

EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health

Health Insurance Act 1973

Health Insurance Legislation Amendment (Intensive Care and Emergency Medicine) Regulations 2020

The *Health Insurance Act 1973* (the Act) sets out the principles and definitions governing the Medicare Benefits Schedule (MBS). The Act provides for payments by way of medical benefits and for other purposes.

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 tables 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 2019* (GMST) and the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2019* (DIST) currently prescribe such tables.

Purpose

The purpose of the *Health Insurance Legislation Amendment (Intensive Care and Emergency Medicine) Regulations 2020* (the Regulations) is to amend the GMST and the DIST from 1 March 2020.

The Regulations implement the Government's response to recommendations from the MBS Review Taskforce (the Taskforce) on intensive care and emergency items, as announced in the 2019-20 Budget under the *Guaranteeing Medicare — Medicare Benefits Schedule Review — response to Taskforce recommendations* measure.

The Taskforce found the existing MBS-funded intensive care and emergency medicine arrangements were complex and the fee structure did not adequately reflect the additional skill, time and risks associated with treating complex patients. The Taskforce recommended to Government that the intensive care and emergency medicine items be restructured to reflect contemporary clinical practice.

Schedules 1 to 4 of the Regulations amend the GMST and the DIST to implement the Government's response to the recommendations from 1 March 2020. This includes:

Emergency medicine

Schedule 1 of the Regulations removes the existing emergency medicine attendance items in Group A21 of the GMST and replaces them with a new schedule of items. This includes the introduction of:

- a new subgroup of attendance items to reflect the level of professional involvement an emergency medicine service requires. The attendance services have been differentiated by clinical complexity and the age of patients;
- new items for emergency medicine services performed by medical practitioners to encourage more doctors to gain emergency attendance experience and improve their capabilities. The fee for these items are 75% of the equivalent service performed by an emergency medicine specialist; and
- new attendance items for goals of care services, performed by medical practitioners in emergency medicine, to support gravely ill patients to make informed decisions regarding treatment of their medical condition.

Schedule 1 of the Regulations will also insert a new subgroup of treatment and therapeutic services which are commonly performed in emergency medicine to simplify the claiming arrangements for patients and doctors.

Intensive Care

Schedules 2 and 3 of the Regulations amend the GMST and the DIST to make changes to intensive care services.

Schedule 2 of the Regulations will change the intensive care procedural services in subgroup 9 of Group T1 of the GMST to better describe and reflect contemporary clinical practice. It will also make a change to the DIST to prevent an ultrasound service from being co-claimed with the catheterisation and cannulation items (13815, 13832, 13840 or 13842) of the GMST.

Schedule 3 of the Regulations will list a new attendance item (13899) for a goals of care service, performed by a specialist in intensive care, to support gravely ill patients to make informed decisions regarding treatment of their medical condition.

Minor or consequential changes

The Regulations will also make minor or consequential changes to the MBS from 1 March 2020:

- Schedule 4 of the Regulations remove item 14200, a gastric procedure to treat patients who have ingested poison. The Taskforce recommended that the gastric lavage procedure (commonly known as ‘stomach pumping’) should be removed from the MBS as it no longer reflects best clinical practice. The Government accepted this recommendation in the 2019-20 Budget as part of the *Guaranteeing Medicare — Medicare Benefits Schedule Review — response to Taskforce recommendations* measure.
- MBS item 41501 is a diagnostic test for patients suffering problems with their voice or throat (known as stroboscopy). Schedule 5 of the Regulations make a small amendment to the item to clarify that patients with malignant vocal fold lesions are eligible for the service. There is no change to existing policy.

Consultation

The MBS Review is conducted by expert committees and working groups focusing on specific areas of the MBS. The Taskforce endorsed reports were released for public comment prior to finalisation of the Taskforce recommendations to Government.

An Implementation Liaison Group (ILG) involving representatives of emergency medicine and intensive care doctors was consulted during development of the Regulations. The ILG included representatives of the Australian Medical Association, the College of Intensive Care Medicine of Australia and New Zealand, the Australian and New Zealand Intensive Care Society, and the Australasian College for Emergency Medicine.

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 March 2020.

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

Details of the *Health Insurance Legislation Amendment (Intensive Care and Emergency Medicine) Regulations 2020*

Section 1 – Name

This section provides that the instrument is the *Health Insurance Legislation Amendment (Intensive Care and Emergency Medicine) Regulations 2020* (the Regulations).

Section 2 – Commencement

This section provides that the Regulations commence on 1 March 2020.

Section 3 – Authority

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

Section 4 – Schedules

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 – Emergency Medicine

- **Amendments to the *Health Insurance (General Medical Services Table) Regulations 2019***

Items [1] to [2] – Amendments to subclauses 1.2.4(1) and 1.2.5(1)

These amendments make consequential amendments to clauses 1.2.4 and 1.2.5 of the GMST by removing references to emergency medicine items in Group A21 which is deleted (refer to amendment 4 in Schedule 1).

Item [3] – Amendment to subclauses 1.2.5(1) and 1.2.6(1)

This amendment includes the new intensive care medicine services (items 14255 to 14288 in Schedule 2) in clauses 1.2.5 and 1.2.6 of the GMST.

Clause 1.2.5 of the GMST provides that medical practitioners must personally attend the service which must be performed on a single patient on a single occasion. Clause 1.2.6 of the GMST provides that medical practitioners must personally attend the service. This applies regardless if the medical practitioner, or a person on behalf of the medical practitioner, performs the service.

Item [4] – Repeal and substitute Division 2.15

This amendment repeals Division 2.15, which contains the existing emergency medicine items, and replaces it with a new schedule of emergency medicine items (21 items in total). This includes the introduction of new attendance items (5001 to 5036) to reflect the level of professional involvement an emergency medicine service requires. The attendance services have been differentiated by:

- the complexity of the medical-decision making;
- the age of patients; and
- the type of doctor who performs the service (medical practitioner or specialist in emergency medicine).

The Regulations list emergency medicine services performed by medical practitioners to encourage more doctors to gain emergency medicine experience and improve their capabilities. The fee for these items is 75% of the equivalent service performed by an emergency medicine specialist.

The new attendance items are intended to be inclusive of medical tasks which are integral to emergency attendance services. The Taskforce advised that services such as electrocardiograms, resuscitation of less than 30 minutes, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, and point-of-care ultrasounds are expected to be performed under the new attendance items.

The Regulations also introduce attendance items for the preparation of goals of care for a “gravely ill patient lacking current goals of care” (refer to amendment 5 in Schedule 3). The goals of care services include:

- Services to be performed in conjunction with, or after, the new attendance services. This includes item 5039 for emergency medicine specialists and item 5042 for medical practitioners. The Taskforce advised that a lower fee would be appropriate for these services as it is expected the doctor would have performed the attendance service on the patient, and would be familiar with the patient’s medical issue and circumstances.
- Services that are not to be performed in conjunction with, or after, the new attendance services. This includes item 5041 for emergency medicine specialists and item 5044 for medical practitioners. The Taskforce advised that an increased fee would be appropriate for these services as the doctor would not be familiar with the patient’s medical issues and circumstances.

A goals of care service involves a comprehensive evaluation of the patient’s issues (including medical, psychological, social and other issues), discussing options for the care of the patient, including alternatives to intensive or escalated care, and developing an agreed plan with the patient (or surrogate decision-maker). The Taskforce recommended introducing goals of care in response to feedback that medical decisions for gravely ill patients are often made without providing sufficient information to patients and their families about the alternatives available to them.

Patients are eligible for a goals of care service if no record can be found of an existing goals of care. Patients who have a record are also eligible if their condition has changed to the point the record does not reflect the patient’s current medical condition, and it is reasonable for new goals of care to be developed. The limitation on eligibility was considered appropriate by the Taskforce as it is preferable for patients to have an existing goals of care with their usual doctor.

Item [5] – Amendment to heading of Subgroup 13 of Group T1

This amendment makes a consequential change to the heading of Subgroup 13 in Group T1 of the GMST to avoid confusing it with new Subgroup 14 (refer to amendment 6 in

Schedule 1).

Item [6] – Insert new Subgroup 14 in Group T1

In its review of emergency medicine, the Taskforce found the arrangements were administratively complex and confusing for patients and doctors. It found significant variation in the services which were being claimed for episodes of emergency medicine, with more than 100 different items being claimed. The Taskforce recommended a new subgroup of therapeutic and procedural items be introduced to simplify the existing arrangements for doctors and patients.

This amendment inserts a new subgroup of therapeutic and procedural services (18 items in total) which are commonly performed in emergency medicine. The new items reflect the significant additional professional involvement associated with issues or tasks that may be performed in an emergency department context, but that are not a standard component of the attendance items (refer to amendment 4 in Schedule 1).

Specifically, items in Subgroup 14 include:

- resuscitation (for at least 30 minutes), minor procedures, procedures and fracture/dislocation management services, anaesthesia services and emergent intubation/airway management, which are to be performed in conjunction with an emergency medicine attendance service in Group A21.
- chemical or physical restraints, which can be performed as a standalone service or in conjunction with an emergency medicine attendance service in Group A21, where an acute severe behavioural disturbance necessitates involuntary management with a team based approach or one-on-one care to ensure the safety of the patient.

It is important to note that the new items cover the most common procedural and therapeutic services but are not intended to cover all possible services performed in emergency medicine. As such, doctors are not be restricted from performing other procedural and therapeutic items on the GMST for emergency medicine services, where clinically relevant.

Item [7] – Definition of “problem focussed history”

This amendment makes a consequential amendment to remove a definition which was only used for the purpose of emergency medicine items 501, 503, 507, which are now deleted by the Regulations (refer to amendment 4 in Schedule 1).

Item [8] – Definition of “recognised emergency department”

This amendment makes a consequential amendment to the definition of “recognised emergency department” to include the meaning of the term in clause 3.1, rather than refer to the meaning given by clause 2.15.1. There is no change to what a “recognised emergency department” is.

Schedule 2– Intensive Care

- ***Amendments to the Health Insurance (Diagnostic Imaging Services Table) Regulations 2019***

Item [1] – Insert clause 2.1.2A

Cannulation and catheterisation are procedures that involve inserting a tube ('catheter' or 'cannula') into a blood vessel, vein or artery. This tube allows fluids to be delivered, blood to be drawn, or blood pressure to be measure.

The tube can be inserted with or without ultrasound guidance. Ultrasound guidance assists the doctor to guide the tube into position by identifying structures beneath the skin, such as blood vessels, nerves and muscles

The Taskforce recommended that the descriptors of cathertisation item 13815 and cannulation items 13832, 13840 and 13842 be changed to convey the expectation that ultrasound guidance should be used, where clinically appropriate. In modern practice, the use of ultrasound guidance is considered best practice in most circumstances and an integral component of cannulation and catheterisation.

Where items 13815, 13832, 13840 or 13842 of the GMST are performed with ultrasound, the Taskforce recommended that a service in the DIST table should not be claimed. This amendment implements that recommendation by inserting clause 2.1.2A in the DIST.

- **Amendment to the *Health Insurance (General Medical Services Table) Regulations 2019***

Item [2] – Amendment to item 13815

This amendment clarifies the requirements of cathertisation item 13815 (refer to amendment 1 in Schedule 2).

Item [3] – Insert items 13832, 13834, 13835, 13837 and 13838

This amendment lists new items (13832, 13834, 13835, 13837 and 13838) for extracorporeal life support, as recommended by the Taskforce.

These services were being performed under items 13851 and 13854 which are restricted to the management of ventricular assist devices only from 1 March 2020 (refer to amendment 4 in Schedule 2).

This amendment clarifies that the new peripheral cannulation item for veno-arterial cardiopulmonary extracorporeal life support (item 13832) should include ultrasound image guidance, where appropriate (refer to amendment 1 in Schedule 2).

Item [4] – Insert item 13840, amend items 13842, 13848, 13851 and 13854, repeal item 13847

Items 13847 and 13848 are for the management of counterpulsation by intraaortic balloon. Although the items are for the same service, the items have a differential fee for services performed on the first day (item 13847) to services performed on the second and subsequent days (item 13848).

The Taskforce recommended removing this distinction as there is no significant difference in the amount of clinical input required on the first day to subsequent days in terms of management of counterpulsation by intraaortic balloon. This amendment repeals item 13847 and amend 13848 to allow for it to be performed each day. Doctors who insert an intraaortic balloon pump should claim item 38609 in the GMST, which is not affected by the Regulations.

Items 13851 and 13854 were originally introduced to cover management of ventricular assist devices, which is a mechanical pump which assists the heart to circulate blood. The Taskforce found that the items are also being performed for extracorporeal membrane oxygenation, which is the use of an external device to provide temporary life support for a person whose heart and lungs are not functioning adequately to sustain life, due to the wording of the descriptors.

The Taskforce recommended amending items 13851 and 13854 to limit their use to the management of ventricular assist devices, and listing new items for extracorporeal life support. This amendment makes the Taskforce changes to items 13851 and 13851 (refer to amendment 3 in Schedule 2 for the new extracorporeal life support items).

This amendment will also clarify that the requirements of the cannulation items (13840 and 13842) include ultrasound image guidance, where appropriate (refer to proposed amendment 1 in Schedule 2).

Schedule 3 – Goals of care preparation for intensive care

- ***Amendments to the Health Insurance (General Medical Services Table) Regulations 2019***

Item [1] – Amendment to subclause 1.2.4(1)

This amendment includes the new intensive care goals of care service (item 13899) in clauses 1.2.4 of the GMST.

Clause 1.2.4 of the GMST lists the requirements of a professional attendance service, including: evaluation of patient's condition; formulating a plan of management, giving advice, providing advice to other authorised persons on the patient's condition and treatment; providing preventative healthcare and recording clinical notes.

Item [2] – Amendment to subclauses 1.2.5(1) and 1.2.6(1)

This amendment includes item 13899 in clauses 1.2.5 and 1.2.6 of the GMST. Clause 1.2.5 of the GMST provides that medical practitioners must personally attend the service which must be performed on a single patient on a single occasion. Clause 1.2.6 of the GMST provides that medical practitioners must personally attend the service. This applies regardless if the medical practitioner, or a person on behalf of the medical practitioner, performs the service.

Item [3] – Insert clause 2.38.10

This amendment prevents an intensive care specialist from performing a goals of care service under item 13899 (refer to amendment 4 in Schedule 3) on the same patient on the same day as a service for the management of a patient in intensive care.

Item [4] – Insert item 13899

This amendment introduces an attendance item for the preparation of goals of care for a “gravely ill patient lacking current goals of care” (refer to amendment 5 in Schedule 3) by an intensive care specialist.

A goals of care service involves a comprehensive evaluation of the patient's issues (including medical, psychological, social and other issues), discussing options for the care

of the patient, including alternatives to intensive or escalated care, and developing an agreed plan with the patient (or surrogate decision-maker). The Taskforce recommended introducing goals of care in response to feedback that medical decisions for gravely ill patients are often made without providing sufficient information to patients and their families about the alternatives available to them.

Patients are eligible for a goals of care service if no record can be found of an existing goals of care. Patients who have a record are also eligible if their condition has changed to the point the record does not reflect the patient's current medical condition, and it is reasonable for new goals of care to be developed. The limitation on eligibility was considered appropriate by the Taskforce as it is preferable for patients to have an existing goals of care with their usual doctor.

The goals of care item is to be performed outside an intensive care unit. This reflects the Taskforce advice that, where it is appropriate for an intensive care specialist to develop a goals of care with a patient, it should be developed prior to admission to an intensive care unit to better support patient decision making and potentially reduce unnecessary or undesirable treatment.

Item [5] – Insert two definitions for goals of care

This amendment inserts two new definitions which have meaning for the new emergency medicine (refer to amendment 3 in Schedule 1) and intensive care (refer to amendment 4 in Schedule 3) goals of care services.

Schedule 4 – Gastric lavage

- **Amendments to the *Health Insurance (General Medical Services Table) Regulations 2019***

Item 14200 is a therapeutic procedure to treat patients who have ingested poison. The Taskforce recommended that the gastric lavage procedure (commonly known as 'stomach pumping') should be removed as it no longer reflects best clinical practice.

These amendments repeal item 14200 and make other consequential amendments in the GMST.

Schedule 5 – Videostroboscopy

- **Amendments to the *Health Insurance (General Medical Services Table) Regulations 2019***

On 1 November 2019, Schedule 1 of the *Health Insurance Legislation Amendment (2019 Measures No. 1) Regulations 2019* commenced. Item 66 of that Schedule inserted into the GMST a new item 41501 for examination of glottal cycles and vibratory characteristics by videostroboscopy for a number of conditions listed under paragraphs (a) to (e). This amendment clarifies that patients with malignant vocal fold lesions are eligible for the service under paragraph (b). The amendment is for clarification only and there is no change to existing policy.

Statement of Compatibility with Human Rights

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

Health Insurance Legislation Amendment (Intensive Care and Emergency Medicine) Regulations 2020

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 Determination

The purpose of the *Health Insurance Legislation Amendment (Intensive Care and Emergency Medicine) Regulations 2020* (the Regulations) is to amend the GMST and the DIST from 1 March 2020.

The Regulations implement the Government's response to recommendations from the MBS Review Taskforce (the Taskforce) on intensive care and emergency items, as announced in the 2019-20 Budget under the *Guaranteeing Medicare — Medicare Benefits Schedule Review — response to Taskforce recommendations* measure.

The Taskforce found the existing MBS-funded intensive care and emergency medicine arrangements were complex and the fee structure did not adequately reflect the additional skill, time and risks associated with treating complex patients. The Taskforce recommended to Government that the intensive care and emergency medicine be restructured to reflect contemporary clinical practice.

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 or advance rights to health and social security by ensuring access to publicly subsidised health services which are clinically effective and cost-effective.

Conclusion

The Regulations are compatible with human rights as they maintain the right to health and the right to social security.

Greg Hunt
Minister for Health