

EXPLANATORY STATEMENT

Health Insurance Act 1973

Health Insurance Legislation Amendment (2017 Measures No. 2) Regulations 2017

Subsection 133(1) of the Act provides that the Governor-General may make regulations, not inconsistent with the Act, prescribing all matters required or permitted by the Act to be prescribed, or necessary or convenient to be prescribed for carrying out or giving effect to the Act.

Part II of the Act provides for the payment of Medicare benefits for professional services rendered to eligible persons. Section 9 of the Act provides that Medicare benefits be calculated by reference to the fees for medical services set out in prescribed tables.

Subsections 4(1) and 4AA(1) of the Act provide that regulations may prescribe a table of medical and diagnostic imaging services which set out items of services, the fees applicable for each item, and rules for interpreting the tables. The *Health Insurance (General Medical Services Table) Regulations 2017* (GMST) and the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2017* (DIST) currently prescribe such tables.

Section 16B of the Act provides that Medicare benefits are payable for an R-type (requested) diagnostic imaging service requested by a person who is not a medical practitioner if specified in regulations. Regulation 11 of the *Health Insurance Regulations 1975* (HIR) specifies the items which can be requested by certain non-medical practitioners.

Purpose

The purpose of the *Health Insurance Legislation Amendment (2017 Measures No. 2) Regulations 2017* (the Regulations) is to amend the GMST, DIST and the HIR from 1 November 2017. The Regulations implement decisions agreed by Government following recommendations of the Medical Services Advisory Committee (MSAC) and the MBS Review Taskforce (the Taskforce).

MSAC reviews new medical services or technology and the circumstances under which public funding should be supported by Medicare. The Taskforce is a clinician-led review of all Medicare services to ensure that they reflect current best clinical practice, align with the latest evidence and promote the provision of health services that improve health outcomes.

Below is a list of the changes made by Government in response to recommendations of the Taskforce and MSAC:

- **Amendments to bone densitometry items**

This change incorporates existing bone densitometry items 12306, 12312, 12315, 12321 into the GMST (which are currently listed in the *Health Insurance (Bone Densitometry) Determination 2012*) and introduces two new items 12320 and 12322 as recommended by the Taskforce.

New items 12320 and 12322 are for the provision of bone density testing for people aged 70 years or older with a certain risk profile at intervals of two (for moderate to marked osteopenia) or five years (for normal to mild osteopenia). These new items

will replace item 12323 which will be removed from the *Health Insurance (Bone Densitometry) Determination 2012*.

This amendment also makes changes to bone densitometry items to specify the type of qualifications required to provide these services. This change is being made to clarify the rules around provider eligibility and ensure the provision of these services is performed by suitably qualified practitioners. These changes also clarify that the interpretation and report must be provided by a specialist or consultant physician.

This change will also see Quantitative Computed Tomography (QCT) items 12309 and 12318 removed from the *Health Insurance (Bone Densitometry) Determination 2012* from 1 November 2017. The Taskforce recommended the removal of these items from the MBS on the basis that QCT provides lower value care in comparison to Dual Energy X-ray Absorptiometry, which is the superior test for bone densitometry.

- **Amendments to ear, nose and throat items (ENT) 41674, 41789, 41793 and 41801**
This change amends items 41674, 41789, 41793 and 41801 to implement changes recommended by the Taskforce. The changes to the ENT items support safe clinical practice and prevent inappropriate claiming of items, supporting the appropriate use of Medicare funding. The implementation of these recommendations includes:
 - amendment to item 41674 to remove cauterisation of the pharynx as this is no longer considered appropriate clinical practice; and
 - amendment to the items for tonsillectomy (41789 and 41793) and adenoidectomy (item 41801) to clarify that the service covers the injection of local anaesthetic and examination of the post nasal space to prevent inappropriate claiming. These items have also been prevented from being co-claimed with item 41764 (examination of the nasopharynx or larynx) as an examination would be expected to form a part of the tonsillectomy or adenoidectomy procedure.
- **Amendments to gastroenterology items**
These changes amend the item descriptor for capsule endoscopy (11820) to clarify the service requirements and eligible patient population. This change also more clearly specifies the use of this item, and restricts the use of this service to those patients that are most clinically appropriate to receive the service.

These changes also restructure and consolidate other gastroenterology services and amend restrictions on co-claiming to align service provision with clinical best practice.

- **Amendment to spinal x-ray items**
This change restricts chiropractors from requesting Medicare-rebateable three and four region spinal x-ray items. Medical practitioners, physiotherapists and osteopaths would continue to be able to request the three and four region spinal x-ray items.

In conjunction with the above amendment, the diagnostic imaging benefits for one and two region spinal x-ray items have been restricted to one per patient per day.

- **Removal of the items which provide a lower rebate for a small number of procedures when performed by a general practitioner**

This change removes the differential fee structure for 62 MBS items as recommended by the Taskforce. These items have a lower or higher fee depending on whether the service is performed by a general practitioner (lower fee) or specialist (higher fee). Under this change the lower rate items (31 items) have been removed and the current specialist rate items retained. The specialist only items have also been amended to allow claiming by all medical practitioners.

- **Restricting co-claiming of same-day consultations with certain procedures and the introduction of three new items**

This amendment restricts the claiming of subsequent specialist and consultant physician consultation items when performed with an operation in Group T8 (surgical operations) that has an MBS fee equal to or greater than \$300, as recommended by the Taskforce. Consultation items can still be claimed with an operation when the fee is less than \$300 or in extenuating circumstances.

Three new professional attendance items (111, 117 and 120) have been introduced for use with an operation in T8 that has an MBS fee equal to or greater than \$300. These items only apply in extenuating circumstances whereby the resulting T8 operation was otherwise unscheduled or unable to be predicted prior to the attendance.

- **A new item for transcatheter occlusion of left atrial appendage**

This change adds a new item (38276) to lower the risk of stroke for patients with non-valvular atrial fibrillation, the most common cause of stroke-causing clots in the left atrial appendage, who are unable to take blood-thinning medications. The service involves insertion of a device that aims to lower the risk of stroke by preventing blood clots from forming in the left atrial appendage of the heart.

- **6 new items for vagus nerve stimulation therapy (VNS Therapy) for patients with medication-resistant epilepsy**

This change adds 6 new items (40701, 40702, 40704, 40705, 40707 and 40708) for VNS therapy. VNS therapy controls seizures by sending regular pulses of electrical energy to the brain via the vagus nerve. The pacemaker-like pulse generator is subcutaneously implanted in the chest and transmits to a lead subcutaneously placed in the neck and connected to left vagus nerve. The new items also include analysis and programming of the pulse generator, and surgical battery replacement.

- **Amendment of items 50950 and 50952 to include microwave tissue ablation for primary liver tumours**

This change amends items 50950 and 50952 to include microwave tissue ablation. The service is available to patients who have tumours that cannot be treated by conventional surgery. These items can still continue to be claimed for radiofrequency ablation procedures.

- **Amendment of items 11204 and 11205 - electroretinography and electrooculography ophthalmology items**

This change amends electroretinography (item 11204) and electrooculography (item 11205) to clarify these services can only be performed by a specialist or consultant

physician. This is because items 11204 and 11205 are highly specialised and should be performed by ophthalmologists in specific conditions including shielded rooms.

- Amendment to the combined positron emission tomography/computed tomography (PET/CT) items for lymphoma**

This change expands the existing nuclear medicine items 61620, 61622, 61628 and 61632 for cancer patients suffering from indolent non-Hodgkin lymphoma. Currently, only patients with stage I or IIA of the disease who are scheduled for radiotherapy treatment can access nuclear medicine diagnostic services. The expansion allows patients with indolent non-Hodgkin lymphoma, a slow-growing type of cancer, to access a combined positron emission tomography/computed tomography scan to monitor the disease's progress. This change also inserts "haemopoietic" before "stem cell transplantation" to better clarify the service, for item 61632. Item 61616 has been removed as the services contained within this item are now available under revised item 61620.
- Removal of sacral nerve items 36658, 36660 and 36662**

This change removes items 36658, 36660 and 36662 from the GMST. These items were originally introduced for the removal and replacement of leads and sacral nerve pulse generators that were implanted prior to 1998. There are now other items in the GMST (36663-36668) that relate to the removal and replacement of leads at any time, so items 36658, 36660 and 36662 are no longer required.

The Regulations also make the following minor amendments:

- Amendment of item 20560 – Initiation of anaesthesia**

This change amends item 20560 to allow claiming of this item in association with percutaneous insertion of a valvular prosthesis procedures. The item can still be claimed in association with open procedures on the heart, pericardium or great vessels of chest.
- Minor amendment to item 38452**

This amendment is to correct a minor typographical error for a medical procedure listed in item 38452.

Consultation

The changes in the Regulations were released for public comment prior to finalisation of the recommendations to Government. This was undertaken through the public consultation process during consideration by MSAC or the Taskforce:

- The Taskforce recommended changes are in Schedules 1 and 2 of the Regulations. This package of changes arose from the Taskforce's first round of clinical committees, which included gastroenterology, diagnostic imaging, ear nose and throat surgery, obstetrics, and the Principles and Rules Committee. The MBS Review is conducted by expert committees and working groups focusing on specific areas of the MBS. The recommendations were released for public consultation prior to the finalisation of its recommendations to Government.
- The MSAC recommended changes are in Schedule 3 of the Regulations. As part of the MSAC process, consultation was undertaken with professional bodies, consumer groups, the public and clinical experts for applications put forward for consideration by the Committee.

Details of the Regulations are set out in the Attachment.

The Act specifies no conditions which need to be met before the power to make the Regulations may be exercised.

The Regulations are a legislative instrument for the purposes of the *Legislation Act 2003*.

The Regulations commence on 1 November 2017.

Authority: Subsection 133(1) of the
Health Insurance Act 1973

ATTACHMENT

Details of the *Health Insurance Legislation Amendment (2017 Measures No. 2) Regulations 2017*Section 1 – Name

This section provides for the Regulations to be referred to as the *Health Insurance Legislation Amendment (2017 Measures No. 2) Regulations 2017*.

Section 2 – Commencement

This section provides that the Regulations to commence on 1 November 2017.

Section 3 – Authority

This section provides that the Regulations are made under the *Health Insurance Act 1973*.

Section 4 – Schedule(s)

This section provides that each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

Schedule 1 – Medicare Benefits Schedule Review: general

For ease of reading, the below list outlines the items related to each change:

- bone densitometry amendments are listed in items 2 and 5;
- ear, nose and throat amendments are listed in items 19 to 22;
- gastroenterology amendments are listed in items 3, 4, 6 to 9, 13 to 16, 23 and 24;
- spinal x-ray amendments are listed in items 1 and 26;
- amendments to remove the items which provide a lower rebate for a small number of procedures when performed by a general practitioner are listed in items 10 to 12, 17, 18, 25, Part 2 and Part 3; and
- amendments restricting the co-claiming of same-day consultations with certain procedures are listed in Schedule 2 (Medicare Benefits Schedule Review: co-claim restriction).

Part 1—Main amendments***Health Insurance (Diagnostic Imaging Services Table) Regulations 2017*****Item [1] – After clause 2.3.1 of Schedule 1**

This item inserts new clause 2.3.1A after clause 2.3.1. This new clause restricts chiropractors, osteopaths and physiotherapists from requesting multiple 1 and 2 region spine x-ray services more than once for a patient on any day.

Health Insurance (General Medical Services Table) Regulations 2017

Item [2] – After clause 2.34.3 of Schedule 1 (before the table)

This item inserts new clause 2.34.4 after clause 2.34.3. New clause 2.34.4 outlines the requirements for claiming items 12306 to 12322, including who can perform the scan and the interpretation and reporting of the results.

Item [3] – Schedule 1 (item 11820, column headed “Description”, paragraph (a))

This item amends the item descriptor for capsule endoscopy (11820) to clarify the service and eligible patient population. This change more clearly specifies the use of this item and restricts the use of this service to those patients that are most clinically appropriate to receive the service.

Item [4] – Schedule 1 (item 11820, column headed “Description”, paragraph (e))

This item amends 11820 to clarify the specific balloon enteroscopy items that cannot be performed with this item.

Item [5] – Schedule 1 (after item 12250)

This item inserts bone densitometry items 12306, 12312, 12315, 12320, 12321 and 12322 after item 12250.

Item [6] – Schedule 1 (item 30473, column headed “Description”)

This item amends item 30473 to clarify that the service should not be claimed with endoscopy with laser therapy item 30479. This item also makes a consequential change to remove the reference to item 30476 which is being removed (see item 8).

Item [7] – Schedule 1 (item 30475)

This item consolidates the services for endoscopic upper gastrointestinal stricture outlined in items 41819 and 41820 into item 30475 and increases the fee from \$320.25 to \$348.95 in recognition of the extra requirements. Items 41819 and 41820 have been removed (see item 23).

Item [8] – Schedule 1 (items 30476, 30478 and 30479)

This item consolidates item 30476 into item 30478. Argon plasma coagulation which is currently listed in item 30479 has also been moved into the more general endoscopic item 30478. Items 30478 and 30479 have also been restricted from being claimed at the same time. Item 30476 has been deleted.

Item [9] – Schedule 1 (items 30487 and 30493)

This item removes items 30487 and 30493 from the GMST. Item 30487 has been consolidated into item 30478. Item 30493 for biliary manometry is being removed from the GMST as it is not supported by the published literature and has no place in contemporary clinical practice.

Item [10] – Schedule 1 (items 30631 and 30635, column headed “Description”)

This item makes a consequential amendment to remove item 30638 from the descriptor of items 30631 and 30635. Item 30638 is one of the 31 items being deleted as part of the removal of items which provide a lower rebate when performed by a general practitioner. Patients will now receive the same Medicare benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [11] – Schedule 1 (item 30640, column headed “Description”)

This item makes a consequential amendment to remove item 30620 from the descriptor of item 30640. Item 30620 is one of the 31 items being deleted as part of the removal of items which provide a lower rebate when performed by a general practitioner. Patients will now receive the same Medicare benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [12] – Schedule 1 (item 30642, column headed “Description”)

This item makes a consequential amendment to remove items 30634 and 30638 from the descriptor of item 30642. Items 30634 and 30638 are two of the 31 items being deleted as part of the removal of items which provide a lower rebate when performed by a general practitioner. Patients will now receive the same Medicare benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [13] – Schedule 1 (items 30688, 30690, 30692 and 30694, column headed “Description”)

This item removes the current restriction on these items being claimed with items 30484, 30485, 30491 and 30494. After consideration by the Taskforce it was agreed that it is clinically appropriate to provide these services during the same episode of care and that patients should not be required to undergo a second episode of anaesthesia.

Item [14] – Before clause 2.44.14 of Schedule 1

This item inserts new clause 2.44.13B before 2.44.14. This clause allows for items 32084, 32087, 32090 or 32093 to be claimed for the same patient on the same day if the second service is provided under a second episode of anaesthesia or other sedation.

Item [15] – Schedule 1 (item 32084, column headed “Description”)

This item places a restriction on the co-claiming of sigmoidoscopy item 32084 with colonoscopy items 32090 and 32093. This is to ensure that item 32084 is not being co-claimed with colonoscopy items 32090 and 32093 unless the service is provided under a second episode of sedation/anaesthesia.

Item [16] – Schedule 1 (item 32087, column headed “Description”)

This item places a restriction on the co-claiming of sigmoidoscopy item 32087 with colonoscopy items 32090 and 32093. This is to ensure that item 32087 is not being co-claimed with colonoscopy items 32090 and 32093 unless the service is provided under a second episode of sedation/anaesthesia.

Item [17] – Schedule 1 (item 35643, column headed “Description”)

This item makes a consequential amendment to remove item 35639 from the descriptor of item 35643. Item 35639 is one of the 31 items being deleted as part of the removal of items which provide a lower rebate when performed by a general practitioner. Patients will now receive the same Medicare benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [18] – Schedule 1 (item 35644, column headed “Description”)

This item makes a consequential amendment to remove item 35639 from the descriptor of item 35644. Item 35639 is one of the 31 items being deleted as part of the removal of items

which provide a lower rebate when performed by a general practitioner. Patients will now receive the same Medicare benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [19] – Schedule 1 (item 41674, column headed “Description”)

This item amends item 41674 to remove the reference to cauterisation of the pharynx as this is no longer considered appropriate clinical practice.

Item [20] – Schedule 1 (item 41789, column headed “Description”)

This item amends item 41789 to clarify that the item covers the service of injection of local anaesthetic and examination of the post nasal space. This item also adds a restriction on the claiming of this item with item 41764.

Item [21] – Schedule 1 (item 41793, column headed “Description”)

This item amends item 41793 to clarify that the item covers the service of injection of local anaesthetic and examination of the post nasal space. This item also adds a restriction on the claiming of this item with item 41764.

Item [22] – Schedule 1 (item 41801, column headed “Description”)

This item amends item 41801 to clarify that the item covers the service of injection of local anaesthetic and examination of the post nasal space. This item also adds a restriction on the claiming of this item with item 41764.

Item [23] – Schedule 1 (items 41819 and 41820)

This item repeals items 41819 and 41820. The services listed in these items have been consolidated into item 30475 (see item 7).

Item [24] – Schedule 1 (item 41831, column headed “Description”)

This item amends item 41831 to clarify that this service is for the specific treatment of achalasia.

Item [25] – Schedule 1 (items 46495, 46498, 46500, 46501, 46502 and 46503, column headed “Description”)

This item makes a consequential amendment to remove item 30106 from the descriptor of items 46495, 46498, 46500, 46501, 46502 and 46503. Item 30106 is one of the 31 items being deleted as part of the removal of items which provide a lower rebate when performed by a general practitioner. Patients will now receive the same Medicare benefit regardless of whether a specialist or general practitioner performs the procedure.

Health Insurance Regulations 1975

Item [26] – Regulation 11

This item repeals and substitutes Regulation 11 of the HIR to restrict the requesting of three and four region spinal x-ray items to medical practitioners, physiotherapists and osteopaths only.

Part 2 – References to the symbol (G)

Health Insurance (General Medical Services Table) Regulations 2017

Item [27] – Clause 1.1.5 of Schedule 1

This item makes a consequential amendment by repealing clause 1.1.5 (Meaning of symbol (G)) from the GMST. Items containing the symbol (G) will be removed meaning the clause is redundant. Patients will now receive the same MBS benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [28] – Clause 3.1 of Schedule 1 (definition of (G))

This item makes a consequential amendment by omitting “(G) has the meaning given by clause 1.1.5” from clause 3.1 of the GMST. All of the items containing the symbol (G) will be removed making this clause redundant. Patients will now receive the same MBS benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [29] – Amendments of listed provisions—repeals

This item repeals 31 items that contain the (G) symbol (30009, 30013, 30041, 30048, 30067, 30074, 30102, 30106, 30110, 30265, 30282, 30620, 30634, 30638, 30675, 35512, 35516, 35526, 35617, 35639, 35676, 35683, 35687, 35712, 35716, 37622, 41665, 41788, 41792, 41796 and 41800). Patients will now receive the same MBS benefit regardless of whether a specialist or general practitioner performs the procedure.

Part 3 – References to the symbol (S)

Health Insurance (General Medical Services Table) Regulations 2017

Item [30] – Clause 1.1.7 of Schedule 1

This item makes a consequential amendment by repealing clause 1.1.7 (Meaning of symbol (S)) from the GMST. This is because the (S) is being removed from 31 items so the clause is now redundant. Patients will now receive the same MBS benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [31] – Clause 3.1 of Schedule 1 (definition of (S))

This item makes a consequential amendment by omitting “(S) has the meaning given by clause 1.1.7” from clause 3.1 of the GMST. This is because the (S) is being removed from 31 items so the clause is now redundant. Patients will now receive the same MBS benefit regardless of whether a specialist or general practitioner performs the procedure.

Item [32] – Amendments of listed provisions—(S)

This item removes the (S) from 31 items (30010, 30014, 30042, 30049, 30068, 30075, 30103, 30107, 30111, 30266, 30283, 30621, 30635, 30641, 30676, 35513, 35517, 35527, 35618, 35640, 35677, 35684, 35688, 35713, 35717, 37623, 41668, 41789, 41793, 41797 and 41801). Patients will now receive the same MBS benefit regardless of whether a specialist or general practitioner performs the procedure.

Schedule 2 – Medicare Benefits Schedule Review: co-claim restriction

For ease of reading, the below list outlines the items related to each change:

- amendments restricting the co-claiming of same-day consultations with certain procedures are listed in Schedule 2 (Medicare Benefits Schedule Review: co-claim restriction).

Health Insurance (General Medical Services Table) Regulations 2017

Item [1] – After clause 1.2.2 of Schedule 1

This item inserts new clause 1.2.2A after clause 1.2.2. This new clause restricts the claiming of items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6019, 6052 and 16404 with an item in Group T8 with a fee of \$300 or more for the same patient on the same day.

Item [2] – Schedule 1 (after item 109)

This item inserts new item 111 after item 109. New professional attendance item 111 (for specialists) is for use with a procedure in Group T8 that has an MBS fee equal to or greater than \$300. This item only applies in extenuating circumstances whereby the resulting procedure was otherwise unscheduled or unable to be predicted prior to the professional attendance.

Item [3] – Schedule 1 (after item 116)

This item inserts new item 117 after item 116. New professional attendance item 117 (for consultant physicians) is for use with a procedure in Group T8 that has an MBS fee equal to or greater than \$300. This item only applies in extenuating circumstances whereby the resulting procedure was otherwise unscheduled or unable to be predicted prior to the professional attendance.

Item [4] – Schedule 1 (after item 119)

This item inserts new item 120 after item 119. New minor professional attendance item 120 (for consultant physicians) is for use with a procedure in Group T8 that has an MBS fee equal to or greater than \$300. This item only applies in extenuating circumstances whereby the resulting procedure was otherwise unscheduled or unable to be predicted prior to the professional attendance.

Schedule 3 - Other amendments

For ease of reading, the below list outlines the items related to each change:

- new cardiac service is listed in item 7;
- new vagus nerve stimulation therapy services are listed in items 9 to 11;
- amendment of items 50950 and 50952 to list new microwave tissue ablation service are listed in item 15;
- amendment to two ophthalmology items to exclude their use by general practitioners are listed in item 4;
- amendment to the combined positron emission tomography/computed tomography items for lymphoma are listed in items 1 to 3;
- removal of three sacral nerve items are listed in item 6;
- amendment of item 20560 (initiation of anaesthesia) is listed in item 5; and
- minor amendment to item 38452 to fix a typographical error is listed in item 8.

Health Insurance (Diagnostic Imaging Services Table) Regulations 2017

Item [1] – Schedule 1 (item 61616)

This item makes a consequential amendment by repealing item 61616. This item has been repealed because the services contained within this item will now be able to be performed under item 61620.

Item [2] – Schedule 1 (items 61620, 61622 and 61628, column headed “Description”)

This item removes the current restriction on items 61620, 61622 and 61628 to allow them to be claimed for indolent non-Hodgkin lymphoma.

Item [3] – Schedule 1 (item 61632, column headed “Description”)

This item removes the current restriction on items 61632 to allow it to be claimed for indolent non-Hodgkin lymphoma. This change also inserts “haemopoietic” before “stem cell transplantation” to better clarify the service.

Health Insurance (General Medical Services Table) Regulations 2017**Item [4] – Schedule 1 (items 11204 and 11205, column headed “Description”)**

This item inserts “, performed by or on behalf of a specialist or consultant physician in the practice of his or her speciality”. This change clarifies who can provide these services.

Item [5] – Schedule 1 (cell at item 20560, column headed “Description”)

This item inserts “percutaneous insertion of a valvular prosthesis” to allow this item to be used for the percutaneous insertion of a valvular prosthesis.

Item [6] – Schedule 1 (items 36658, 36660 and 36662)

This item repeals items 36658, 36660 and 36662 which are now redundant. These items were originally introduced for the removal and replacement of leads and sacral nerve pulse generators that were implanted prior to 1998.

Item [7] – Schedule 1 (after item 38275)

This item inserts new item 38276 after item 38275. This new item is for the provision of a service to insert a device that aims to lower the risk of stroke by preventing blood clots from forming in the left atrial appendage of the heart.

Item [8] – Schedule 1 (item 38452, column headed “Description”)

This item makes a minor spelling amendment by omitting “sub-xyphoid”, and substituting with “subxiphoid”.

Item [9] – Schedule 1 (after item 40700)

This item inserts new items 40701 and 40702 after item 40700. These new items are for the provision of placement and surgical repositioning or the removal of an electrical pulse generator for vagus nerve stimulation therapy.

Item [10] – Schedule 1 (after item 40703)

This item inserts new items 40704 and 40705 after item 40703. The new items are for the provision of surgical placement of lead, including connection of lead to left vagus nerve and intra-operative test stimulation and surgical repositioning or removal of lead attached to left vagus nerve for vagus nerve stimulation therapy.

Item [11] – Schedule 1 (after item 40706)

This item inserts new items 40707 and 40708 after item 40706. The new items are for the provision of electrical analysis and programming and surgical replacement of battery for vagus nerve stimulation therapy.

Item [12] – Schedule 1 (items 50950 and 50952)

This item amends items 50950 and 50952 to allow these items to be claimed for the provision of microwave tissue ablation to treat primary liver tumours in certain patients.

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Health Insurance Legislation Amendment (2017 Measures No. 2) Regulations 2017

This Disallowable Legislative Instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Disallowable Legislative Instrument

The purpose of the *Health Insurance Legislation Amendment (2017 Measures No. 2) Regulations 2017* (the Regulations) is to amend the GMST, DIST and the HIR from 1 November 2017. The Regulations implement decisions agreed by Government following recommendations of the Medical Services Advisory Committee or the MBS Review Taskforce.

Human rights implications

The Regulations engage Articles 9 and 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), specifically the rights to health and social security.

The Right to Health

The right to the enjoyment of the highest attainable standard of physical and mental health is contained in Article 12(1) of the ICESCR. The UN Committee on Economic Social and Cultural Rights (the Committee) has stated that the right to health is not a right for each individual to be healthy, but is a right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

The Committee reports that the '*highest attainable standard of health*' takes into account the country's available resources. This right may be understood as a right of access to a variety of public health and health care facilities, goods, services, programs, and conditions necessary for the realisation of the highest attainable standard of health.

The Right to Social Security

The right to social security is contained in Article 9 of the ICESCR. It requires that a country must, within its maximum available resources, ensure access to a social security scheme that provides a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care. Countries are obliged to demonstrate that every effort has been made to use all resources that are at their disposal in an effort to satisfy, as a matter of priority, this minimum obligation.

The Committee reports that there is a strong presumption that retrogressive measures taken in relation to the right to social security are prohibited under ICESCR. In this context, a retrogressive measure would be one taken without adequate justification that had the effect of reducing existing levels of social security benefits, or of denying benefits to persons or groups previously entitled to them. However, it is legitimate for a Government to re-direct its limited resources in ways that it considers to be more effective at meeting the general health needs of all society, particularly the needs of the more disadvantaged members of society.

Analysis

The Regulations will maintain rights to health and social security by ensuring access to publicly subsidised health services which are clinically effective and cost-effective.

Conclusion

This Disallowable Legislative Instrument is compatible with human rights as it does not raise any human rights issues.

Greg Hunt

Minister for Health