Health Legislation Amendment (Data-matching and Other Matters) Bill 2019

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Date introduced: 23 October 2019
House: House of Representatives
Portfolio: Health
Commencement: The day after the Act receives Royal Assent.

Links: The links to the Bill, its Explanatory Memorandum and second reading speech can be found on the Bill’s home page, or through the Australian Parliament website. When Bills have been passed and have received Royal Assent, they become Acts, which can be found at the Federal Register of Legislation website.

All hyperlinks in this Bills Digest are correct as at December 2019.
Purpose of the Bill
The purpose of the Health Legislation Amendment (Data-matching and Other Matters) Bill 2019 (the Bill) is to amend the National Health Act 1953 and the Health Insurance Act 1973, to enable a data-matching scheme for permitted Medicare compliance and related purposes. The Bill will also make minor amendments to the Privacy Act 1988, the Private Health Insurance Act 2007, the Therapeutic Goods Act 1989 and the Military Rehabilitation and Compensation Act 2004.

Structure of the Bill
The Bill contains two Schedules:

• **Schedule 1** amends the National Health Act to:
  – give the Chief Executive Medicare the power to undertake data-matching
  – enable the disclosure of therapeutic goods and private health insurer information to the Chief Executive Medicare and
  – require the Minister to make data-matching principles by legislative instrument.

Schedule 1 also makes consequential amendments to the Health Insurance Act, the Privacy Act, the Private Health Insurance Act and the Therapeutic Goods Act.

• **Schedule 2** amends the Health Insurance Act to enable services involving a professional attendance provided under certain laws administered by the Minister for Veterans’ Affairs to be considered for a prescribed pattern of service for the purposes of the Professional Services Review scheme. Schedule 2 also amends the Military Rehabilitation and Compensation Act to enable the disclosure of information to the Chief Executive Medicare.

Background
In 2017–18, Commonwealth expenditure on Medicare and Department of Veterans’ Affairs health services was over $36 billion. Ensuring that health practitioners and providers claim for Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and other health benefits appropriately is essential for maintaining the integrity of these programs. In the 2018–19 Budget, the Government announced funding of $9.5 million over five years from 2017–18 to continue to improve Medicare compliance arrangements. This followed an earlier announcement in the 2017–18 Budget, ‘Guaranteeing Medicare—Medicare Benefits Schedule—improved compliance’, to support the integrity of health benefit claims under Medicare services through improved compliance arrangements and debt recovery practices. The legislation introducing these changes came into effect on 1 July 2018.

The 2018–19 Budget Measure ‘Guaranteeing Medicare—improving safety and quality through stronger compliance’, seeks to improve compliance arrangements and debt recovery practices through better targeting investigations into fraud, inappropriate practice and incorrect claiming.

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and will use data analytics and behavioural driven approaches to compliance. It was announced at the time that legislation would be introduced to support these aims.

**Current compliance activities**

The majority of health practitioners, providers and patients claim MBS, PBS and Child Dental Benefits appropriately; however a small number do not. Fraudulent, or non-compliant, activities can include making Medicare claims for services that are not received or provided and inappropriate practice, among other things. The Department of Health (the Department) estimates that two to five per cent of claiming may be non-compliant.

The Department currently has a well-established Medicare compliance program which encompasses a range of compliance activities, including:

- provider education
- audits where sustained or opportunistic non-compliance is identified
- targeted letter campaigns where unintentional non-compliance is identified
- professional review where inappropriate practice is identified
- investigations of suspected fraudulent activity and prosecution of fraud through the Commonwealth Director of Public Prosecutions and
- the recovery of debts that have been identified as a result of incorrectly claimed benefits.

The Department uses a combination of tip-offs and data analysis of existing Medicare datasets to detect fraud and incorrect claiming.

According to the 2017–18 Department of Health Annual Report, in 2017–18 the Health Benefit Compliance program resulted in ‘20 fraud cases successfully prosecuted; 109 requests to the Director of Professional Services Review to review the appropriateness of services of health practitioners; and 3,074 completed audits and reviews of health providers. A total of $48.7 million of debt was raised for recovery.’ The 2018–19 Department of Health Annual Report did not report on the amount of debt recovered through the Health Benefit Compliance program.

The Australian National Audit Office is currently undertaking an audit to assess the effectiveness of the Department of Health’s approach to health provider compliance which is due to be tabled in May 2020.

**Data matching**

Data matching is the comparison of two or more sets of data to identify similarities or discrepancies. Data matching is currently used by a number of Government agencies for compliance purposes including Centrelink and the Australian Taxation Office.
The Bill will enable the matching of a number of datasets, including MBS and PBS information, Therapeutic Goods information, and information provided by private health insurers (see ‘Key issues and provisions’ for further information).

Matching of PBS and MBS data

Currently, given the sensitive nature of the information they contain, under section 135AA of the National Health Act and the associated National Health (Privacy) Rules 2018 (the Privacy Rules) linkage of PBS and MBS data is only permitted in a narrow range of circumstances, including:

- if it is necessary to comply with the law
- for the purpose of determining an individual's eligibility for a benefit under one program, where eligibility for that benefit is dependent upon services provided under the other program
- where the Chief Executive Medicare believes on reasonable grounds that the linkage is necessary to prevent or lessen a serious and imminent threat to the life or health of any individual or
- for disclosure to an individual where that individual has given their consent.14

These limitations mean that the MBS and PBS cannot currently be linked for compliance purposes. The authorisation for data matching contained within the Bill will exempt data matching from these restrictions when data is matched for a permitted purpose as defined in the Bill.15

Similar restrictions do not apply to other datasets that may be matched under the Bill.16

Consultation and exposure draft

The Department undertook a consultation on the proposed legislative change in late September 2019, releasing a consultation guide, an exposure draft of the Bill and associated Regulations, and the executive summary of a Privacy Impact Assessment (PIA).17 The PIA made a number of recommendations including:

- improved transparency and openness regarding privacy policies and data sharing/matching, in particular by amending existing privacy policies
- minimisation of data collection (only collecting what is necessary)
- establishing a security compliance framework for all participating entities
- expansion of data destruction and
- the establishment of privacy governance arrangements, including regular reviews.18

The Department agreed to all recommendations, with the exception of establishing a security compliance framework, to which it agreed in principle noting that it already has ‘strong security

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16. Ibid., p. 12.
measures in place to safeguard data received and retained by the Department’ as do other agencies and that a security compliance framework will be established.\textsuperscript{19}

As a result of the consultation and the PIA, some changes were made to the Bill prior to its introduction. These included changes relating to data disclosure and the introduction of the requirement for the Minister to make data matching principles.

Stakeholder submissions in response to the consultation paper are outlined in the ‘Position of major interest groups’ section below.

**Committee consideration**

**Senate Selection of Bills Committee**

In its report on 28 November 2019, the Senate Selection of Bills Committee recommended the Bill not be referred to committee for inquiry.\textsuperscript{20}

**Senate Standing Committee for the Scrutiny of Bills**

In its report on 13 November 2019, the Senate Standing Committee for the Scrutiny of Bills (the Committee) raised two concerns about the Bill relating to the use of delegated legislation to develop the data matching principles and the broad delegation of administrative powers.\textsuperscript{21} The Minister’s response was provided in the Committee’s report on 27 November 2019.\textsuperscript{22} For information on the Committee’s concerns and the Minister’s response, see the discussions on ‘Data matching principles’ and ‘Other amendments’ in the ‘Key issues and provisions’ section below.

**Policy position of non-government parties/independents**

The Australian Labor Party supports the Bill.\textsuperscript{23} During the second reading debate, the Shadow Minister for Health stated that ‘this [Bill] is this is about cracking down on fraud’ and ‘Government agencies should have the ability to compare data to deal with that...’. The Shadow Minister also noted that there is a ‘small risk that data matching presents to the privacy and security of patients’ and doctors’ information’ and that this needs to be managed effectively through the proposed data matching principles.\textsuperscript{24}

At the time of writing, no comments by independents specifically on the Bill had been identified.

**Position of major interest groups**

As already noted, the Bill has been amended since an exposure draft was released for consultation in September 2019. At the time of writing, there were few comments by key interest groups on the Bill as introduced into Parliament; however, a number of stakeholders provided submissions during the consultation period.

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\textsuperscript{24}. Ibid.
Responses to the consultation paper and exposure draft

All key stakeholders that responded during the consultation period were supportive of ensuring accountability in the health benefits system, by identifying, managing and preventing fraudulent and incorrect claiming; however, a number of submissions raised concerns with the exposure draft. Issues which have been addressed through changes from the exposure draft are not discussed in this digest.

The Australian Medical Association (AMA) expressed concern that the Bill will override the existing Privacy Rules governing the matching of MBS and PBS data, noting the sensitivity of the data and the privacy issues that can be experienced with large Medicare datasets. The AMA also raised concerns relating to data sharing, such as the ability for the Chief Executive Medicare to authorise any Commonwealth entity to undertake data matching for a permitted purpose, and delegation, noting that the Chief Executive Medicare can delegate their powers to ‘any person’. The AMA noted that the revised Bill addressed many of the concerns raised in their submission.

Both the Royal Australian College of General Practitioners (RACGP) and the medical indemnity insurer MIGA expressed concern about the breadth and scope of the data matching in compliance activities. While the consultation guide stated that the proposed data-matching and sharing arrangements would not change the powers or approach taken by the Department in conducting its compliance activities, the RACGP considered that data matching would allow examination of outliers, rather than targeting of fraudulent activity, stating:

On several occasions, the RACGP has expressed concerns to the Department about the compliance measures currently in place, including the impact of lengthy investigative processes on the health and wellbeing of providers.

Member feedback has also indicated that there is a growing perception that compliance activities are designed to monitor and target statistical outliers, as opposed to targeting fraudulent activity. Providers are concerned that they may be identified as an outlier due to their patient population and be subjected to a stressful process of proving that they are not guilty of inappropriate billing.

High billing is not necessarily an indication of incorrect billing. Many providers have legitimate reasons for billing particular item numbers at rates higher than their peers. Should the Bill pass into law, it should seek to address incorrect billing as opposed to over-billing, and incorrect billing should be based on Medicare rules and regulations as opposed to outlier statistics.

MIGA noted:

On MIGA’s assessment of the Medicare data matching proposals they appear to allow for the Department to take a very different approach in its compliance activities.

25. Australian Medical Association (AMA), Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], October 2019, pp. 1–2.
26. Ibid., pp. 2–3.
30. Royal Australian College of General Practitioners, Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], 18 October 2019, p. 1.
Proposed Section 132B of the *National Health Act 1953* (Cth) allows Medicare data matching using any information lawfully provided to Medicare, except for that collected for the purposes of the *My Health Records Act 2012* (Cth).

The proposals would permit large scale ‘compliance’ focused programs looking to financial recovery from large numbers of doctors and other health practitioners who act in good faith, reasonably believe they are meeting Medicare requirements and provide appropriate clinical care, but have not followed each and every aspect of complex Medicare item requirements, making small, unintentional errors.\(^\text{31}\)

MIGA and the RACGP also questioned the costs of implementing further compliance measures. The RACGP noted that only a small proportion of medical practitioners intentionally commit fraud and that ‘[w]hile the consultation paper notes that $180 million in funding would be lost if only one half of a percent of Medicare payments are fraudulently, incorrectly or inappropriately billed, it does not indicate how much has actually been saved as a result of Medicare compliance measures’. \(^\text{32}\) MIGA considered that fraudulent, inappropriate and incorrect claiming is likely to be ‘much less’ than $180 million. \(^\text{33}\)

Both the Aboriginal Health Council of Western Australia (AHCWA) and the Queensland Aboriginal and Torres Strait Islander Health Council (QAIHC) supported the intent of the Bill, but expressed concern about the impact on Aboriginal Community Controlled Health Services. \(^\text{34}\) AHCWA noted that the Bill may have unintended consequences for health services in remote areas due to differences in service provision, for example:

Another key challenge for the ACCHS sector is managing a highly mobile workforce. Many ACCHSs rely on part-time fly-in, fly-out doctors and, in some places, services depend significantly on locums.

This fragmented medical workforce can cause particular problems for Medicare billing for work done by [Aboriginal Health Workers] AHWs, [Aboriginal Health Practitioners] AHPs and practice nurses ‘on behalf of the doctor’. Some ACCHSs choose to bill these items in the name of the doctor who provides, and continues to provide, the majority of care to the patient. Under this arrangement, billing may occur while the doctor is briefly on leave and being covered by a locum whose job would include the supervision of AHWs, AHPs and practice nurses. Other ACCHSs choose to bill in the name of the “duty doctor” for the day, even though that doctor may be temporary, has never seen the patient before, and may never do so again. \(^\text{35}\)

Other stakeholder concerns raised during the consultation process can be found in the ‘Provisions and key issues’ section.

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Financial implications

The Bill implements aspects of the 2018–19 Budget Measure Guaranteeing Medicare — improving safety and quality through stronger compliance, which invested $9.5 million over five years from 2017–18 to continue to improve Medicare compliance arrangements. It is not clear what the cost of the specific measures in the Bill is likely to be.

Statement of Compatibility with Human Rights

As required under Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011 (Cth), the Government has assessed the Bill’s compatibility with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of that Act. The Government considers that the Bill is compatible, as any limitations on human rights are reasonable, necessary and proportionate to ensuring the integrity of Medicare and enabling greater access to healthcare for Australians.

Parliamentary Joint Committee on Human Rights

At the time of writing, the Parliamentary Joint Committee on Human Rights had not considered the Bill.

Key issues and provisions

Schedule 1—Data Matching

The Bill provides for data matching to be undertaken by the Chief Executive Medicare, or another Commonwealth entity authorised by the Chief Executive Medicare, for specified compliance-related permitted purposes aimed at maintaining the integrity of the Medicare program. This is a key component of the Bill, which arose from a measure announced in the 2018–19 Budget, as highlighted in the ‘Background’ section.

Currently, under the National Health Act and the associated Privacy Rules, the matching of MBS and PBS data is restricted to a narrow range of circumstances, which excludes matching for the purposes of compliance. Schedule 1 of the Bill introduces proposed Part VIII A into the National Health Act to allow data matching across a range of datasets, including the MBS and PBS. As noted in the Explanatory Memorandum, ‘the authorisation for data matching contained within the Bill will exempt data matching from the current restrictions when the matching is for a permitted purpose as defined in the Bill’.

Permitted purposes

Item 1 of Schedule 1 inserts proposed section 132A into the National Health Act. This proposed section provides definitions to be used within proposed Part VIII A, including the definition of a permitted purpose for data matching. Under this definition, purposes permitted for the matching of data include:

- identifying whether a person may have claimed or been paid in excess of what was payable under a Medicare program and recovering overpayments of benefits

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36. Explanatory Memorandum, op. cit., p. 3.
37. The Statement of Compatibility with Human Rights can be found at pages 4–5 of the Explanatory Memorandum to the Bill.
• detecting or investigating contraventions of a federal law relating to a Medicare program
• detecting or investigating whether a person may have engaged in inappropriate practice
• analysing services, benefits, programs or facilities provided under a Medicare, in connection with one of the above purposes and
• educating healthcare providers about Medicare program requirements.

The Explanatory Memorandum states that these permitted purposes are specific to Medicare compliance; however, while most of the purposes are confined to the Medicare program, proposed paragraph (d) of the definition of permitted purpose, ‘detecting or investigating whether a person may have engaged in inappropriate practice’ may create the potential for broader use of the data.

Concern regarding this part of the definition was raised by the New South Wales Council of Civil Liberties in its submission to the consultation process, which stated ‘[t]his purpose is not limited to Medicare programs or health care providers and has the potential for wider applications, other than ensuring the integrity of the system’. The MIGA and the RACGP also expressed concern, as outlined in the ‘position of major interest groups’ section above, about the scope of the data matching permitted under the Bill, with the RACGP stating ‘there is a growing perception that compliance activities are designed to monitor and target statistical outliers, as opposed to targeting fraudulent activity’.

In the second reading speech, the Minister for Health stated:

While data matching permitted by the bill will enhance my department’s ability to detect Medicare fraud and noncompliance, it will not expand its existing compliance powers. Nor will it change the approach taken by the department in conducting its compliance activities which are designed to be proportionate to the type of noncompliance detected.

Data matching by Chief Executive Medicare

Proposed section 132B enables the Chief Executive Medicare to match data, to which he or she has lawful access, for a permitted purpose. Proposed subsection 132B(1) outlines the information that the Chief Executive Medicare is permitted to match. This includes the following information/datasets:

• MBS
• PBS
• Therapeutic Goods Information
• information provided in accordance with the Health Practitioner Regulation National Law
• information voluntarily provided by private health insurers
• information provided in accordance with certain laws administered by the Minister for Veterans’ Affairs

42. New South Wales Council of Civil Liberties (NSWCCL), Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], 11 October 2019, p. 3.
43. Royal Australian College of General Practitioners, Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], 18 October 2019, p. 1; MIGA, Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], 11 October 2019, pp. 3–4.
any other information that can be lawfully provided to the Chief Executive Medicare (excluding information that is held or has been obtained by the Chief Executive Medicare exclusively for the purpose of performing functions under the *My Health Records Act 2012*) and

• information held by Chief Executive Medicare for the purposes of a Medicare program. 45

The Minister outlined the rationale for the matching of these data sets in the second reading speech:

The bill will permit data matching across the MBS and PBS for Medicare compliance purposes. This will enable, for example, the identification of instances where the Commonwealth pays for a PBS medicine that is not actually supplied.

The bill also provides for data matching between the Department of Health and the Australian Health Practitioner Regulation Agency to ensure that restrictions placed on registered healthcare providers by their professional board are adhered to in Medicare claiming.

It would also allow for therapeutic goods information to be used by the Department of Health to help ensure Medicare claims in relation to unapproved medical devices are appropriate.

... The bill supports matching of data from Medicare and the Department of Veterans’ Affairs to ensure that services provided under both programs are considered for the purposes of the prescribed pattern of services, where exceeding a certain number of services on a certain number of days may be considered inappropriate practice.

Data matching with records held by the Department of Home Affairs that indicate whether a person is overseas will allow confirmation that both the healthcare provider and patient were in Australia at the time of their claimed services.

... The bill also allows private health insurers to voluntarily share information with the Department of Health for the purposes of detecting fraud and recovering incorrect payments. 46

The Bill does not allow access to My Health Record data for the purposes of Medicare compliance activities. 47

**Proposed subsection 132B(2)** will enable the Chief Executive Medicare to authorise, in writing, any Commonwealth entity to match data on the Chief Executive Medicare’s behalf. The consultation guide produced by the Department of Health for the exposure draft indicates that data matching is intended to occur with datasets from the following Commonwealth agencies: the Department of Veterans’ Affairs, Department of Home Affairs, Australian Health Practitioner Regulation Agency and the Therapeutic Goods Administration; however, the Bill does not limit authorisation for data matching to these agencies. 48 As such, data matching could be undertaken by any authorised Commonwealth entity for a permitted purpose. The AMA and the NSWCCL

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47. Australian Digital Health Agency (ADHA), *My Health Record*, ADHA website.
expressed concern at the breadth of this subsection given the sensitive nature of the data involved.\footnote{AMA, Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], October 2019, p. 3.; NSWCL, Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], 11 October 2019, p. 1.} **Proposed subsection 132B(3)** provides that a Commonwealth entity authorised to match data on the Chief Executive Medicare’s behalf must comply with any terms or conditions that the Chief Executive Medicare imposes. In addition, entities would be required to disclose the results of any data matching undertaken to the Chief Executive Medicare on request.  

**Proposed subsection 132B(4)** provides that information must not be data matched until the principles made by the Minister under **proposed subsection 132F(1)** have commenced (see ‘Data matching principles’ below).  

**Item 4 of Schedule 1** is an application provision which provides that **proposed section 132B** ‘applies in relation to information collected, accessed or obtained before, on or after the commencement of this item’.\footnote{Explanatory Memorandum, op. cit., p. 9.} This allows data collected prior to the commencement of legislation to be used in data matching.  

**Disclosure of information**  
Currently, under section 135A of the *National Health Act*, the provision or communication of information in relation to a Medicare program is prohibited except in limited circumstances. \footnote{Proposed subsections 132D(1) and (2). The Australian Privacy Principles are in Schedule 1 to the *Privacy Act 1988*.} **Item 2** inserts **proposed subsection 135A(5D)** into the Act to enable the Secretary of the Department of Health or the Chief Executive Medicare to disclose protected information to an authorised Commonwealth entity for the purposes of data matching under **proposed subsection 132B(1)**.  

**Proposed sections 132C** and **132D** provide for the disclosure to the Chief Executive Medicare of therapeutic goods information by the Secretary and of treatment information by private health insurers, respectively. The Bill does not permit any patient information collected by the Government to be shared with private health insurers.  

A private health insurer—either on request from the Chief Executive Medicare or on their own initiative—may disclose information relating to hospital treatment or general treatment provided to a person they insure, for the purposes of facilitating data-matching, if either:  

- the insurance policy is taken out after the Bill’s commencement  
- the insurance policy provided that information of that kind could be disclosed if authorised under an Australian law or  
- the insurer had notified the person under the Australian Privacy Principles that information of that kind could be disclosed if authorised under an Australian law.\footnote{Proposed subsection 132D(3). Item 8 of Schedule 1 inserts a note into section 323-1 of the *Private Health Insurance Act* to this effect.}  

Information disclosed in such circumstances will be taken to be authorised for the purposes of the *Private Health Insurance Act*.\footnote{Proposed section 132E clarifies that the Australian Information Commissioner has privacy functions in relation to **proposed Part VlllA**, to the extent that it relates to information about an}  

**Privacy**  
**Proposed section 132E** clarifies that the Australian Information Commissioner has privacy functions in relation to **proposed Part VlllA**, to the extent that it relates to information about an
individual and ‘provides that a breach of a provision of the new Part VIIIA, in relation to an individual, constitutes an act or practice involving interference with the privacy of an individual for the purposes of section 13 of the Privacy Act.’ The Explanatory Memorandum notes that individuals can make a complaint to the Australian Information Commissioner if they believe their privacy has been interfered with.

Item 3 of Schedule 1 inserts proposed subsection 135AA(5C) which provides that none of the privacy restrictions regarding data matching and storage under section 135AA, or in the Privacy Rules issued under that section, prevent data matching being carried out under proposed section 132B.

The Privacy Act 1988 and Australian Privacy Principles (APPs) regulate the handling of personal information by Commonwealth government agencies and certain private sector organisations. Under the Privacy Act, health information is considered ‘sensitive information’ and is therefore afforded a higher level of protection than other types of personal information. Limitations include that sensitive information can only be collected with consent (unless a specified exception applies) and can only be used or disclosed for a secondary purpose to which it was collected if this is directly related to the primary purpose of collection. However, it is an exception to these restrictions if the collection, use or disclosure is required or authorised by an Australian law. This means that, in relation to the current Bill, disclosure and use of information for the purposes of data matching would not constitute an interference with privacy if it was done in accordance with proposed Part VIIIA of the National Health Act.

Item 7 of Schedule 1 makes a consequential amendment to the Privacy Act to allow the Australian Information Commissioner to conduct an assessment of whether information matching and handling under proposed Part VIIIA is occurring in accordance with that Part.

Data matching principles

Proposed subsection 132F(1) requires the Minister to make principles, by legislative instrument, in relation to the matching of information under proposed subsection 132B(1). The principles are intended to provide governance of the data matching process. Proposed subsection 132F(2) sets out the requirements for the principles, including appropriate record keeping; ensuring that the information matched is accurate and up to date; ensuring data matching is necessary and the destruction of personal information when no longer needed. Proposed subsection 132F(3) provides that the principles must take into account any guidelines on data matching made by the Australian Information Commissioner under paragraph 28(1)(a) of the Privacy Act.

54. Ibid., p. 8. Section 36 of the Privacy Act allows an individual to complain to the Privacy Commissioner about an act or practice that may be an interference with their privacy. The Commissioner may then investigate the act or practice, and may issue a non-binding determination regarding whether there has been an interference with the individual’s privacy, and specifying reasonable and appropriate remedial steps to be taken (section 52). Also see: Office of the Australian Information Commissioner (OAIC), ‘Chapter 1: Privacy complaint handling process’, Guide to privacy regulatory action, OAIC website, last updated 7 November 2019.
57. Privacy Act, Schedule 1, APP 3 and APP 6.
58. Ibid., Schedule 1, APP 3.3 and 3.4(a), APP 6.1 and 6.2(b).
59. These are currently the OAIC, ‘Guidelines on data matching in Australian Government administration’, OAIC website, 18 June 2014.
Proposed section 132F is significantly amended from that presented in the exposure draft, which did not include provision for the making of publicly-available principles. The Explanatory Memorandum notes that the principles will be subject to stakeholder engagement as the ‘rules are subject to Parliamentary oversight as a disallowable instrument and are subject to the consultation requirements of the Legislation Act 2003’.60

Scrutiny of Bills Committee

The Senate Standing Committee for the Scrutiny of Bills (the Committee) expressed concern regarding proposed section 132F. While proposed subsection 132F(2) sets out a number of requirements for the principles, the Committee considered that ‘significant matters, such as the principles for how a data-matching scheme will operate, should be included in the primary legislation unless a sound justification for the use of delegated legislation is provided’.61 In particular, noting that the data matching scheme will involve the use and disclosure of large amounts of personal information and that the principles will provide one of the main safeguards to ensure this information is handled appropriately, the Committee considered that having the principles in delegated legislation may result in Parliament not having ‘appropriate oversight of whether the safeguards for the data matching scheme are sufficient’.62 The Committee requested the Minister’s advice as to ‘why it is considered necessary and appropriate to leave the data-matching principles to delegated legislation’.

In response, the Minister stated that a number of operational provisions that govern the data matching scheme are set out in primary legislation, including:

• the restriction to data matching for specified compliance-related permitted purposes only (defined in proposed section 132A)
• existing secrecy provisions in the Health Insurance Act and the National Health Act which govern disclosure of information obtained in the course of duties
• oversight by the Australian Information Commissioner in relation to a breach of proposed Part VIII A and
• minimum requirements for the data matching principles, including undertaking reasonable steps to ensure data accuracy, the destruction of personal information when no longer needed and a requirement to take into account the Australian Information Commissioner’s Guidelines to Data-matching in Australian Government Administration (proposed section 132F).63

The Minister noted that the technical nature of the principles would not be appropriate for the primary legislation, and having the principles in a legislative instrument would allow greater flexibility to respond to changes in best practice. Further, it was noted that the principles will sunset in ten years, allowing a review of their appropriateness.64

The Committee noted the Minister’s response and requested that the key information provided by the Minister be included in the explanatory memorandum, ‘noting the importance of this

60. Ibid., p. 9. Section 17 of the Legislation Act 2003 provides that before a legislative instrument is made, the rule-maker must be satisfied that any appropriate consultation, which is reasonably practicable to undertake, has been undertaken. However, under section 19, the fact that consultation does not occur does not affect the validity or enforceability of a legislative instrument.
61. Senate Standing Committee for the Scrutiny of Bills, Scrutiny digest, 8, 2019, op. cit., p. 21.
62. Ibid., p. 22.
64. Ibid., pp. 22–23.
document as a point of access to understanding the law and, if needed, as extrinsic material to assist with interpretation’. 65

Schedule 1—Delegation

Item 5 inserts proposed subsections 6(9)–(12) into the National Health Act which provide that the Chief Executive Medicare can delegate any of their powers or functions under the Act to any person. The Explanatory Memorandum states that this delegation would be in line with the Secretary’s existing powers of delegation within the National Health Act and would allow delegation, for example, to officers for the purposes of undertaking data matching. 66 Both the AMA and the Senate Standing Committee for the Scrutiny of Bills (the Committee) raised concerns with the breadth of this item. The AMA noted in its submission to the consultation process:

New amendments have been included in the Bill which allow the CEO Medicare to delegate their powers to “any person”. Unlike other recent legislation (such as the Medical Indemnity changes) there is no requirement that the person be a member of the Senior Executive Service.

There is also no requirement that the person be a public servant. Theoretically the CEO Medicare could delegate their data matching powers – including their powers to determine the systems and processes – to private health insurers or a foreign government.

The sensitivity of MBS and PBS information makes it appropriate the legislation requires the CEO Medicare to maintain a public register of all organisations authorized to data match under delegated powers. 67

Scrutiny of Bills Committee

The Committee expressed concern about the broad powers of delegation under item 5 of Schedule 1 of the Bill, stating that there should be ‘a limit set either on the scope of powers that might be delegated, or on the categories of people to whom those powers might be delegated’. 68 The Committee further considered that the explanatory memorandum did not provide a sufficient justification for such a broad delegation of administrative powers. The Committee requested the Minister’s advice as to ‘why it is necessary to allow all of the Chief Executive Medicare’s powers and functions to be delegated to any person’. 69

The Minister noted that the powers in the Bill relate to the task or act of matching data rather than the making of decisions. Further, the Minister stated that ‘data matching is highly technical and specialised and carried out by data experts who may not be holders of nominated office and unlikely to be Senior Executive Service officers.’ As such, the Minister considered that the powers of delegation cannot be limited to certain office holders. 70

The Committee noted the Minister’s response, but reiterated its preference that delegations of administrative power be confined to the holders of nominated offices or members of the Senior Executive Service. Alternatively, the Committee considered a limit could be set on the scope and type of powers that may be delegated. The Committee remained concerned that it appeared that

65. Ibid., p. 23.
67. AMA, Submission to the Department of Health, Consultation on Health Legislation Amendment (Data-matching) Bill 2019 [Exposure draft], op. cit., pp. 2–3.
68. Senate Selection of Bills Committee, op. cit., p. 22.
69. Ibid., p. 23.
‘any of the Chief Executive Medicare's existing or future powers under the National Health Act 1953 (and Regulations and legislative instruments made under the Act) will be able to be delegated to any person.’

The Committee considered that it may be appropriate to amend item 5 of Schedule 1 to the Bill to limit the delegation of the Chief Executive Medicare’s powers to the delegation of the proposed new data-matching powers in proposed Part VIIIIA of the National Health Act. In addition, the Committee stated:

The committee otherwise draws its scrutiny concerns to the attention of senators and leaves to the Senate as a whole the appropriateness of allowing all of the Chief Executive Medicare's powers and functions under the Act to be delegated to any person.

Schedule 2—Other amendments

The Professional Services Review Scheme, established in 1994, aims to protect the integrity of Medicare and the PBS by reviewing and examining possible inappropriate practice by health practitioners when they provide Medicare services or prescribe PBS medicines. Inappropriate practice, as defined in section 82 of the Health Insurance Act, includes:

• unacceptable conduct—situations where a practitioner’s practice or conduct in providing Medicare services or prescribing PBS medicines would be considered unacceptable to the general body of their peers and

• prescribed patterns of services—rendering 80 or more professional attendance services on 20 or more days during a 12 month period.

The Professional Services Review Scheme is governed by Part VAA of the Health Insurance Act.

Proposed amendments to the Health Insurance Act under Schedule 2 of the Bill will improve the Commonwealth’s ability to deal with inappropriate practice, by enabling services involving a professional attendance provided under certain laws administered by the Minister for Veterans’ Affairs to be considered for a prescribed pattern of service. Currently the Professional Services Review Scheme does not consider services provided by the Department of Veterans’ Affairs (DVA) when determining whether a practitioner has engaged in prescribed patterns of service and as such, the Department of Health has limited visibility of whether a simultaneous claim has been made with the DVA for a service where an MBS claim was made.

The proposed amendments made by items 1–7 insert references to the relevant DVA laws to be considered under the Professional Services Review Scheme into the Health Insurance Act and are adequately described in the Explanatory Memorandum.

Item 8 of Schedule 2 amends the Military Rehabilitation and Compensation Act to enable the disclosure of information to the Health Secretary for a purpose of the Health Department or to the

71. Ibid., pp. 24–25.
72. Ibid., p. 25.
73. Professional Services Review (PSR), ‘About the PSR Scheme’, PSR website, n.d.
78. Explanatory Memorandum, op. cit., p. 11–12.
Chief Executive Medicare for a purpose relating to the Chief Executive Medicare’s powers and functions.

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