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SUBMISSION

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Consultation – Intravitreal eye injections

By email: surgicalservices@health.gov.au

The Australian Medical Association (AMA) welcomes the opportunity to provide feedback on the proposed reclassification of intravitreal eye injection (IVI) services under MBS items 43030 and 43032 to Type C procedures, and on broader issues relating to affordable access to IVI. The AMA's comments are informed by our previous submission to the MBS Review Taskforce's (the taskforce) review of Ophthalmology and Psychiatry Reports, ongoing engagement with ophthalmology stakeholders, and consideration of the latest data and public commentary.

The AMA has previously supported clinician-led, evidence-based reforms that do not compromise patient safety or access (see AMA submission to MBS Review Taskforce, 2019, pp. 1–3). We have consistently warned any change must not increase patient costs or reduce access, especially for vulnerable groups.

We strongly endorse the Government's decision to maintain current MBS fee levels for IVI, as any reduction would risk service viability and patient access, particularly in rural and remote areas. To protect affordability and equity, the AMA calls for transparent certification processes, monitoring of out-of-pocket costs, and investment in bulk-billing and public outpatient services.

The AMA opposes any expansion of IVI provision to non-medical practitioners without rigorous clinical governance, regulatory oversight, and evidence of safety and efficacy. We urge ongoing monitoring of the impact of reclassification on patient behaviour and treatment adherence, with a commitment to remedial action if unintended consequences arise.

The AMA supports reclassifying IVI services as Type C procedures, provided robust safeguards ensure hospital-based treatment remains available where clinically necessary and patients are not financially disadvantaged.

Reclassification of IVI Services to Type C Procedures

The AMA recognises IVI is a well-established, sight-saving treatment for retinal conditions such as neovascular age-related macular degeneration, diabetic macular oedema, and retinal vein occlusion. Most IVI procedures are safely and efficiently performed in outpatient settings, typically in ophthalmologists' private rooms, consistent with contemporary clinical practice and international standards.

The AMA also notes the emergence of new and future IVI treatments, including longer-acting agents and gene therapies, which are likely to expand the patient population requiring IVI while potentially

reducing injection frequency. These advances underscore the need for a flexible, well-resourced system capable of adapting to evolving clinical practice and patient needs.

The taskforce's recommendation to reclassify IVI services under MBS items 43030 and 43032 to Type C procedures reflects this reality. The AMA acknowledges this change is intended to ensure hospital-based IVI is reserved for cases with a genuine clinical need, thereby reducing unnecessary healthcare expenditure and aligning with best practice.

The AMA supports the principle of reclassification, provided robust safeguards are in place to ensure:

- Patients with a legitimate clinical need for hospital-based IVI retain full access to private health insurance benefits, with clear and consistent certification processes.
- No patient is financially disadvantaged or deterred from accessing essential IVI treatment following this change; Please note the below section on increased out-of-pocket costs for treatment in rooms.
- There is ongoing monitoring of the impact on patient access, out-of-pocket costs, and treatment adherence, with a willingness to adjust policy if unintended consequences emerge.

Affordable access to IVI: Broader issues and options

The AMA remains concerned regarding the overall affordability of IVI for Australian patients. While we acknowledge the rationale for reclassifying IVI services, there is potential for increased out-of-pocket costs for privately insured patients who may lose access to private health insurance benefits for hospital-based IVI unless a Type C certificate is provided due to private health insurance largely only covering in-patient care. The consultation paper highlights a proportion of IVI services are still delivered in hospital, and there is a risk some patients may discontinue or reduce treatment if faced with higher costs.

Data indicates the average out-of-pocket cost for IVI is $140 per service, with higher costs in remote and disadvantaged areas. Only 25% of services are bulk billed, and public hospital clinics are often at capacity or unavailable, particularly outside metropolitan centres. The AMA acknowledges the Government's decision to maintain current MBS fee levels for IVI and supports this as a necessary safeguard for service sustainability.

The AMA also notes the restrictive nature of accepted clinical indications for Type C certification. The AMA supports the principle that clinical need must be the sole determinant for hospital-based IVI, and calls for transparent, nationally consistent certification protocols to prevent administrative ambiguity or inequity in access to private health insurance benefits. These measures will help ensure reclassification delivers its intended benefits without unintended consequences for patients or providers.

The AMA recommends the following measures to support affordable and equitable access:

- Expansion of bulk-billing and public outpatient IVI services, particularly in rural and regional areas, to reduce financial barriers and geographic inequity.
- Targeted support for vulnerable groups, including pensioners and those in remote communities, who face the highest relative costs and travel burdens.

The AMA echoes the call from the sector for a continued pause on the reclassification of IVI services to Type C procedures until a comprehensive strategy is in place to ensure public hospitals are

adequately funded and resourced to meet the likely increase in demand. We are aware current data indicates only a small fraction of public hospitals provide outpatient IVI services. Existing capacity is already stretched, particularly in rural and regional areas. Proceeding with reclassification without addressing these system limitations risks forcing vulnerable patients into an under-resourced public system, undermining both access and quality of care.

The AMA urges the government to prioritise investment in public hospital outpatient ophthalmology services as a precondition for any change to the classification of IVI services.

Workforce and scope of practice

The AMA supports a coordinated national strategy to ensure equitable access to IVI services, including expanding public outpatient capacity and implementing targeted affordability measures such as incentives for bulk-billing pensioners. The AMA also encourages ongoing review of funding mechanisms, including the Extended Medicare Safety Net and public hospital funding arrangements, to ensure they are responsive to the needs of patients requiring regular IVI treatment. These steps are essential to address the financial and geographic barriers that currently prevent many Australians from accessing sight-saving treatment.

The AMA strongly opposes the taskforce's recommendation to review the ophthalmology workforce and consider expanding the pool of providers able to deliver IVI, including nurse practitioners and optometrists.

IVI is a medical procedure best performed by ophthalmologists, given the complexity of diagnosis, management, and potential complications. The AMA remains unequivocal that any expansion of IVI provision beyond ophthalmologists must be subject to rigorous, independent clinical evaluation and regulatory oversight. International models cited in the consultation paper are not transferable to the Australian context without robust evidence of safety, efficacy, and cost-effectiveness.

The AMA recommends any future changes to IVI service classification be accompanied by robust, ongoing monitoring of patient outcomes, access, and system impacts, with a commitment to further stakeholder consultation and policy adjustment as required. This will ensure reforms remain responsive to emerging challenges and patient needs.

We urge the Department of Health, Disability and Ageing to reject any workforce reforms that dilute clinical accountability or fragment care pathways, particularly in the absence of comprehensive risk assessment and stakeholder consensus. Furthermore, the AMA calls for a formal review of the impact of reclassification on patient behaviour and treatment adherence, with a commitment to remedial action should data indicate increased financial barriers or reduced access for any cohort.

The AMA supports ongoing efforts to address workforce maldistribution and improve access in underserved areas but, as always, cautions against changes that may compromise patient safety or fragment care.

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