



Health Legislation Amendment Bill 2005

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Health Legislation Amendment Bill 2005

Date Introduced: 14 September 2005

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Most parts of the Bill commence on the day of or the day after Royal Assent. Schedule 2, items 8 to 11 and 22 to 25 commence the day after Royal Assent, or immediately after the commencement of Schedule 1 of the *National Health Amendment (Prostheses) Act 2005*, whichever is the later

Purpose

The purpose of the Bill is threefold:

- Schedule 1 proposes to amend the *National Health Act 1953* to extend, until 30 June 2006, the existing arrangements for approving pharmacists to provide medicines under the Pharmaceutical Benefits Scheme (PBS)
- Schedule 2 proposes to amend provisions within the National Health Act relating to private health insurance which do not include reference to dependants of private health contributors (and thus which could result in contributors' dependants not receiving hospital benefits even where the dependant is included on the contributor's policy)
- Schedule 3 proposes two changes to provisions within the *Health Insurance Act 1973* relating to the conditions under which Medicare benefits are payable. The first set of changes proposes to clarify the scope of existing powers in the Health Insurance Act to set conditions, limitations and restrictions on particular items in the Medicare Tables (which set out the circumstances in which benefits for certain medical, pathology and diagnostic imaging benefits are payable). The second set of changes proposes the insertion of a new power in the Health Insurance Act to allow the Minister to determine that Medicare benefits are not payable for certain services rendered in specified circumstances.

Background

Schedule 1—Amendments relating to the Australian Community Pharmacy Authority

Current arrangements for approving pharmacists to supply PBS medicines were due to cease on 30 June 2005 but were extended to 31 December 2005 as a result of the *Health Legislation Amendment (Australian Community Pharmacy Authority) Act 2005* (passed in June this year).

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This Bill proposes to make a further extension of these arrangements until 30 June 2006.

Pharmacy Location Rules

In summary, current arrangements require that applications by pharmacists to supply medicines subsidised through the PBS from either new or relocated premises must be referred to the Australian Community Pharmacy Authority (ACPA). The Secretary, Department of Health and Ageing, may only grant permission to supply PBS medicines following approval of an application by ACPA.

ACPA is required to consider all applications against location-based criteria which must be satisfied in order for a pharmacist to obtain approval to supply PBS medicines from particular premises. These criteria are set out in what are known as the Pharmacy Location Rules and include such things as the minimum distance between pharmacies and whether there is a community need for pharmaceutical services in a particular location.¹ The Pharmacy Location Rules also prevent pharmacies which are located within, adjacent to, or connected to, a supermarket, and to which members of the public have direct access from within the premises of the supermarket, from being approved to supply pharmaceutical benefits.

The purpose of the Location Rules is twofold: first, to provide widespread community access to pharmaceutical services, and second, to ensure the continued viability of existing pharmacies. The Location Rules have been somewhat controversial since their introduction, with some commentators and interest groups suggesting that they are a source of insufficient competition within the pharmacy sector.² Negotiations over pharmacy locations rules have taken on added significance as a result of further efforts by the Woolworths retail chain to gain government permission for the establishment of in-store pharmacies.³ For example, Woolworths has recently proposed a trial of dedicated pharmaceutical dispensing areas within the supermarkets, staffed by qualified pharmacists.⁴

Review of Location Rules

The Rules and their administration by ACPA are being reviewed as part of negotiations between the government and the Pharmacy Guild of Australia for the Fourth Community Pharmacy Agreement.⁵ According to a recent media report, a draft report by Allen Consulting commissioned by the government and the Pharmacy Guild to inform this review, proposed the abolition of the current location rules and their replacement with an arrangement whereby the government varies the dispensing fees paid to pharmacists depending on the supply of pharmacies in a particular location.⁶ The media report also suggested that, according to Allen Consulting, the current rules had allowed pharmacies to increase their incomes without passing on the benefits to consumers, and that competition between pharmacists, including from within supermarkets, would lead to 'the delivery of higher quality pharmacy services'.⁷

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The Pharmacy Guild responded by arguing that the Allen Consulting report was ‘incomplete, inaccurate and entirely at odds with the term of reference [of the review into Pharmacy Location Rules]’. According to Guild National Vice-President, Bill Scott, the draft report’s comments on increasing pharmacy profitability did not take into account that pharmacies had also increased both the number of prescriptions dispensed and other services provided over the previous decade.⁸ He added that the replacement system suggested by Allen Consulting would simply replace ‘one set of regulation with another’.⁹

Comments earlier this year by the Prime Minister, John Howard, and the Minister for Health and Ageing, Tony Abbott, suggest that the government would not be seeking to make significant changes to the Pharmacy Location Rules in the Fourth Agreement but would be intending to achieve savings in the amount of dispensing fees paid to pharmacists.¹⁰

According to recent media reports, the Fourth Agreement is close to being finalised, and will include a ‘relaxation’ of the existing Location Rules to allow pharmacies to be established in all-night medical centres and large shopping centres ‘where an economic case can be made’. The ban on supermarket chains such as Woolworths and Coles Myer operating in-house pharmacies will be maintained. The recent media reports also suggest that the 10 per cent margin pharmacists are currently allowed will be wound back (though it is unclear to what extent).¹¹ This is in line with the government’s stated aim of achieving a reduction in the rate of growth of payments to the pharmacy sector ‘with the long-term aim of limiting pharmacy sector revenue to 0.4 per cent of GDP in 2040’.¹² (Further, according to the recent media reports, the new agreement will include a \$150 million Community Service Obligation, under which expensive, low-demand medicines will be made available to rural and remote communities.)

Basis of policy commitment

Provisions for the Pharmacy Location Rules and ACPA will no longer be in force after 31 December 2005. As noted above, these provisions were due to cease on 30 June 2005 but extended to 31 December 2005 as a result of the *Health Legislation Amendment (Australian Community Pharmacy Authority) Act 2005*. According to the government, this extension was necessary in order to allow further time to ‘consider and make decisions in relation to the findings and recommendations of the review’ of the Pharmacy Location Rules and role of ACPA.¹³

The purpose of the Bill is to provide a further extension of provisions relating to the Pharmacy Location Rules and ACPA from 31 December 2005 until 30 June 2006. According to the Parliamentary Secretary for Health and Ageing, Christopher Pyne, this extension is necessary in order to ‘enable the government, in consultation with the Pharmacy Guild of Australia, to carefully consider the findings and recommendations of the review’ of these provisions.¹⁴

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Commentary on the Bill

While, as noted above, issues related to the Pharmacy Location Rules have been somewhat controversial, the measures contained in this Bill are relatively procedural and have not attracted significant public commentary or analysis.

While the Labor Party supported the previous extension of provisions for the Pharmacy Location Rules and ACPA from 30 June to 31 December 2005, it was critical of the government's role in negotiations towards the Fourth Community Pharmacy Agreement. For example, the Shadow Minister for Health and Ageing, Julia Gillard, criticised the government for not concluding its review into the location rules and ACPA 'in a timely way' (that is, sufficiently prior to the cessation of the Third Community Pharmacy Agreement on 30 June 2005).¹⁵ It is likely that similar criticisms may be made in relation to this Bill given that (a) it provides for a *further* extension of time in which to conclude the Location Rules review process and (b) despite indications from the government that negotiations for the Fourth Community Pharmacy Agreement 'would be concluded well before September 30 [2005]',¹⁶

Financial impact

Schedule 1 is not expected to have a direct financial impact.

Schedule 2—Amendments relating to dependants

The operation of private health insurance funds and the provision of private health insurance products are regulated by the *National Health Act 1953*. Various provisions within the relevant sections of the National Health Act make reference to *contributors* to health funds (that is, the persons who take out a private health insurance policy), but do not include references to the *dependants* of contributors even though dependants of contributors may also be members of the health fund. The absence of explicit references to dependants in the National Health Act creates a technical loophole which could result in dependants of contributors being excluded from private health insurance cover, even where dependants are listed on a health insurance policy and where the contributor has paid for them to be covered.

Accordingly, the purpose of the amendments proposed by Schedule 2 is to insert references to dependants of contributors in the relevant sections of the National Health Act, so as make clear that the relevant provisions within the Act apply to contributors *and* their dependants.

Thus, the amendments proposed by Schedule 2 do not represent any change to existing policy, but rather seek to close existing technical loopholes which could be used to exclude dependants of contributors to private health insurance funds from receiving the cover to which they are entitled.

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Financial impact

Schedule 2 is not expected to have a direct financial impact.

Schedule 3—Amendments relating to health services tables etc.

Schedule 3 proposes two changes to provisions within the *Health Insurance Act 1973* relating to the conditions under which Medicare benefits are payable. The first set of proposed changes would clarify the scope of existing powers in the Health Insurance Act to specify particular conditions under which benefits for certain medical, pathology and diagnostic imaging benefits are payable.

The second set of changes included in Schedule 3 (contained in item 5) propose the insertion of a new power in the Health Insurance Act to allow the Minister to determine, by legislative instrument, that Medicare benefits are not payable for certain services provided in specified circumstances. The changes proposed by item 5 of Schedule 3 have been highly controversial. Subsequently, the Health Minister, Tony Abbott, indicated recently that these changes would not be pursued when the Bill is debated in the parliament. Notwithstanding this decision by the government, this Digest discusses the nature of the changes proposed by the Bill as introduced and the issues raised by them.

Clarifying scope of existing powers to set conditions for payment of Medicare benefits in Medicare Tables

Currently, Medicare benefits are payable for medical or professional services set out in the ‘Medicare tables’: the general medical services table, the diagnostic imaging services table, and the pathology services table.¹⁷ The Medicare tables set out items of services, the relevant fees for each item, and rules for interpreting the items and the table.¹⁸

According to the Explanatory Memorandum, ‘it has been a long standing practice to specify the circumstances in which items of medical, diagnostic imaging and pathology services will apply by including conditions, restrictions and limitations in the Medicare Tables’. Examples include restrictions on the number of times particular items may be claimed in specified periods, requiring practitioners to have particular qualifications to perform particular services, and requiring that particular services only be provided to patients who meet certain criteria.¹⁹

The Health Insurance Act currently allows for the regulations under which the Medicare tables are made to set out rules for the interpretation of the tables. The amendments proposed by items 1 to 4 of Schedule 3 will amend the Health Insurance Act to make it clear that the rules of interpretation can include conditions, limitations and restrictions on services provided under particular items. Thus, the amendments proposed by items 1 to 4 do not represent any change to existing practice (but rather seek to codify the validity of current arrangements), and as such are likely to be uncontroversial.

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As far as the Parliamentary Library is aware, the changes proposed by items 1 to 4 of Schedule 3 are not affected by Minister Abbott's decision not to pursue the controversial elements of Schedule 3.

Minister's powers to set conditions for payment of Medicare benefits in certain circumstances: what was proposed?

As noted above, the proposal contained in Schedule 3, item 5 has been highly controversial since the Bill was introduced. Health Minister Abbott has subsequently indicated that the changes proposed by this section of the Bill will not be pursued.

Currently, the Health Insurance Act permits the making of regulations to prescribe certain circumstances in which Medicare benefits for certain professional services are not payable.²⁰ However, the Explanatory Memorandum points out that the existing provisions 'cannot be utilised in most circumstances', because regulations cannot be made under these provisions 'unless they are made in accordance with a recommendation of the Medicare Benefits Advisory Committee (MBAC), and MBAC is no longer in existence'.²¹ (The Medicare Benefits Advisory Committee and its replacement body, the Medical Services Advisory Committee, are discussed below.)

Accordingly, Schedule 3, item 5 proposed a new power through which the Minister will be able to determine that Medicare benefits are not payable for certain services or services provided in certain circumstances.

Rationale for proposed change

According to Health Parliamentary Secretary Christopher Pyne's second reading speech, a power of the kind proposed by Schedule 3, item 5 was required 'to allow swift action to be taken to prevent medical practitioners claiming existing Medicare Benefits Schedule items for services which they were never intended to cover or which the Government does not wish to fund through Medicare'.²²

The Explanatory Memorandum explains that 'there are occasions in which the Government decides it is not appropriate for certain services to be funded under Medicare'. The existing regulation making powers in the Health Insurance Act (section 19A) have been used in the past to specify that Medicare benefits are not payable for certain services. The Explanatory Memorandum to the Bill gives the example of services rendered in relation to the removal of tattoos.²³ The Explanatory Notes to the Medicare Benefits Schedule provide other examples of restrictions on services that have been enacted under section 19A of the Health Insurance Act in the past, including:

- professional services rendered in association with the injection of human chorionic gonadotrophin (a hormone produced by the placenta during pregnancy²⁴) in the management of obesity

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- professional services rendered in relation to the use of hyperbaric oxygen therapy (a medical treatment in which oxygen under high pressure is inhaled²⁵) in the treatment of multiple sclerosis, and
- professional services rendered for the purposes of, or in relation to, the removal from a cadaver of kidneys for transplantation.²⁶

Because of the existing requirement that regulations of this nature be made in accordance with a recommendation of the MBAC which no longer exists, the government argued that an amendment to the Health Insurance Act was required to allow the existing provisions to continue to be used to make determinations along these lines.²⁷

The Explanatory Memorandum also explained that:

... some medical practitioners utilise existing [Medicare Benefits Schedule] items for services the items were never intended to cover. This issue most commonly arises in relation to new medical technologies. Practitioners sometimes claim benefits for new technologies under existing items, before the Government is satisfied that the new technology is safe, or represents value for money.²⁸

A press release issued by the Health Minister, Tony Abbott in response to concerns about the changes (see below) cited the cases of vertebroplasty, a technique used for treating spinal fractures, and uterine artery embolisation, used in the treatment of fibroids, as examples of techniques which ‘have not yet been proven to be safe, effective and cost effective and should not be claimed by doctors under Medicare’ (though both techniques are currently being assessed by the Medical Services Advisory Committee (MSAC)—see below for more information about the role of the MSAC).²⁹

The Explanatory Memorandum also explained that rapid advances in medical technology mean that the practice of billing Medicare for technologies and procedures which have not been approved for Medicare benefits ‘has the potential to drive up the costs of Medicare and also impact on the broader health system through, for example, increased private health insurance premiums’.³⁰ This point was underscored recently by the release of the Productivity Commission’s report on the impacts of advances in medical technology in Australia, which found that advances in medical technology may have driven up to one-third of the growth in real health spending over the past decade. The Commission also found that while future technological advances are ‘likely to support further dramatic improvements in healthcare’, they are also likely to ‘raise expenditure significantly’.³¹ Hence, the government argued that in order to contain expenditure on new technologies which have not been approved for Medicare benefits, there was a need for the Minister to have power to respond quickly when instances of Medicare being billed for unapproved procedures became apparent.³²

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How will the proposed new power differ to existing arrangements for modifying the MBS?

The powers proposed by Schedule 3, item 5 of the Bill would not have changed the existing process for adding new items to the Medicare tables, or for reviewing existing items.

Currently, new items for new medical technologies and procedures are added to the Medicare tables on the advice of the MSAC. MSAC advises the Minister for Health and Ageing on evidence relating to the safety, effectiveness and cost effectiveness of new medical technologies, and the circumstances under which new medical technologies should be funded through Medicare.³³ Prior to the establishment of MSAC (after the 1997–98 Budget), new items were added to the Medicare tables on the advice of the MBAC. MBAC was superseded by MSAC.

Reviews of existing items in the general medical services table are currently overseen by the Medicare Benefits Consultative Committee (MBCC). (There are separate arrangements for the diagnostic imaging and pathology services tables.) The MBCC reviews particular services or groups of services within the general medical services table to ‘ensure that the Schedule reflects and encourages appropriate clinical practice’. It also has a role in advising the Minister on appropriate fee (and consequently, Medicare rebate) levels.³⁴

Thus, the new powers proposed by Schedule 3, item 5 would not have given the Minister any new discretionary power to add new items to the Medicare tables or withdraw existing items. Rather, they would have given the Minister the power to prescribe certain procedures for which Medicare benefits would not be payable (such as new and untested procedures), or prescribe conditions under which Medicare benefits are payable for existing items.³⁵

Key issues raised by the proposed new powers

While the amendments to the Health Insurance Act proposed by Schedule 3, item 5 would not have represented a major change to existing processes for listing new items on the Medicare tables or reviewing existing items, the proposed amendments nonetheless raised several important issues.

These included consultation and decision-making processes and the adequacy of existing powers.

Consultation and decision-making process

The Explanatory Memorandum and supporting documentation did not make clear what kinds of decision-making processes would have preceded a determination made under the new power proposed by Schedule 3, item 5.

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As noted above, according to the Explanatory Memorandum ‘there are occasions in which the Government decides it is not appropriate for certain services to be funded under Medicare’. However, it was not clear from the EM or other associated documentation *how* the government comes to such decisions, for example, how the government is alerted to instances of Medicare being billed for procedures or technologies it has not approved.

The *Legislative Instruments Act 2003* requires that rule-makers consult before making a legislative instrument, so presumably there would have been some consultation process before any enactment of the new powers.³⁶ According to the Health Minister, Mr Abbott, protocols to be used in determining whether benefits should be payable in respect of a particular procedure would have included ‘consultation with the AMA prior to a decision being made’.³⁷ Beyond this, however, no details of the protocols to which the Minister referred, nor any other details about what kind of consultation process may have preceded a determination being made under the new powers, were made available. Further, there did not appear to be any role (at least not formally) for MSAC in providing advice on determinations made under the proposed new powers.

Adequacy of existing provisions

As explained briefly above, the Health Insurance Act already provides for regulations along the lines of those envisaged by the government under the amendments proposed by Schedule 3, item 5 to be made. However, as the Explanatory Memorandum explains, these are effectively defunct because they can only be used in accordance with a recommendation from the MBAC which no longer exists.

However, it is not clear why the existing regulation making powers could not have been modified, instead of creating a new (apparently more discretionary) power in the Health Insurance Act.

For example, the reference to MBAC in the relevant part of the Health Insurance Act (subsection 19A(2)) could be replaced with a reference to MSAC (or a more general reference to a committee established to advise the Minister on medical services benefits, since MSAC is not mentioned anywhere else in the Health Insurance Act).

While this would be more cumbersome than the system mooted by Schedule 3, item 5 (in that the process for making regulations is more complex and time consuming than the process for making Ministerial determinations by legislative instrument), it would alleviate the problems that the Explanatory Memorandum points to with existing regulation making powers (that is, that they make reference to a committee which no longer exists) and would also ensure that any determinations made under the proposed new powers are made on the basis of expert advice.

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Position of significant interest groups

Various doctors' groups expressed concern about the amendments to the Health Insurance Act proposed by Schedule 3, item 5. For example, the Australian Medical Association (AMA) President Mukesh Haikerwal has said that he feared the new power could be used to reduce Medicare rebates for particular procedures as a means of making budget savings: 'It could be used to say if you are over 90, you can't have a hip replacement ... It may go to other ethical issues just as sinister. This is a huge sledgehammer that will have collateral damage problems'.³⁸

Doctors Reform Society president Tim Woodruff questioned whether the proposed new powers would have been used by the Minister to prevent Medicare funding for abortion. According to Dr Woodruff, 'legislative changes which allow the Health Minister to decide himself what operations and procedures should be rebateable under Medicare strikes at the very heart of the universality of Medicare'. Further, Dr Woodruff said that Australia already has an independent assessment process for determining what operations and procedures should be covered by Medicare (this is the MSAC process discussed above): 'If its too slow, speed it up by all means, but not by giving a politician with no medical knowledge the power to decide on the basis of moral beliefs'.³⁹

In response to these concerns, Health Minister Tony Abbott said that the claims of 'sinister intentions' behind the amendments to the Health Insurance Act proposed by Schedule 3, item 5 had 'no foundation'.⁴⁰

ALP/Australian Democrat/Greens policy position/commitments

Opposition parties expressed concerns similar to those raised by doctors' groups about the amendments to the Health Insurance Act proposed by Schedule 3, item 5. Australian Democrats leader Lyn Allison expressed her reservations as follows: 'Access to health care should always be made on the basis of the best available evidence not the religious views of particular politicians ... If this is about stopping Medicare funding for abortion, the Minister must be up front with his colleagues and the vast majority of Australians who disapprove of changes to the status quo on abortion'.⁴¹ Similarly, Labor Health spokeswoman Julia Gillard said that she was 'highly suspicious' about the proposed powers, and that her 'antennae [were] raised'.⁴²

Financial impact

Schedule 3 was not expected to have a direct financial impact (though it is aimed at providing a means through which to contain *future* costs).

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Main Provisions

Schedule 1—Amendments relating to the Australian Community Pharmacy Authority

Item 1 proposes to amend subsection 90 (3C) of the *National Health Act 1953* so that subsections relating to the role of APCA in approving applications to supply pharmaceutical benefits will continue in force until the end of 30 June 2006 unless sooner repealed.

Item 2 proposes to amend section 99Y to provide that provisions relating to the establishment, membership and functions of the ACPA, and the requirement for the Minister to determine the rules with which ACPA must comply in making its recommendations, will continue in force until the end of 30 June 2006.

Schedule 2—Amendments relating to dependants

Schedule 2 proposes a series of amendments to the *National Health Act 1953* to include references to dependants of contributors:

- **items 1 and 2** amend relevant definitions (in sections 4(1) and 73AAI(2))
- **items 3 to 7** amend provisions within the section of the Act pertaining to hospital purchaser-provider agreements (section 73BD)
- **items 8 to 11** amend provisions within the (new) section of the Act pertaining to gap and no-gap prostheses (section 73BDAAA)
- **items 12 to 15** amend provisions within the Act (in section 73BDAA) pertaining to practitioner agreements
- **items 16 to 20** amend provisions within the Act pertaining to medical-purchaser provider agreements (in section 73BDA)
- **item 21** amends a provision within the section of the Act which pertains to gap cover schemes (section 73BDB)
- **items 22 to 33** amend relevant provisions within Schedule 1 of the Act, which pertain to the conditions of registration of private health funds.

Schedule 3—Amendments relating to health services tables etc.

Items 1 to 4 relate to the first set of changes to the *Health Insurance Act 1973* proposed by Schedule 3—those clarifying the scope of existing powers to specify particular conditions in the Medicare tables under which benefits for certain medical, pathology and diagnostic imaging benefits are payable:

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- **items 1 to 3** add references to the new subsection proposed by item 4 in the sections pertaining to the Medicare tables elsewhere in the Health Insurance Act
- **item 4** inserts a new section in the Health Insurance Act (4BAA) which clarifies that the Medicare tables may set conditions, limitations or restrictions on services provided under items in the Medicare tables

Item 5 pertained to the second set of changes proposed by Schedule 3 as discussed above (which the Minister has indicated he will not pursue). It proposed the insertion of new subsections (19A(3) and 19A(4)) to the Health Insurance Act which would have allowed the Minister to determine, by legislative instrument, that Medicare benefits are not payable in respect of professional services rendered in specified circumstances. In accordance with the Legislative Instruments Act, any determinations made under the powers proposed by item 5 would have been disallowable.

Concluding Comments

Schedule 1— Amendments relating to Australian Community Pharmacy Authority

As noted above, as part of negotiations for the Fourth Community Pharmacy Agreement, the government and the Pharmacy Guild undertook a joint review of the Pharmacy Location rules and the role of ACPA in their administration. Through this Bill, the government is seeking to extend existing arrangements in order to allow it, in consultation with the Guild, more time to consider the findings of the review. Given the controversy surrounding these rules and the protracted nature of negotiations between the government and the Pharmacy Guild, the outcome of the review will be eagerly anticipated by the various stakeholders in the pharmacy sector.

Nevertheless, the measures contained in the Bill to extend the arrangements for approving pharmacists to supply PBS medicines have not attracted significant public commentary or analysis. The fact that the relevant measures in this Bill represent the second attempt by the government to extend the time available to consider the findings of the review of Pharmacy Location rules is likely to attract some criticism from the Opposition.

Schedule 2—Amendments relating to dependants

As discussed above, the amendments proposed by Schedule 2 are aimed at amending loopholes within the National Health Act which might be used to exclude dependants of contributors to private health funds from receiving benefits (even where the contributor has paid for them to be covered). Thus, the amendments proposed by Schedule 2 do not represent any change to government policy and are likely to be uncontroversial.

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Schedule 3—Amendments relating to health services tables etc.

Schedule 3 proposes two sets of amendments to provisions within the Health Insurance Act pertaining to the Medicare tables. The first set of amendments—clarifying the provisions within the Health Insurance Act to set conditions, limitations and restrictions on services within the Medicare tables—simply codify existing practice and are likely to be uncontroversial.

The second set of proposed amendments—inserting a new power within the Health Insurance Act to allow the Minister to determine, by legislative instrument, that Medicare benefits are not payable for services delivered in certain circumstances—have attracted commentary and criticism from doctors' groups and opposition parties. The key issue raised by the proposed amendments is the basis on which decisions will be made to restrict Medicare funding for particular services under the new powers: for example, what kind of consultation process will precede any determination being made, and the extent to which the Minister will receive expert advice before making a determination under the new powers. However, since the Bill was introduced into the Parliament, Health Minister Tony Abbott has indicated that the controversial changes proposed by Schedule 3 will not be pursued.

Endnotes

1. A consolidated version of the Pharmacy Location Rules can be accessed from the Australian Community Pharmacy Authority website at:
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pbs-general-pharmacy-acpa-consdeterm.htm> (accessed 22 May 2005).
2. See, for example, P. Kerin, 'High price of anti-competition', *Business Review Weekly*, 30 June 2005, p. 34; N. Ballenden, 'The pharmacy: why it can't stay a closed shop', *Consuming Interest*, Winter 2005, pp. 18-20; M. Metherell, 'Pharmacy profits hit a nerve', *Sydney Morning Herald*, 16 May 2005; B. Glasson, 'Getting tough on turf', *Australian Doctor*, 18 February, 2005; A. Fels and F. Brenchley, 'Dispense some competition to the pharmacies', *Sydney Morning Herald*, 8 April 2004; J. Albrechtsen, 'Strip these white coats of subsidies', *Australian*, 1 September 2004.
3. See for example, C. Jimenez and K. Murphy, 'Woolies in pharmacy trial furore', *Australian*, 10 May 2005; M. Polimeni, 'Woolies in fresh pharmacy assault', *Canberra Times*, 7 May 2005.
4. AAP, 'Woolworths touts pharmacy trial', *Australian*, 9 May 2005.
5. Hon. Tony Abbott, Minister for Health and Ageing, 'Fourth Community Pharmacy Agreement', *Media release*, 18 April 2005, see
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-mediarel-yr2005-ta-abb036.htm> (accessed 11 October 2005).

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6. M. Metherell, 'Pharmacy profits hit a nerve', op. cit. See also D. Gibson, 'Pharmacists defend competition curbs', *West Australian*, 17 May 2005.
7. *ibid.*
8. Pharmacy Guild of Australia, 'Pharmacy draft report incomplete and inaccurate', *Media release*, 16 May 2005, see http://www.guild.org.au/public/currentissues/media_location_report_160505.pdf.
9. *ibid.*
10. See, for example, M. Davis, 'Pharmacists stick to script', *Australian Financial Review*, 25 June 2005; 'Pharmacy Guild opposes plans by Woolworths for in-store pharmacies', *7.30 Report*, ABC television, 19 July 2005.
11. S. Lewis, 'Chemists win deal on drugs for bush', *The Australian*, 24 October 2005, p. 1. See also M. Polimeni, 'No fund deal yet: chemists', *Canberra Times*, 25 October 2005, p. 6.
12. Abbott, 'Fourth Community Pharmacy Agreement', op. cit.
13. Explanatory Memorandum, p. 1. According to the government, the purpose of the review was '[T]o evaluate the net public benefit of the [Pharmacy Location] Rules in terms of achieving their policy objectives, identify any significant anomalies in their application and administration and report on alternatives to remedy any such deficiencies and anomalies'. See Explanatory Memorandum, op. cit.
14. Hon. Christopher Pyne, Parliamentary Secretary to the Minister for Health and Ageing, 'Health Legislation Amendment Bill 2005 Second Reading Speech', House of Representatives, *Debates*, 14 September 2005, p. 2.
15. Julia Gillard, Shadow Minister for Health, 'Health Legislation Amendment (Australian Community Pharmacy Authority) Bill 2005 Second Reading Speech', House of Representatives, *Debates*, 25 May 2005, p. 2.
16. Hon. Tony Abbott, Minister for Health and Ageing, 'Fourth Community Pharmacy Agreement—wholesale distribution of PBS medicines', *Media release*, 9 August 2005.
17. Explanatory Memorandum, p. 9; *Health Insurance Act 1973*, sections 4, 4AA, 4A.
18. Explanatory Memorandum, p. 9. Doctors are not obliged to charge the fee set out in the Medicare tables, however these fees are relevant to determining the level of Medicare *rebate* for particular services (as the amount of the rebate is tied to the fee set out in the Medicare tables).
19. Explanatory Memorandum, pp. 9, 10.
20. *Health Insurance Act 1973*, s. 19A.
21. Explanatory Memorandum, p. 11. See *Health Insurance Act 1973*, ss. 19A(2).
22. Pyne, 'Second Reading: Health Legislation Amendment Bill 2005', op. cit.
23. Explanatory Memorandum, p. 11.
24. 'Human chorionic gonadotrophin *n.*', *A Dictionary of Nursing*, Oxford University Press, 2003. Accessed via *Oxford Reference Online*, Oxford University Press, Dept of the

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- Parliamentary Library, 28 September 2005: see <http://www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t62.e4108>.
25. 'Hyperbaric oxygen therapy', *Food and Fitness: A Dictionary of Diet and Exercise*, Michael Kent, Oxford University Press, 1997. Accessed via *Oxford Reference Online*, Oxford University Press, Dept of the Parliamentary Library, 28 September 2005: see <http://www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t38.e890>.
 26. Department of Health and Ageing, *Medicare Benefits Schedule*, 1 November 2004 edition, p. 21. These determinations are contained in regulation 14 of the *Health Insurance Regulations 1975* (made pursuant to section 19A and 133 of the HIA). Regulation 14 was added in 1985, and various amendments were made between 1985 and 1995. Presumably these determinations were sanctioned by MBAC, or were of the kind not requiring such sanction (if not, they would be invalid).
 27. Explanatory Memorandum, p. 11.
 28. *ibid.*
 29. Tony Abbott, Minister for Health and Ageing, 'Government tightens up Health Insurance Act', *Media release*, 21 September 2005, see <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2005-ta-abb112.htm?OpenDocument&yr=2005&mth=9> (accessed 11 October 2005).
 30. Explanatory Memorandum, p. 11.
 31. Productivity Commission, 'Impacts of Advances in Medical Technology in Australia', *Media release*, 20 September 2005. See: <http://www.pc.gov.au/study/medicaltechnology/finalreport/mediarelease.html> (accessed 5 October 2005).
 32. Pyne, 'Second Reading: Health Legislation Amendment Bill 2005', *op. cit.*; Abbott, 'Government tightens up Health Insurance Act', *op. cit.*
 33. MSAC website, see <http://www.msac.gov.au/terms.htm> and <http://www.msac.gov.au/bckgrd.htm> (Accessed 11 October 2005).
 34. Department of Health and Ageing website: MBCC Guidelines. See: <http://www.seniors.gov.au/internet/wcms/publishing.nsf/Content/health-medicarebenefits-mbccguidelines>, accessed 7 October 2005.
 35. Pyne, 'Second Reading: Health Legislation Amendment Bill 2005', *op. cit.*; Abbott, 'Government tightens up Health Insurance Act', *op. cit.*
 36. *Legislative Instruments Act 2003*, section 17. According to subsection 17(3), 'such consultation could involve notification, either directly or by advertisement, of bodies that, or of organisations representative of persons who, are likely to be affected by the proposed instrument. Such notification could invite submissions to be made by a specified date or might invite participation in public hearings to be held concerning the proposed instrument'.
 37. Abbott, 'Government tightens up Health Insurance Act', *Media release*, *op. cit.*

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38. S. Dunlevy, 'Medicare under the knife—Abbott wants to ban benefits for some surgery', *Daily Telegraph*, 21 September 2005, p. 9.
39. AAP, 'Doctors warn Medicare bill aimed at stopping abortions', *AAP*, 21 September 2005. See also Doctors Reform Society, 'Doctors predict Health Minister Abbott could ban abortion', *Media release*, 21 September 2005.
40. Abbott, 'Government tightens up Health Insurance Act', *Media release*, op. cit.
41. AAP, 'Doctors warn Medicare bill aimed at stopping abortions', *AAP*, 21 September 2005.
42. Dunlevy, 'Medicare under the knife—Abbott wants to ban benefits for some surgery', op. cit.

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