EXPLANATORY STATEMENT

Health Insurance Act 1973

Health Insurance Legislation Amendment (2018 Measures No. 2) Regulations 2018

Subsection 133(1) of the *Health Insurance Act 1973* (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.

Subsection 4(1) of the Act provides that regulations may prescribe a table of medical 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 2018* (GMST) prescribes such a table.

Paragraph 10(2)(aa) of the Act provides that Medicare benefits are payable in respect of a service at an amount equal to 100% of the schedule fee if prescribed in regulations. Regulation 6EF of the *Health Insurance Regulations 1975* (HIR) specifies that the services described in an item in the GMST and mentioned in Schedule 6 of the HIR are services for which the Medicare benefit is 100% of the schedule fee.

Purpose

The purpose of the *Health Insurance Legislation Amendment (2018 Measures No. 2) Regulations 2018* (the Regulations) is to amend the GMST and the HIR from 1 July 2018 to implement changes announced in the 2018-19 Budget under the *A Stronger Rural Health Strategy* measure. This measure creates a new fee structure for standard and non-standard attendances performed by other medical practitioners (OMPs) who are new entrants to general practice from 1 July 2018. Under this measure, the benefit a patient will receive for a general practice (GP) service will be based on the training of the medical practitioner, the area the service is rendered, and the type of general practice service.

The package of changes includes:

- New OMPs (from 1 July 2018) providing services in a metropolitan area (Modified Monash 1 – MM1) will be paid at a rate that is 80% of the benefit for the equivalent specialist GP items, except for standard GP services:
  - the GP in-hours attendance items (Group A1, Level A-D); and
  - the attendance items associated with the PIP incentive payment (Group A18);
- New OMPs in MM 1 will be paid under the equivalent OMP items for these standard GP services (Group A2 and A19); and
- New OMPs providing services in a regional or remote area (MM 2-7) will be paid at a rate that is 80% of the benefit for the equivalent specialist GP item, for all types of services. This includes standard GP services.

OMPs currently participating in an OMP Program will remain eligible for higher specialist GP rates for a period of five years (until 1 July 2023). Access to these Programs will be closed to new applicants from 1 July 2018 through changes to the relevant administrative guidelines. OMP Programs include the Rural Other Medical Practitioners Program, the Outer-Metropolitan Other Medical Practitioners Program, the MedicarePlus for Other Medical Practitioners Program and the After-Hours Other Medical Practitioners Program.

Background information

There are two types of GP services: standard services and non-standard GP services. Standard services comprise consultation services for any clinical indication (level A to D), and are the most commonly claimed GP service by volume. Non-standard GP services comprise specific purpose general practice services, such as group therapy and chronic disease management.

Since 1989 it has been government policy that OMPs receive a lower fee for the services they provide than specialist GPs. The MBS fee differential is intended to compensate specialist GPs for having met each of the standards for working in independent private practice, including continuing professional development requirements.

While the quality intent of the fee differential is clear, its current application is limited to standard general practice attendances. Specialist GPs and GP trainees working towards specialist recognition may claim a higher fee (items in groups A1 and A18) than an OMP (items in groups A2 and A19) for these items. However the current fee differential is limited in scope as:

- No fee differential applies to an OMP if they have been approved to practise as an eligible non-vocationally recognised medical practitioner by participating in one of the OMPs Programs. Under the current conditions, status as an eligible non-vocationally recognised medical practitioner is extended to an OMP if they are deemed to be addressing a defined workforce shortage or are engaged in after-hours work.
- Several MBS item groups that are for non-standard attendances can be provided by OMPs with the same MBS fee as their specialist GP counterparts, despite their lack of a specialist qualification.

The current limits on the fee differential means OMPs are not compelled to achieve fellowship before becoming eligible to render services at the specialist GP rate. To address this issue, the Government announced it would create a new fee structure for standard and non-standard attendances performed by OMPs who are new entrants to general practice from 1 July 2018.

The Regulations amend the existing general practice Medicare items to restrict OMPs from continuing to access the existing non-standard GP items at the specialist GP rate.

The *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018* (the Determination) will be made by 1 July 2018 to allow OMPs to continue rendering general practice services under Medicare. The items in the Determination will reflect the new benefit structure. The Regulations will also amend Schedule 6 of the HIR to add the new items which will be listed in the Determination. This will make the benefit payable at 100% of the schedule fee, consistent with most general practice items.

Consultation
The Department consulted with stakeholders on key elements and principles of the *A Stronger Rural Health Strategy* measure. This included stakeholders representing general practice.

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*.

Schedule 1 and item 1 of Schedule 2 of the Regulations commence immediately after the commencement of the *Health Insurance (General Medical Services Table) Regulations 2018*. Schedule 2, items 2 to 7 of the Regulations commence immediately after the commencement of the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2018*.

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

ATTACHMENT

Details of the *Health Insurance Legislation Amendment (2018 Measures No. 2) Regulations 2018*

Section 1 – Name

This section provides for the Regulations to be referred to as the *Health Insurance Legislation Amendment (2018 Measures No. 2) Regulations 2018.*

Section 2 – Commencement

This section provides that Schedule 1 and item 1 of Schedule 2 of the Regulations commence immediately after the commencement of the *Health Insurance (General Medical Services Table) Regulations 2018*. Schedule 2, items 2 to 7 of the Regulations commence immediately after the commencement of the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2018*.

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 – Amendments relating to medical practitioners

Health Insurance (General Medical Services Table) Regulations 2018

Items 1 and 2 - Subclauses 2.8.1(1) and (2) of Schedule 1
These items make an amendment to the prolonged attendances items in Group A5 (items 160 to 164) by limiting them to being rendered by a general practitioner, specialist or consultant physician. There is no other change to the application of the items.

Item 3 – Schedule 1 (items 170 to 172)
This item makes an amendment to the group therapy items in Group A6 (item 170 to 172) by limiting them to being rendered by a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of his or her specialty of psychiatry as per the current requirements). There is no other change to the application of the items.

Items 4 and 5 – Division 2.10 of Schedule 1
These items make a minor editorial amendment to the heading of Division 2.10 and the heading in the table in Division 2.10 to include “and Non-Specialist Practitioner Items”. These changes reflect the addition of OMP items (otherwise known as ‘non-specialist practitioner items’) to this group that have been made through the *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018*.

Item 6 - Division 2.10 of Schedule 1 (Group A7 table, before item 173)
This item makes a minor editorial amendment by adding 'subgroup 1 – Acupuncture' in the table before item 173. This change is to reflect the addition of subgroups to this group that have been made through the *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018*.

Items 7 to 14, 57 and 58
These items amend the health assessment items (701, 703, 705, 707 and 715) and relevant clauses in Group A14 to limit these items to being rendered by a general practitioner. There is no other change to the application of the items.

Items 15 to 26
These items amend the GP chronic disease management items (721 to 732), case conference items (735 to 758) and for participation in a multidisciplinary case conference items (871 and 872) and relevant clauses in Group A15. These changes limit the rendering of items 721 to 732 and 735 to 758 to a general practitioner, and items 871 and 872 to a general practitioner, specialist or consultant physician. There is no other change to the application of the items.

There are no changes to the consultant physician items 820 to 866 and 880 in Group A15.

Items 27 to 33
These items amend the domiciliary and residential medication management reviews items (items 900 and 903) and relevant clauses in Group A17. These changes limit the rendering of these items to a general practitioner. There is no other change to the application of the items.

Item 34 – at the end of subclause 2.20.1(1) of Schedule 1
This item makes an amendment to the video conferencing consultation items (2100 to 2220) in Group A30 by limiting them to being rendered by a general practitioner, specialist or consultant physician. There is no other change to the application of the items.

Item 35 - Division 2.20 of Schedule 1 (Group A30 table, table heading)
This item makes a minor editorial amendment to the heading in the table in Group A30 by removing "(including a general practitioner, specialist or consultant physician)". This change is to make the table name consistent with the name of the division.

Item 36 - Schedule 1 (item 2143)
This item makes a minor editorial amendment to the wording in item 2143. This change is to make this item descriptor consistent with the other items in this group (A30) but does not change the application of the item.

Items 37 to 50
These items amend the mental health care items (2700 to 2727) and relevant clauses in Group A20 to limit the items to being rendered by a general practitioner. The exiting requirements around mental health skills training will remain unchanged. There is no other change to the application of the items.

Items 51 to 53
These items amend the pregnancy support counselling item (4001) and relevant clauses in Group A27 to limit the item to being rendered by a general practitioner. There is no other change to the application of this item.

Item 54 - Schedule 1 (item 10992)
This item makes a consequential amendment to bulk-billing incentive item 10992 to include the new OMP items being created by the *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018*. This will allow a bulk-billing incentive to be paid for these new items.

Items 55 and 56 - Clause 3.1 of Schedule 1
These items make a consequential amendment by repealing the definition of 'associated medical practitioner' and substituting with 'associated general practitioner'. This is to reflect the changes made to this definition in Groups A15 and A20.

Health Insurance Regulations 1975

Items 59 to 62
These items make consequential amendments to Schedule 6 of regulation 6EF of the HIR by adding new items which are prescribed in the *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018*). This change is to enable 100% benefit to be payable for these items, consistent with the structure for general practice services.

Schedule 2 - Amendments relating to the 2018 services tables

Health Insurance Regulations 1975

Item 1 - Subregulation 13(21) (definition of service time)
This amendment makes an editorial amendment by omitting "2.43.4 in Part 2" of the general medical services table and substituting with "2.44.4". This is to reflect this clause being renumbered in the remake of the general medical services table.

Items 2 to 7 - Regulation 20C
These items make consequential amendments to the table in regulation 20C to reflect amendments made to the diagnostic imaging services table. This change is to adjust for advancement in technology by removing the reference to specific ultrasound transducer frequencies. These ultrasound transducer requirements no longer reflect clinical best practice making the requirement to register them unnecessary and burdensome.

Statement of Compatibility with Human Rights

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

Health Insurance Legislation Amendment (2018 Measures No. 2) Regulations 2018

This 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 Legislative Instrument

The purpose of the *Health Insurance Legislation Amendment (2018 Measures No. 2) Regulations 2018* (the Regulations) is to amend the GMST and the HIR from 1 July 2018. The Regulations amend the existing general practice Medicare items to restrict OMPs from continuing to access the existing non-standard GP items at the specialist GP rate.

This change is part of the *A Stronger Rural Health Strategy* measure which was announced in the 2018-19 Budget. The change will expand the MBS fee differential between specialist GPs and other medical practitioners working in general practice in recognition of the value in general practice specialisation.

The *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018* will be made by 1 July 2018 to allow OMPs to continue rendering general practice services under Medicare. The items in that determination will reflect the new benefit structure.

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 and cost effective.

There are 94 general practice Medicare items which are affected across standard services (Level A to D) and non-standard GP services (group therapy, chronic disease management, etc.). Patients will continue to have access to these items where the service is rendered by a general practitioner at the same rate to incentivise better value care through targeted benefits.

General practice services rendered by an OMP will remain Medicare-eligible so patients will continue to be able to access clinically necessary services. The benefit paid for these services will be changed to reflect the superior quality of a service rendered by a specialist GP. This will encourage doctors in general practice to train towards and complete vocational training.

Conclusion

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

Greg Hunt

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