MBS Telehealth Review

A submission to the Medicare Benefits Scheme (MBS) Review Advisory Committee draft report on the telehealth post-implementation review

November 2023

MSI AUSTRALIA

Acknowledgement

We acknowledge the Traditional Owners and Custodians of the land on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present. We also acknowledge the enduring connection to their Traditional estates across Australia and to the ongoing passion, responsibility and commitment for their lands, waters, seas, flora and fauna as Traditional Owners and Custodians.

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1. Background

Medicare Benefits Schedule (MBS) Telehealth items have been available since 2002, and a number of additional items have been made available temporarily through disasters such as bushfires, and the COVID19 pandemic. All remaining temporary items are due to expire on 31 December 2023.

On 14 November 2022, the Minister for Health and Aged Care, the Hon Mark Butler MP, requested that the MBS Review Advisory Committee (MRAC) conduct a post implementation review of telehealth services. [1] Scope was to:

- *Advise on the appropriateness of current settings for video and telephone consultations to ensure the right balance between access, quality and safety*
- *Review, and update if necessary, the MBS Review Taskforce Telehealth Principles to provide a framework for future consideration of MBS funded telehealth services*
- *Advise on current patient eligibility settings and related exemptions, noting that this work will be informed by the Strengthening Medicare Taskforce.*

The MRAC have developed a draft report and has requested feedback on 'their understanding of the existing model of care and issues of consideration, with particular emphasis on any (yet) unidentified consequences that may result from proposed changes'.[2] The following submission has been structured in direct response to the recommendations.

MSI Australia

We are Australia's leading, specialised, non-profit advocate and provider of abortion and contraception services. MSI Australia is a part of MSI Reproductive Choices, a global non-profit which has been providing sexual and reproductive healthcare services for over 45 years. Our 9,000 team members worldwide work across 37 countries providing contraception, comprehensive abortion care, and maternal healthcare services wherever they're needed.

[1] Australian Government Department of Health (2023), Consultation webpage, viewed 23 October 2023 at https://consultations.health.gov.au/medicare-reviews-unit/mrac-draft-report-post-implementation-review-of-te/.

[2] Australian Government Department of Health (2023), Consultation webpage, viewed 23 October 2023 at https://consultations.health.gov.au/medicare-reviews-unit/mrac-draft-report-post-implementation-review-of-te/.

2. Consultation Response

Telehealth services play a vital role in ensuring access to care, particularly for vulnerable populations in need of timely medical attention. In terms of privacy, telehealth can provide similar or superior levels of discretion in healthcare provision.[3]

MBS support for sexual and reproductive healthcare via telehealth was initially called upon by hundreds of clinicians across Australia.[4] Medical abortion via telehealth is a long term and trusted model of abortion care.[5]

When provided by sexual and reproductive health providers medical abortion via telehealth has become an important mechanism for early gestation abortion access,[6] violence prevention and women's safety.[7] MBS item numbers for telehealth have become an essential part of abortion access for people in rural, regional and remote areas.[8]

It is critical that temporary Blood-Borne Virus and Sexual and Reproductive (BBVSR) MBS items be made permanent, to increase equitable access to essential healthcare.[9]

While we support some of the report recommendations, we have significant concerns about components of Recommendation's 5 and 9. Further information is below.

[3] Fix, I., Seymour, J., Sandhu, M.V., Melville, C., Mazza, D., Thompson, T., 'At-home telemedicine for medical abortion in Australia: a qualitative study of patient experiences and recommendations' BMJ Sex Reprod Health 2020; 0:1–6. doi:10.1136/bmjsrh-2020-200612.

[4] MSI Australia and ASHM (2020), Open letter on temporary MBS item numbers, at https://www.msiaustralia.org.au/wp-content/uploads/TelehealthOpenLetter.pdf.

[5] Fix, I., Seymour, J., Sandhu, M.V., Melville, C., Mazza, D., Thompson, T., 'At-home telemedicine for medical abortion in Australia: a qualitative study of patient experiences and recommendations' BMJ Sex Reprod Health 2020; 0:1–6. doi:10.1136/bmjsrh-2020-200612.

[6] Mazza, Danielle, Seema Deb, and Asvini Subasinghe. "Telehealth: an opportunity to increase access to early medical abortion for Australian women." *The Medical Journal of Australia* 213, no. 7 (2020): 298-299.

[7] Australia's National Research Organisation for Women's Safety, *Submission 132 to the House Standing Committee on Social Policy and Legal Affairs for the inquiry into family, domestic and sexual violence*, p. 35.

[8] Ireland, S., Belton, S., & Doran, F. (2020). 'I didn't feel judged': exploring women's access to telemedicine abortion in rural Australia. *Journal of primary health care*, *12*(1), 49-56.

[9] SPHERE Women's Sexual and Reproductive Health Coalition (2023), 'A consensus statement on the use of telehealth for contraception and abortion care' at https://www.spherecre.org/images/Consensus_statement_on_telehealth_contraception_and_abortion.pdf.

Recommendation 1: Adopt the revised MBS Telehealth Principles.

Telehealth items in the MBS should consider the following:

1. *Should be patient-focused and based on patient need, as determined by the clinician and the patient.*
2. *Must support and facilitate safe and quality services for patients, aligning with the clinical requirements of the equivalent face-to-face service and demonstrating clinical efficacy.*
3. *Should be provided in the context of coordinated and continuous care between patient and clinician.*
4. *Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.*
5. *Must offer both telephone and video along with face-to-face consultations, though modality for any service is subject to Principles 1 and 2. Video should be encouraged over phone where it will provide a better patient and/or provider experience.*
6. *Should support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation, enabling remuneration of both the treating clinician and patient-end clinician.*
7. *Should provide sufficient notice of changes to MBS telehealth items for clinicians and patients to adjust to change.*

Supported. We suggest replacing the term 'patient' with more contemporary language that reflects people's lived experience.

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.

Supported. We fully support the suggested constraints on asynchronous telehealth delivery and the exemption from the 12-month rule for the BBVSR items.

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.

Supported. The proposed incentives and potentially others that emerge through this review will provide improved measures for timely and quality care for people in complex circumstances.

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

We refer to the Australian and Other Drugs Council for their submission on this recommendation.[10]

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

Supported in principle, conditional of further development.

These temporary items have enabled timely access to essential sexual and reproductive healthcare. Making these items permanent is an important part of increasing medical abortion access in Australia, as concluded by the recent and bipartisan Senate Inquiry on Universal Access to Reproductive Healthcare.[11]

Our primary concern is the restriction of these BBVSR numbers to GP specialists, thus excluding care provision by a group of experienced clinicians who provide vital sexual and reproductive healthcare, including abortion.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has developed advanced training in sexual and reproductive health, encompassing abortion care. Additionally all trainees undertake a mandatory abortion care module, embedding expertise within the gynaecology and sexual and reproductive health workforce. This is not currently mandated in other speciality training curricula. Yet, the current restrictions prevent non-GP specialists from providing urgent sexual health and sexual and reproductive healthcare via telehealth services.

This exclusion creates a gap in access to care, particularly when local GPs may have conscientious objections, and some patients therefore face gatekeeping by their primary care providers. At the last estimation only 10% of GPs were providing medical abortion care. Extending these BBVSR items to specialist gynaecologists and sexual health physicians would ensure equitable access to time sensitive procedures and care.

Moreover, there is no provision for a "non-referred" item for this number, thus completely excluding non-GP specialists from their use. For example, the MBS item 92735 is for phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (*not including a* general practitioner, *specialist* or consultant physician) of more than 5 minutes in

[10] Australian and Other Drugs Council (2023), website at https://aadc.org.au/.
[11] Parliament of Australia (2023), Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia, at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ReproductiveHealthcare/Report.

duration but not more than 20 minutes if the attendance.[12] This description specifically excludes specialists unlike other non-referred items for "other medical practitioners", see item 53 as an example.

This means that non-GP specialists cannot deliver urgent sexual and reproductive healthcare without a GP referral when patients are often needing to access a telehealth service as their local GP's are conscientious objectors. This discrepancy hinders the provision of timely care for individuals who need it most.

A number of existing items are used both by GP specialists and non-GP specialists, such as the Intrauterine Device (IUD) insertion item. This is precedent for enabling this item to be used by non-GP specialists in sexual and reproductive health.

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

Supported. These are surplus to requirements if the BBVSR items are maintained. These changes can enhance accessibility of care of those in need whilst introducing measures to safeguard good clinical care.

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

Supported.

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

Supported. Evidence from across the world shows that nurses and midwives can and should play a greater, more autonomous role in abortion care provision, particularly for medical abortion care.[13]

The current Commonwealth Scope of practice review, ‘Unleashing the Potential for our health workforce’ highlights the importance of reshaping the health workforce and extending scope of care.[14] The Therapeutic Goods Administration (TGA) removed requirements that had limited medication abortion care to doctors in July this year. This was followed by an out of session meeting at the Pharmaceutical Benefits

[12] Department of Health (2023), ‘MBS item 92735 is for phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner’ at https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=92735&qt=ItemID.

[13] MSI Australia (2022), Nurse-led Medical Termination of Pregnancy in Australia: Legislative Scan, at https://resources.msiaustralia.org.au/Nurse-led-MToP-in-Australia-legislative-scan.pdf.

[14] Australian Government Department of Health (2023), Scope of Practice Review at https://www.health.gov.au/our-work/scope-of-practice-review.

Advisory Committee which changed regulations to support abortion provision by Nurse Practitioners and Authorised Midwives.[15]

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

Not supported. It is problematic to make non-GP specialist MBS items only available face-to-face for initial consultations. The stated rationale behind this change is to align with GP specialists concerning the 1-in-12 rule and the establishment of a clinical relationship. This rule is not relevant for non-GP specialists as it is usual that they do not have an existing relationship with their new patients. In fact it would be unusual for them to have this established relationship with a newly referred patient unlike their relationship with their primary care provider.

In the context of non-GP specialists, this proposed change presents several challenges particularly for our most vulnerable patients including those in regional, rural and remote jurisdictions where an initial face-to-face meeting might not be feasible. Telehealth services, particularly for initial consultations, offer significant benefits for regional clients, reducing the burden of travel and allowing patients to access at least initial specialised care without geographical constraints. [16]

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.

Supported.

[15] Pharmaceutical Benefits Advisory Committee (2023), Out of Session Items Recommended Between Meetings March 2023 to July 2023, at https://www.pbs.gov.au/industry/listing/elements/pbac-meetings/pbac-outcomes/out-of-session/items-recommended-between-meetings-OOS-Mar23-Jul23-v2.pdf.

[16] Cheng, Y., Boerma, C. J., McGeechan, K., & Estoesta, J. (2023). Impact of policy changes of Medicare-rebated telehealth services on medical abortions provided at a family planning service during the coronavirus (COVID-19) pandemic. *Sexual Health*.

Further information

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