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THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND HEALTH LEGISLATION AMENDMENT BILL (NO. 2) 1995

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Human Services and Health, the Hon Dr Carmen Lawrence, MP)

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HUMAN SERVICES AND HEALTH LEGISLATION AMENDMENT BILL (NO 2) 1995

GENERAL OUTLINE

This Bill proposes amendments to the *Health Insurance Act 1973* and the *National Health Act 1953*.

Amendments to the *Health Insurance Act 1973* will allow the Health Insurance Commission to police and endorse more effectively arrangements relating to Temporary Resident Doctors and Occupational Trainees.

Also, amendments will be made to the *Health Insurance Act 1973* which relate to requirements for the payment of Medicare benefits for diagnostic imaging services. These amendments are designed to ensure that Medicare benefits are payable for diagnostic imaging services rendered by consultant physicians, to provide for the form of requests for diagnostic imaging services, and to provide for improved arrangements for remote area exemptions.

The amendments to be made to the *National Health Act 1953* are to change the safety net arrangements which apply to general patients under the Pharmaceutical Benefits Scheme.

Temporary Resident Doctors and Overseas Trained Doctors

Amendments to the *Health Insurance Act 1973* are sought in order to allow the Health Insurance Commission to police and enforce more effectively arrangements relating to Temporary Resident Doctors and Occupational Trainees.

Temporary Resident Doctors (TRDs) and Occupational Trainees (OTs) are currently allowed to enter Australia on temporary visas which entitle them to work in public hospitals or in 'areas of need', such as underserviced rural and remote areas. As part of the 1995 Federal Budget, measures were announced that are aimed at reducing the number of temporary doctors moonlighting in the system. The term 'moonlighting' refers to those temporary doctors performing services outside their 'host' institution or area of need, usually billing against another doctor's provider number. Moonlighting doctors breach their visa conditions and also their conditions of registration.

The problem of moonlighting is exacerbated by the fact that TRDs and OTs either have access to Medicare provider numbers in their own right (the Health Insurance Commission presently grants access to Medicare benefits to any registered doctor who applies), or can use another doctor's provider number to bill private services, despite conditions being placed on their visa and/or registration. The *Health Insurance Act 1973* allows Medicare benefits to be paid for professional services rendered by or on behalf of a medical practitioner.

There is currently little to prevent TRDs and OTs from either leaving the area to which they were assigned (eg., moving from the area of need to which he/she was recruited to urban general practice) or engaging in private practice, regardless of the conditions imposed on the individual visa and/or registration specifying that services are not to be provided outside the public sector.

In order to address this problem, several changes to the Health Insurance Act are proposed to prevent temporary doctors from being able to breach their visa or registration conditions.

Diagnostic Imaging

The Bill also amends the *Health Insurance Act 1973* in relation to the payment of Medicare benefits for diagnostic imaging services.

The amendments are designed to ensure that Medicare benefits are payable for diagnostic imaging services rendered by consultant physicians, to provide for the form of requests for diagnostic imaging services, and to provide for improved arrangements for remote area exemptions.

Provisions in the *Health Insurance Act 1973* which came into effect from 1 May 1991, implemented the "arm's length" provisions where Medicare benefits were not payable for diagnostic imaging services unless the rendering medical practitioner had received a written request for the service from another medical practitioner or, for certain prescribed items, a written request from a dental practitioner, a chiropractor, a physiotherapist or a podiatrist.

The existing requirements excepted certain services rendered by a specialist practising in his or her specialty, following a written request, from attracting Medicare benefits at the lower rate that would apply if the service was rendered by a practitioner who was not a specialist or who rendered the service outside his or her specialty. The difference in rates of benefit relates to a service identified as an "NR-type" service and the equivalent service identified as an "R-type" service (an "NR-type" service has a Schedule fee equal to approximately 75% of its equivalent "R-type" service).

The existing provisions also exempted services rendered by a specialist who provided the service in the course of practising in his or her specialty (other than in diagnostic radiology) where that specialist had determined that the service was necessary.

Those provisions did not refer specifically to consultant physicians who rendered a diagnostic imaging service in circumstances similar to those rendered by specialists.

The Bill provides for Medicare benefits to be payable for diagnostic imaging services rendered by consultant physicians when rendered in the same

circumstances by specialists and provides that the Commonwealth will not recover the Medicare benefits that have been paid in respect of those services from 1 May 1991.

The Bill provides that the form and content of written requests for diagnostic imaging services by dental practitioners, chiropractors, physiotherapists and podiatrists may be prescribed in the same way as those by medical practitioners.

This Bill also provides for remote area exemptions to be for a shorter term than the present fixed period of three years. It also provides for exemptions to be granted from the date the application was received rather than from the date on which the exemption is granted, which could be some weeks after the practitioner applied for exemption due to, for example, a delay in making a decision because an application was being investigated.

Safety Net Arrangements for Pharmaceutical Benefits

This Bill also amends the *National Health Act 1953* by changing the safety net arrangements which apply to general patients under the Pharmaceutical Benefits Scheme.

General patients will be eligible to be issued with a safety net concession card when the total of the amounts charged for supplies of pharmaceutical benefits made to the patient and to members of the patient's family during an entitlement period is $600. Further supplies of pharmaceutical benefits made during that entitlement period will be at the concessional rate of patient contribution.

There are no changes to the existing safety net arrangements in respect of concessional beneficiaries.

FINANCIAL IMPACT STATEMENT

With respect to the proposed amendments to the *Health Insurance Act 1973*, those in relation to Temporary Resident Doctors and Occupational Trainees, will result in significant savings to the Commonwealth by reducing outlays under Medicare.

On the best statistics which the Department of Immigration and Ethnic Affairs is able to provide, in excess of 700 occupational trainees and 700 temporary resident doctors enter the Australian medical workforce annually. It has been conservatively estimated that at least 10 per cent of these doctors will be moonlighting to some extent.

The Commonwealth has estimated that each additional, full time, medical practitioner entering the medical workforce generates a net cost to the Medical Benefit Scheme of $176,077 per year.

It is also estimated that addressing "moonlighting" of temporary resident doctors

and occupational trainees should reduce the number of providers billing against the MBS by 15 full time equivalents in 1995-96 and 30 per annum thereafter.

On the basis of these figures, reducing "moonlighting" by temporary residents and occupational trainees over the next four years will result in savings of $18.5 million:

1995/96	1996/97	1997/98	1998/99
$2.6m	$5.3m	$5.3m	$5.3m

In relation to diagnostic imaging, the Bill is not expected to result in any significant additional expenditure.

The provisions relating to consultant physicians are intended to ensure the Commonwealth will not recover payments that have already been made from 1 May 1991 and to provide a clear authority for the payment of Medicare benefits in the circumstances outlined.

There are no additional costs associated with amendments to the form of requests.

Amendments to the remote area exemption provisions will increase the appropriations to the extent that Medicare benefits would become payable for any diagnostic imaging services rendered between the date exemptions had previously been granted and the date the application was received. It is estimated that the increase will approximate $2,000 pa.

Administrative expenses associated with the changes to the provisions relating to diagnostic imaging are minimal.

In relation to pharmaceutical benefits, the increase to $600 in the level of expenditure which qualifies a general patient for the issue of a safety net concession card is estimated to reduce outlays by $10m in 1995-96 and by $30m in each of 1996-97, 1997-98 and 1998-99.

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NOTES ON CLAUSES

Clause 1 - Short title

This clause specifies the short title of the Act as the *Human Services and Health Legislation Amendment Act (No. 2) 1995.*

Clause 2 - Commencement

Clause 2 provides that Items 5 to 10 and 12 commence on Royal Assent and Items 1 to 4, 11 and 13 to 19 commence on 1 January 1996.

Clause 3 - Schedule

This clause provides that the Acts specified in the Schedule are amended as set out in the Schedule.

SCHEDULE

Amendments to the *Health Insurance Act 1973*

ITEMS 1 and 2

The proposed amendments to sub-section 3(1) are as a consequence of amendments outlined in Items 3 and 4.

ITEM 3

Under the current provisions of the Act, TRDs and OTs providing medical services in breach of their visa/registration condition are able to escape detection by providing services 'on behalf of' another practitioner. In such circumstances a bill for these services is rendered under the name of the doctor on whose behalf the service was rendered.

These proposed amendments to Section 3 will ensure that this mechanism for billing for such services provided by TRDs and OTs will be removed. Effectively TRDs and OTs will no longer be able to substitute directly for another medical practitioner. Through the insertion of proposed sub-section 3(17), professional services may still be provided on behalf of a medical practitioner, but only by someone who is not a medical practitioner who provides the service under the supervision of the medical practitioner in accordance with accepted medical practice. While the supervising medical practitioner need not be present for the entire service, he or she must have a direct involvement in at least part of the service. For instance, a radiographer may take an x-ray of a patient in a rural area

and send that x-ray to be interpreted by a radiologist in an urban area.

Services rendered by or on behalf of approved pathology practitioners will not be affected by this amendment.

ITEM 4

The purpose of these proposed amendments to section 3 of the Act is to provide:

- a more effective mechanism to enforce existing requirements in the Health Insurance Act for TRDs and OTs to work within the conditions of their registration/visa conditions; and

- administrative review of decisions affecting the eligibility of TRDs and OTs for Medicare benefits.

Most TRDs and OTs work in salaried positions in public hospitals. Eligibility for Medicare benefits, which is necessary for doctors providing private, fee-for-service medical services, is therefore not necessary for most TRDs and OTs to perform the medical services for which they have been employed.

By excluding TRDs and OTs from the definition of "medical practitioner", moonlighting TRDs and OTs can be detected more easily and the HIC is more effectively empowered to refuse benefits for services rendered by these doctors.

However, a proportion of TRDs are employed to provide medical services in private practice. These doctors, for example, may work in rural areas. Providing private, fee-for-service medical services, these doctors need to be eligible for Medicare benefits. Consequently, it is proposed that the Minister have the power to determine these doctors to be 'medical practitioners' for the purposes of the Act and therefore eligible for Medicare benefits.

Allowing the Minister to attach conditions to such a determination ensures that the requirement for TRDs and OTs to work within the terms of their registration/visa can now be enforced by the Commonwealth.

The proposed new sub-sections 3J(4) ensures that TRDs and OTs will not receive Medicare benefits should they be detected providing services in breach of the conditions imposed on them in a determination affecting them.

In order to detect effectively those TRDs and OTs who are moonlighting, it is necessary for information held by the Department of Immigration and Ethnic Affairs about the visa conditions applying to TRDs or OTs to be shared with the Health Insurance Commission. The provisions contained in the proposed sub-section 3J(5) provide the Secretary of the Department of Immigration and Ethnic Affairs with the necessary authority to release relevant information to the Health Insurance Commission.

Under the proposed section 3K, TRDs and OTs who have applied to the Minister for a determination will have access to administrative review processes, including internal review and access to the Administrative Appeals Tribunal.

ITEM 5 - Subparagraph 16B(1)(a)(i)

This item relates to those diagnostic imaging services where there are two different rates of Medicare benefit applicable for the same service. These are mostly plain x-rays of the extremities. The higher rate relates to the item which is identified as an "R-type" service and the lower rate relates to the item which is identified as an "NR-type" service.

This item makes provision for the payment of Medicare benefits for a diagnostic imaging service at the rate of benefit applicable for an "R-type" service, rather than at the "NR-type" rate, where the service was rendered by a consultant physician practising in his or her specialty where a written request was made.

ITEM 6 - Paragraph 16B(6)(a)

This item amends the subsection that provides an exemption from the requesting provisions for specialists (other than specialists in diagnostic radiology). The current subsection provides for an exemption where the service was rendered in the course of the specialist practising in his or her specialty and where that practitioner had determined that the service was necessary.

This item provides an exemption for consultant physicians where the service was rendered in the same circumstances as set out for specialists.

ITEM 7 - Paragraph 16B(7)(c)

This item provides that a remote area exemption will apply if the service was rendered during the period when a remote area exemption was in force.

ITEM 8 - Paragraph 23DQ(1)(a)

This item deletes the reference to a medical practitioner in the existing subsection that provides that regulations may be made specifying the form and content of a request for a diagnostic imaging service (see also Item 9 below).

ITEM 9 - Section 23DQ

This item identifies the class of practitioner to whom the regulations setting out the form and content of requests will apply. The practitioners identified are medical practitioners, dental practitioners, chiropractors, physiotherapists and podiatrists.

ITEM 10 - Section 23DZA

This item omits the existing section which provides that a remote area exemption remains in force for 3 years unless earlier revoked, and substitutes a new section. The new section provides for a remote area exemption to have effect from the day it is granted, or an earlier or later day but not earlier than the day the application was received. It also provides that an exemption stays in force for a period of 3 years or such shorter period specified in the exemption unless earlier revoked. An exemption may also specify a period that has ended before the exemption is granted.

ITEMS 11, 12 and 13

These items are designed to change the references to only the male gender to refer to both genders.

ITEMS 14 and 15

Under the proposed amendments to sub-section 130(7) the Health Insurance Commission will be permitted to share information concerning TRDs and OTs in breach of their registration/visa with the Department of Immigration and Ethnic Affairs. Such information will assist the Department of Immigration and Ethnic Affairs to police breaches of visa conditions more effectively.

ITEMS 16 and 17

Amendments to paragraph 130(9)(b) and sub-section 130(10) are consequential to the proposed amendments to sub-section 130(7) and ensure that officers who have access to information made available under the provisions of sub-section 130(7) are subject to the same penalties and requirements to observe secrecy as other officers outside the Health Insurance Commission.

ITEM 18

This item provides that where Medicare benefits have been already paid in respect of diagnostic imaging services rendered by consultant physicians, the Commonwealth will not seek to recover those payments. Of course this does not apply in circumstances where fraud etc has been committed by the recipient of the benefits.

Amendments to the *National Health Act 1953*

ITEM 19 amends subsection 84C(1AA) by increasing to $600 the level of expenditure which qualifies a general patient to obtain a safety net concession card

and thus obtain pharmaceutical benefits at the concessional rate for the remainder of the entitlement period.

ITEM 20 amends the note to subsection 84C(1AA) by substituting $600 for $400 as the amount which is subject to periodical adjustment under section 99G.

ITEM 21 amends paragraphs 87(2)(b) and (c) by increasing to $600 the expenditure level at which a general patient becomes eligible to be charged only the concessional rate for the supply of a pharmaceutical benefit.

ITEM 22 amends the note to subsection 87(2) by substituting $600 for $400 as one of the amounts which are subject to periodical adjustment under section 99G.

ITEM 23 amends the definition of "general patient safety net" in section 99F by increasing to $600 the amount which is subject to indexation under section 99G.

ITEM 24 amends subsection 99G(1A) by providing that the increase in the general patient safety net level to $600 takes the place of the indexation which would otherwise be due on 1 January 1996.

ITEM 25 amends subsection 99G(3A) to provide that the new general patient safety net level of $600 is to be the basis for future indexation.

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