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SUBMISSION

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AMA submission: MRAC Telehealth Post-Implementation Review

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MBS funded telehealth has been an overwhelmingly positive addition to Australia's healthcare system. Telehealth allowed patients to continue to access care during the COVID-19 pandemic and continues to facilitate access in the post-pandemic landscape where access to healthcare is a significant concern for policy makers.

While positive, the AMA remains strongly of the view that telehealth services should be available:

- as an adjunct to usual medical practice
- for regular patients of a practice, or in the case of non-GP specialist services, as part of the treatment of a referred patient
- when it is clinically appropriate for the patient's circumstances.

Telehealth is not a complete substitute for face-to-face visits to the doctor, but as part of appropriate care it provides an accessible option when it is not physically feasible, necessary, or appropriate to attend the practice in person.

The MRAC Review has some positive recommendations which the AMA is happy to support, however there are some major concerns, the most significant being the removal of the initial videoconference item for non-GP specialists. The MRAC has not provided any real justification for this proposal which will limit patient access and fundamentally contradicts the first "principle" of MBS telehealth items being "patient-focused".

The AMA also remains concerned with the use of "principles" for telehealth items in general. While the "principles" themselves are sound, we do not understand their long-term function and do not support individual MBS item groups having their own set of "principles" as a rule.

Further detail is provided in response to the specific recommendations below.

In general, the AMA is disappointed this review has missed the opportunity to identify patients and communities who are underserved by the MBS and align MBS telehealth items with these communities.

We would also have liked the MRAC to further explore positive integration of asynchronous telehealth. The report notes that there are possibilities, and the AMA would see the introduction of MyMedicare as a way to potentially fund asynchronous communication with patients to assist with the

management of chronic conditions. We hope MRAC will explore this in the future, noting there are some positive models that already exist in Australia.

Recommendation 1: Adopt the revised MBS Telehealth Principles.

The AMA remains opposed to the use of MBS telehealth "principles". As detailed in previous correspondence with the MRAC, we do not see how MBS items for telehealth would have different principles from the other roughly 5700 MBS items. We would be open to establishing a set of principles for the MBS to guide all review processes and note that some of the principles listed would be appropriate for an overarching guideline for the *whole* MBS

If the intention is to ensure best practice telehealth, the Medical Board of Australia's telehealth guidelines already provide guidance from the statutory medical registration and medical practice standard viewpoint. The AMA is aware that there are other health professionals that provide telehealth and as such are not subject to these guidelines, however the issue with using the enforcement of the MBS billing requirements as a tool to force behaviour is that much of the concerning telehealth delivery exists outside of the MBS, and that, as seen in our opposition to Recommendation 9 below, against the recommendations for good telehealth practice promulgated by the Medical Board.

The AMA also has the 10 Minimum Standards for Telemedicine which act as a guide to ensure telehealth provides continuity of care and enhances patient access to appropriate care.

The content of the principles is much improved on the initial draft, in particular principle 5 no longer preferences video of telephone, and principles 6 and 7 are positive for clinicians. However, the reality is that these are not principles, they are objectives. The AMA agrees with them as objectives. For example, the AMA is supportive of allowing clinician participation at both ends of the MBS telehealth consultation as an objective for MBS item structuring.

As principles, it is unclear how they function. For example, should a future MBS change see a telehealth item change with insufficient time for clinicians to adjust, how does the clinician use principle 7?

Recommendation 2: Reintroduce some telephone services as an option for patients receiving continuing care, such as for GP services with a known clinician and 'subsequent' consultant clinician services.

The AMA strongly supports this recommendation. This is in line with the AMA's longstanding position that telehealth should ideally be provided by a practitioner with a long-standing relationship with the patient, as outlined in the 10 Minium Standards for Telemedicine.

Recommendation 3: Consider how MyMedicare and other options could better remunerate clinicians directly for the additional administrative workload that is often associated with managing complex patients.

The AMA supports this work and looks forward to engaging in this further.

Recommendation 4: Discontinue temporary nicotine cessation MBS items with exemptions after 31 December 2023.

The AMA strongly objected to the establishment of these condition-specific items which existed outside of the usual relationship rules from their introduction. These items have only served to create an industry entirely based around prescribing vaping products which we expect will continue beyond the cessation of these items as privately billed consults.

Noting the significant vaping reforms underway which will require a prescription from a GP to obtain a vape from a pharmacy, we strongly encourage a proactive communications campaign to ensure that people understand that they will need to either have a telehealth consult with their usual GP, or see a GP face-to-face to be eligible for an MBS rebate.

Recommendation 5: Make temporary BBVSR MBS items with exemptions permanent, without any modifications to the referral process for BBVSR specialised care.

The AMA supports this proposal.

Recommendation 6: Subject to permanent GP BBVSR telehealth items, discontinue the exemption to GP telehealth eligibility requirements for GP non-directive pregnancy counselling services.

The AMA does not oppose this proposal.

Recommendation 7: Retain eligibility exemptions for telehealth GP mental health MBS treatment items. Make telehealth GP mental health care planning and review item non-exclusively linked to MyMedicare.

The AMA supports this proposal. While the AMA shares the MRAC's concerns regarding entrepreneurial telehealth enterprises, these concerns are far outweighed by the need to ensure access to mental health care by a GP. As noted earlier, enforcement of the MBA's telehealth guidelines should minimise the risk posed by some of these providers.

Recommendation 8: Extend eligibility requirements to nurse practitioner MBS and midwifery MBS telehealth items.

The AMA supports this proposal. The AMA is aware of nurse practitioner led telehealth services which use this exemption to initiate patients on medications for specific conditions where no prior relationship exists with the patient. There are specific examples in the weight loss industry where, for example, nurse practitioner have adopted telehealth only models of care that extending to the prescribing of medications including Ozempic.

The AMA does not support these types of telehealth models which fragment care and undermine continuous, whole person care, regardless of prescriber.

While this is beyond the scope of this review, the AMA is concerned that nurse practitioners do not have telehealth guidelines as medical practitioners do. While removing the exemption will limit the ability for these models to access MBS rebates for these services, without guidelines like the MBA's

guidelines, these services will be able to continue to bill privately – potentially through asynchronous models.

> **Recommendation 9: For initial consultations, make non-GP specialist MBS items available only face-to-face, with subsequent consultations available through telephone or video at the clinician's discretion.**

The AMA strongly opposes this recommendation. While face-to-face care remains a critical part of good medical practice, the access these items provide is incredibly valuable. This proposal is fundamentally opposed to principle 1 of this review – it is not "patient-focused", ignores "patient need", and ignores the determination of the clinician that it is appropriate and often the most efficient means of organising a patients care. For a number specialties, an initial telehealth consultation can provide an opportunity to arrange necessary diagnostic tests – providing the basis for a much more informed subsequent consultation – often proceeding on a face to face basis. In referring a patient to a non-GP specialist, the GP introduces a new practitioner into the usual care team. Continuity of care is then shared between clinicians.

The impetus for MBS telehealth items was the COVID-19 pandemic and the need to ensure Australians could continue to access essential healthcare. While the restrictions on movement are gone and the threat of contagion far lower, the obstacles of life – illness, emergency or accident – all still exist. Ensuring patients at least have a videoconference item as a back up to ensure they can make an appointment they would otherwise have to reschedule is of significant value.

It is also a matter of access. As rurality increases, MBS usage decreases. Providing people who live outside of metropolitan and even regional centres with telehealth access to non-GP specialist consultation provides access where it has not previously existed. The AMA has heard of specific concerns regarding the impact this recommendation would have on access to psychiatrists and developmental paediatricians for people living outside metropolitan centres.

The importance of this access is acknowledged in the Medical Board of Australia's telehealth guidelines:

> "The guidelines allow a patient to consult a doctor for the *first time* using telehealth and for a doctor to issue new and repeat scripts as part of a telehealth consultation. The Board does not expect a patient to have had an in-person appointment with a doctor before they have a telehealth appointment."

In this context, Recommendation 9 contravenes practice guidelines from the Medical Board, and can therefore be regarded as improper medical regulatory action in that it restricts practice recommendations from the Medical Board.

Furthermore, the Medical Board of Australia's telehealth guidelines specifically state:

> "The Board recognises the important role that telehealth can play in accessing episodic and emergency care, particularly in rural and remote settings, for patients who are unable to travel for an in-person consultation, to support inclusive care, and when patients may not be able to consult with their usual doctor."

In this context, Recommendation 9 further contravenes specific guidance on good medical practice from the Medical Board. Therefore, it can be concluded that Recommendation 9 is contrary to the accepted Australian standard of medical care, and against the principles of good medical practice promulgated by the Medical Board of Australia – the statutory regulator of medical practice. It is very

concerning that the MRAC recommends the MBS to undertake action that, in this context, is contrary to the standard of good medical practice established by the Medical Board.

The AMA does not understand where this recommendation originates from as the only real justification provided in the report is to align these items with the 1-in-12 GP rule. This is a very weak justification for a change that would fundamentally alter how Australians are able to access care. MBS items work differently across specialties, and it remains appropriate to do so with telehealth items.

It also lacks internal consistency with the MRAC's considerations of telehealth services for allied health:

> "The MRAC did not consider it necessary to apply eligibility requirements to allied health telehealth items, as many allied health services require a GP referral, which are subject to eligibility requirements, and thus continuity of care can be maintained in this way."

Non-GP specialist services also require a GP referral based on a specific health issue being experienced by a patient, and are therefore also able to maintain continuity of care.

The AMA is concerned that this recommendation is driven purely by a desire to introduce cost restraints on the MBS. This is not only bad policy for the health of Australians, it is bad economic policy as limiting access will only lead to people presenting in worse health in other parts of the system.

The efficiencies that telehealth has delivered for our health system have not been acknowledged in this report. The AMA's Health is the Best Investment report found that the estimated benefit of telehealth from reducing travel in 2021–22 was $1.35 billion, and that further integration of telehealth across both the public and private sectors could save up to around $14 billion each year.

We need to start considering the efficiencies telehealth has delivered for patients and the broader economy.

In the above context, recommendation 9 is strongly opposed by the AMA, on the grounds that it is contrary to the accepted standard of medical practice for telehealth recommended by the Medical Board and that it limits the accessibility of GP and non-GP specialist care to rural, remote and disadvantaged communities.

> **Recommendation 10: Reintroduce GP patient-end support, and extend it to include nurse and allied health patient-end support for telehealth with a GP. If the MBS is not a suitable funding pathway for patient-end support services, explore other funding possibilities.**

The AMA is strongly supportive of this proposal. This is a positive model of collaborative care which sees health professionals working together for the patient. The MBS is the appropriate funding mechanism for the GP in these consultations. We would welcome the opportunity to consult further on the funding for this model of care.

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