 2003, p.86). However, as noted above, until the measures proposed by the Bill come into effect and the Minister determines which prostheses will be no gap and gap permitted, and what the relevant benefits will be, it is not possible to predict what the out-of-pocket costs associated with gap permitted prostheses will be.
- 31 The Hon. Tony Abbott MP, *New ministerial advisory committee for prostheses*, op. cit.
- 32 Julia Gillard MP, *Private Health Insurance Premiums on the Way Up Again*, Media Release, 1 December 2004.

© Copyright Commonwealth of Australia 2004

Except to the extent of the uses permitted under the *Copyright Act 1968*, no part of this publication may be reproduced or transmitted in any form or by any means including information storage and retrieval systems, without the prior written consent of the Department of Parliamentary Services, other than by senators and members of the Australian Parliament in the course of their official duties.

This paper has been prepared to support the work of the Australian Parliament using information available at the time of production. The views expressed do not reflect an official position of the Information and Research Service, nor do they constitute professional legal opinion.

Members, Senators and Parliamentary staff can obtain further information from the Information and Research Services on (02) 6277 2632.

Warning:

This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.

This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.