Telehealth
Post-Implementation Review

DRAFT REPORT

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Summary

In 2022, the Australian Government Minister for Health and Aged Care asked the Medicare Benefits Schedule (MBS) Review Advisory Committee (MRAC) to conduct a post-implementation review of telehealth services and:

- 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 Taskforce Telehealth Principles to provide a framework for future consideration of MBS-funded telehealth
- advise on current patient eligibility settings and related exemptions.

In conducting its review, the MRAC considered data from independent research (literature and systematic reviews), Department of Health and Aged Care-driven stakeholder interviews and workshops with general practice clinicians and managers, and MBS claims data about different aspects of telehealth.

Telehealth services in Australia

Over the past few years, there has been a major shift in the role of telehealth in the delivery of Medicare services. Although MBS telehealth items have existed since 2002, their use expanded drastically in response to the COVID-19 pandemic, when new, temporary MBS telehealth items were created to ensure continued access to health care. The most significant changes at this time were the broadening of health providers and patients able to use telehealth and enabling services by phone. Before COVID-19, telehealth was primarily for non-general practitioner (GP) specialists and patients living outside major cities. Most of the temporary MBS telehealth items introduced during the pandemic have since been made permanent.

Since the beginning of COVID-19 telehealth items, GPs have been the largest group of telehealth providers, accounting for approximately 6 out of every 7 services.

Telehealth use peaked in the second quarter of 2020. Although it declined when social distancing requirements were removed, telehealth use remains widespread. The proportion of services by telehealth in 2022–23 was 20% for GPs, 11% for non-GP specialists, 12% for allied health and 3% for other providers including nurse practitioners and midwives.

Clinician uptake

Telehealth was rapidly adopted by most health service providers in the context of the pandemic. More than half of all telehealth providers provided their first video or telephone consultation within a month of the items commencing.

Video consultations as a proportion of all telehealth consultations is increasing. However, use of video varies by clinician type. GPs are using video the least: rising to 5% of GP telehealth consultations in 2022–23. This is likely to reflect a range of issues, including additional time taken for technical set-up; lack of guidance and support; and the preferences, capabilities and technological access of both clinicians and patients.

This contrasts with the much higher use of video consultations by allied health and non-GP specialists, which comprised 75% and 48% of telehealth consultations in 2022–23, respectively.

Patient uptake

Patients' uptake of telehealth is also variable. For example, analyses of linked demographic and MBS data show that against a backdrop of overall reduced access to GP services in 2020 compared to 2019, telehealth is used less by males, people aged over 70, people of lower socioeconomic status, people in outer regional and remote areas, and people with low English proficiency (Butler et al. 2023). Despite these observations, telehealth users who participated in the Australian Bureau of Statistics Patient Experiences in Australia survey were more likely to be middle aged or older, and older patients were more positive about their telehealth use than younger people (ABS 2021).

Patients have historically used telehealth differently outside major cities, and may have had more experience with video services, with access to most non-GP specialist consultations by video since 2011.

Telehealth business models

Outside of the MBS, there has been growth in online-only GP business models that offer telehealth services for medical certificates, prescriptions and referrals. These services are marketed as a convenient way to access health care where the outcomes are pre-determined and patient led. However, given they are generally provided as a quick once-off consultation, where the patient is unknown to the clinician and without access to the patient's medical records, they do not support safe, quality or continuous care.

While these private services are not Medicare claimed, they may have downstream effects on the volume and clinical appropriateness of Pharmaceutical Benefits Scheme (PBS) prescriptions and MBS referrals (for example, for pathology, imaging or non-GP specialist review). In addition, a patient's care may be further fragmented as they do not have their regular health provider (usually a GP but may be a nurse practitioner) coordinating this care.

Balancing access, quality and safety

Face-to-face consultation remains the preferred standard of health care, and must remain accessible to patients. At the same time, telehealth can improve access to health care for some groups in some circumstances. The MRAC therefore considers it appropriate that the Australian Government continue supporting better uptake of telehealth where quality and safety standards can be met.

In considering whether and when telehealth services can meet quality and safety standards, the MRAC considered both stakeholder feedback, and research evidence, including Bond University's systematic literature reviews, and case study research by the Australian National University. However, the limitations of existing research comparing face-to-face care to telehealth, and comparing telephone and video modalities, mean that strong, evidence-based recommendations are not yet possible. Further research into many aspects of telehealth is needed.

Comparing telehealth and face-to-face health care

The limited research suggests that telehealth can be equivalent to face-to-face care for the management of known conditions of known patients. However, telehealth is clearly inadequate when hands-on clinical assessment is needed. Telehealth is likely to be less effective for new diagnoses, particularly in cases where clinical information requirements are extensive and/or complex.

Video vs telephone modalities

Bond University's systematic literature review found no major differences between video and telephone consultations in patient satisfaction, clinical effectiveness or cost-effectiveness. Similarly, stakeholders gave strong feedback from different clinical practices that, in many cases, there is no discernable difference in outcome between video and telephone consultations. However, there are major gaps and limitations in the existing research, and more studies with longer follow-ups are needed before any firm, evidence-based recommendations on telehealth modality can be made.

Despite these research limitations, the MRAC considers it self-evident that video consultations more closely approximate face-to-face consultations than phone consultations, as they give clinicians access to both verbal and non-verbal information. This makes video preferable or necessary in some circumstances, such as with paediatric patients, when diagnosing conditions with visual signs, and whenever observation of the patient is critical. However, there are challenges in accessing video for both clinicians and patients, such as digital literacy, costs and internet access.

Overall, clinicians must balance patient needs and preferences with clinical safety and effectiveness, and give clear guidance to the practice manager and staff about when to offer a telehealth consultation and which modality to use.

Telehealth in the MBS

In line with its discussions about access, quality and safety, the MRAC proposed revisions to the MBS Telehealth Principles, which provide a framework for treatment via telehealth in the MBS. The MRAC also considered the potential for introducing asynchronous telehealth items, the role of patient-end support in the MBS, and where exemptions to established clinical relationship criteria should continue to apply.

Asynchronous telehealth

Currently, the MBS only supports the synchronous (real-time) delivery of telehealth services that are analogous to in-person consultations – for which the patient must be present. Some stakeholders have advocated for the creation of MBS items for asynchronous care, such as writing referrals, filling out forms or reviewing reports.

While acknowledging that many clinicians' administrative workloads are increasing, the MRAC does not support the creation of new items for asynchronous telehealth services. However, other options could be explored, such as reviewing the remuneration for some MBS items; instituting longer, time-tiered items for complex patients; or considering other (non-MBS) funding pathways to remunerate clinicians for administrative work.

Exemptions to established clinical relationship criteria

Currently, GPs and clinicians working in general practice can only provide MBS-rebated telehealth services if they have an existing and continuous relationship with the patient (the ‘12-month rule’). Some items are exempt from this requirement.

The MRAC considers that telehealth items should only be exempt from the established clinical relationship criteria after consideration of risks and where:

- presentations and issues are relatively acute and immediate service is time critical
- ‘unrestricted’ access has a clear public health advantage
- misuse by patients or providers is unlikely
- a single consultation or episode of care is sufficient and unlikely to fragment care or adversely affect outcomes.

As well as agreeing to these general principles, the MRAC considered specific temporary telehealth items that are currently exempt from the 12-month rule, but for which the exemption is due to expire. The MRAC recommended that telehealth bloodborne virus and sexual and reproductive health (BBVSR) and GP mental health treatment items remain exempt from the 12-month rule, citing (among other things) the need to ensure continued access for vulnerable populations.

At present, the 12-month rule does not apply to nurse practitioners and allied health clinicians. To support continuity of care and align with the Telehealth Principles, the MRAC considered it appropriate to extend application of the 12-month rule to nurse practitioner MBS telehealth items. The MRAC recommended that the 12-month rule will continue to be exempt for allied health MBS telehealth items.

Currently, MBS items for non-GP specialist consultations do not have the 12-month rule eligibility requirements that applies for most GP telehealth services. Given the different organisation of items on the MBS, consideration was given to ‘initial’ non-GP specialist consultations by telehealth, and whether this was appropriate. Requiring an established clinical relationship for non-GP specialist telehealth services would mean individual telehealth consultations as a ‘subsequent’ service only, to ensure continuous, high-value care across these clinician groups.

Home visits and patient-end support

Given the decline in GP home visits, the MRAC considered how the MBS could be used to harness patient-end support for telehealth consultations with a GP. The MRAC recommended the reintroduction of patient-end support by GPs with non-GP specialists, with extension to nurses or allied health clinicians to facilitate GP consultations.

Recommendations

Recommendation 1: Adopt the revised MBS Telehealth Principles.

MBS Telehealth Principles (revised)

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.

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.

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.

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

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

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

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.

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

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.

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.

Acronyms, abbreviations and definitions

ANU	Australian National University
BBVSR	bloodborne virus and sexual and reproductive health
GP	general practitioner
HTA	health technology assessment
MBS	Medicare Benefits Schedule
MM	Modified Monash
MRAC	MBS Review Advisory Committee
MSAC	Medical Services Advisory Committee
PBS	Pharmaceutical Benefits Scheme

Definitions

Telehealth is defined broadly by many sources as “the use of technology to deliver healthcare services at a distance”. The structural requirements of MBS items necessitate a real-time video and audio (video), or audio-only (telephone) consultation with a patient. In this report, “telehealth” can refer to both video and phone, with some matters identified as specific to video or phone.

Introduction

MBS items for telehealth services have been available since 2002 (ANAO 2023), but were restricted to patients in eligible areas, patients of Aboriginal Community Controlled Health Organisations and patients in residential aged care. However, due to natural disasters and public health emergencies (drought, bushfires and the COVID-19 pandemic), additional access and COVID-19 MBS items were created to ensure that people could still access health care when a conventional face-to-face consultation was not possible. The most significant changes at this time were the broadening of health providers and patients able to use telehealth and enabling services by phone. Before COVID-19, telehealth was primarily via video and for non-GP specialists and patients living outside major cities.

Most of the telehealth items introduced in response to the COVID-19 pandemic were made permanent on 1 January 2022, superseding many items that had been part of an iterative expansion since 2002, and were accompanied by a number of additional temporary items listed in mid-January 2022. Some of these temporary items are due to expire on 31 December 2023, after which all temporary items will cease or revert to the original MBS criterion.

The COVID-19 MBS telehealth items have changed the approach to delivering Medicare services in Australia, shifting from almost entirely face-to-face services to an increased number of non-face-to-face services. This has also permitted more widespread use of telephone consultations without a video element, and direct phone and video services by general practitioners (GPs) and other primary care clinicians that had not previously offered either service.

Telehealth may appear to improve access, but there is risk of decreased quality and safety associated with non-face-to-face consultations. Also, commercialisation of online-only telehealth services may threaten continuity of care by providing one-off episodes of care and/or low-value health care. These online-only services may also increase the number of subsequent inappropriate referrals, consultations and prescriptions.

Minister’s request for this review

On 14 November 2022, the Minister for Health and Aged Care, the Hon Mark Butler MP, requested that the MRAC conduct a post-implementation review of telehealth services, 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 (first published in the Taskforce’s Telehealth Recommendations 2020) to provide a framework for future consideration of MBS-funded telehealth
- advise on current patient eligibility settings and related exemptions, noting that this work will be informed by the Strengthening Medicare Taskforce.

Information about the MBS Continuous Review and the MRAC is in Appendix A.

Balancing access, quality and safety

Telehealth services must balance improved access with high-quality and safe health care. Further, telehealth services should assist with continuity of care to deliver the best health outcomes for patients.

Research and systematic literature reviews

To inform its deliberations and recommendations, the MRAC was presented with data from:

- independent research, including
  - systematic literature reviews from Bond University (Scott et al. 2021, 2023a, 2023b; Scott & Glasziou 2023)
  - case study research from the Australian National University (ANU) (Butler et al. 2023) investigating telehealth in primary care
- Australian Department of Health and Aged Care (the department)-driven research conducted by the Health Design Lab and the Medical Benefits Division Design Lab (Health Design Lab, unpublished), including stakeholder interviews and workshops with general practice clinicians and managers
- MBS data, collated and presented by the department.

Limitations of the research

The MRAC noted the very limited availability and diversity of high-quality evidence comparing telehealth modalities and comparing telehealth to face-to-face consultations; further research is therefore needed. Further, most studies to date focus on immediate or short-term clinical aspects of care, with little research into patient views on telehealth services.

The MRAC considered the available evidence while deliberating, but acknowledged that the gaps in evidence made it challenging to make strong, evidence-based recommendations. The MRAC noted that during deliberations research reports from Bond University and ANU were yet to be finalised.

In particular, the MRAC noted the following research gaps to be particularly problematic:

- comparison of telehealth modalities (telephone vs video) in primary care
- potential uptake of telephone and video services across the different community groups, and different needs and services
- how consumers feel about telehealth services across Australia
- patients' needs, understanding of risks and benefits, and drivers of choices regarding telehealth, and lack of education about telehealth modalities for both patients and providers.

The MRAC's deliberations and recommendations were informed by the best possible data available to the committee at the time.

Telehealth as a substitute for in-person care

The MRAC noted from the research that no new relevant evidence had been found since the 2021 systematic review (Scott et al. 2021). Overall, telehealth and face-to-face consultations could have equal efficacy for ongoing management of known conditions for a known patient (Scott et al. 2023a). It is acknowledged that the latest systematic review did not yield as much new research as anticipated. Also, several studies were subject to bias, had small sample sizes and were conducted overseas. The MRAC noted Bond University's research conclusions that, 'while history taking and verbal assessments can be done acceptably by telehealth, only some elements of physical examination are sufficiently reliable and valid' (Scott et al. 2023a). When hands-on clinical assessment was necessary for diagnosis, and especially for a new diagnosis, telehealth was unlikely to be suitable and a face-to-face consultation was highly preferred (Scott et al. 2023a). Most research in this area focused specifically on pre-planned assessments. In these instances, unplanned, unstructured and opportunistic telehealth assessments are likely to be of lower quality when compared with face-to-face, potentially impacting patient safety. Missed opportunities for early diagnosis can have tragic outcomes, including delayed diagnosis and intervention, which was reported in relation to cancer treatment during and after the COVID-19 pandemic. Even if telehealth has potential to increase patients' access, there were perceived risks of both lower quality of care and lower value services when telehealth is not used optimally. Further, the MRAC noted that it is more difficult to diagnose via telehealth as the information requirements for that diagnosis increase – for example, additional information from pathology or imaging tests.

Comparing video and telephone consultations

The MRAC noted through Bond University's systematic review that studies comparing video consultations to telephone consultations revealed no major differences in patient satisfaction, clinical effectiveness or health care use (cost-effectiveness) (Scott & Glasziou 2023). However, these studies in the systematic review had several limitations, including:

- lack of currency (half of the studies were conducted prior to 2012 before widespread availability of smartphones and 'used special video call devices installed in patients' homes, which would pose a challenge for scalability of the intervention' [Scott et al. 2023a])
- a medium to high risk of bias
- none reported on patient safety or adverse events
- none reported on diagnosis or initiating new treatment
- none were set in primary care that directly compared video to telephone consultation.

Overall, the MRAC agreed with the authors that this is an emerging area of study that requires more research.

Clinician use of telehealth services

Telehealth was rapidly adopted by most health service providers in the context of the pandemic. More than half of all telehealth providers provided their first video or telephone consultation within a month of the items commencing of telehealth services (Figure 1). Since the beginning of COVID-19 telehealth items, GPs have been the largest group of telehealth providers, accounting for approximately 6 out of every 7 services (Figure 2).

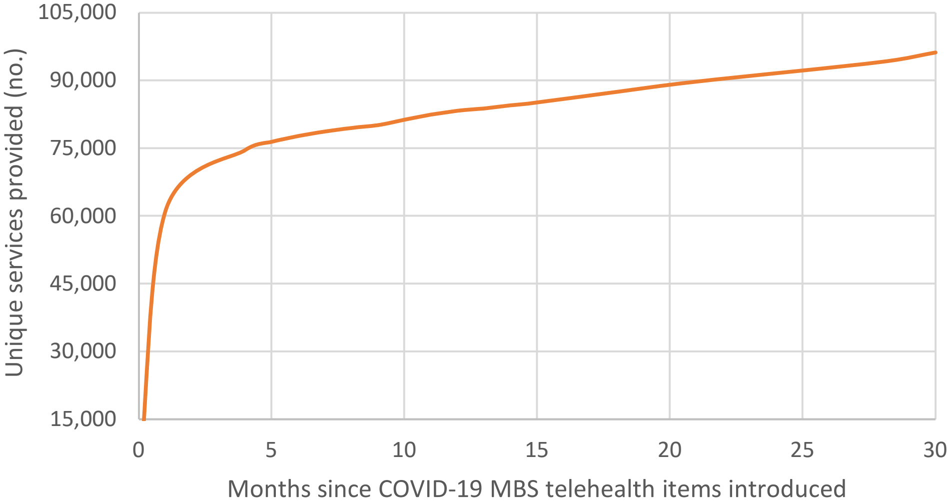

Figure 1 Cumulative uptake of MBS COVID-19 telehealth services (unique service providers)

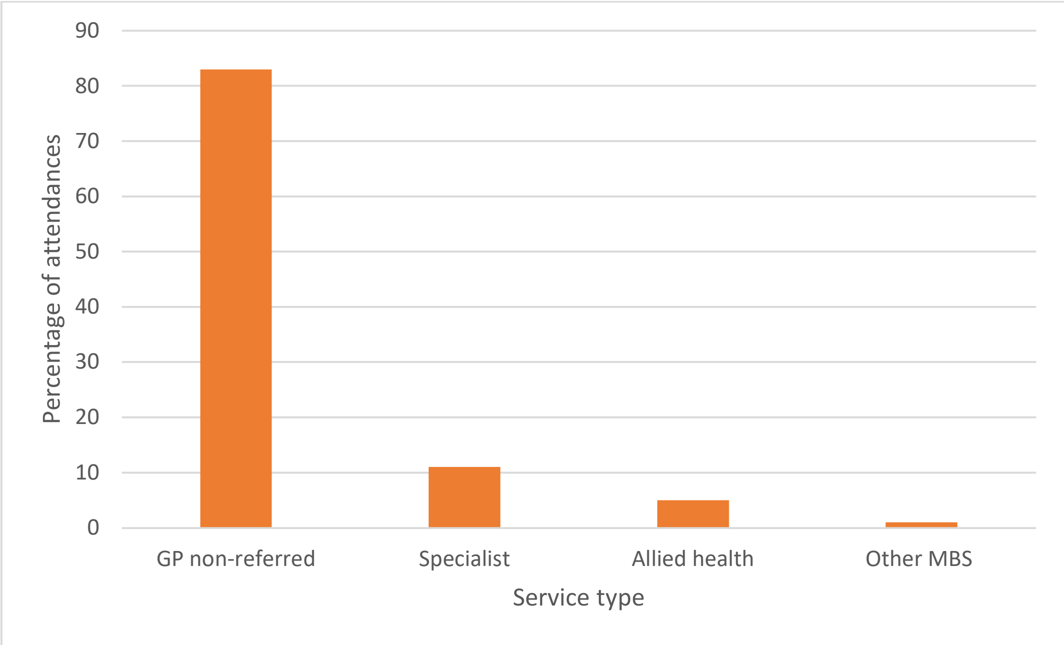

Figure 2 Proportion of telehealth consultations by MBS broad type of service, April 2020 – June 2023

The proportion services by telehealth in 2022–23 was 20% for GPs, 11% for non-GP specialists, 12% for allied health and 3% for other providers including nurse practitioners and midwives (Figure 3).

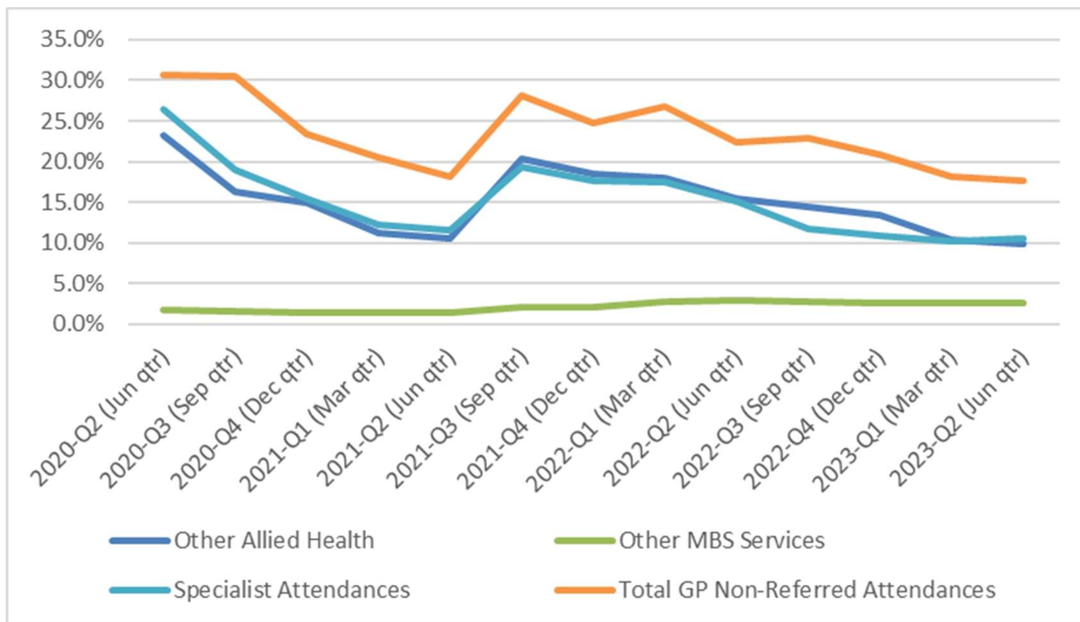

Figure 3 **MBS broad type of services, proportion of services by telehealth (phone and video), 1 April 2020 – 30 June 2023**

The MRAC noted that GPs on average are using video the least of all clinician types, at less than 5% of all telehealth consultations claimed in 2022–23 (see Figure 4).

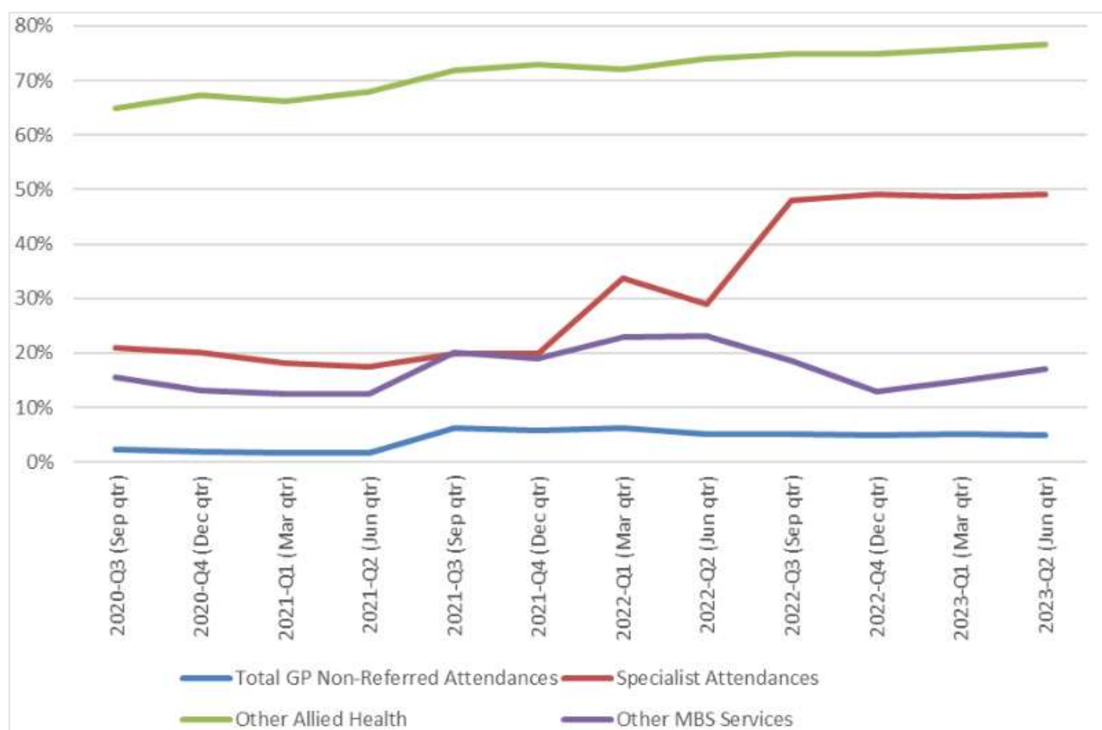

Figure 4 **Percentage of video telehealth consultations, by clinician, 1 July 2020 – 31 March 2023**

Referring to the Modified Monash (MM) Model for rurality, the MRAC noted from MBS data that, since July 2021, most users of telehealth services are in major cities (MM 1), and most of these consultations are for GP services. As rurality increases (MM 2–7), telehealth GP services decrease, but non-GP telehealth and allied health services both increase (see Figure 5).

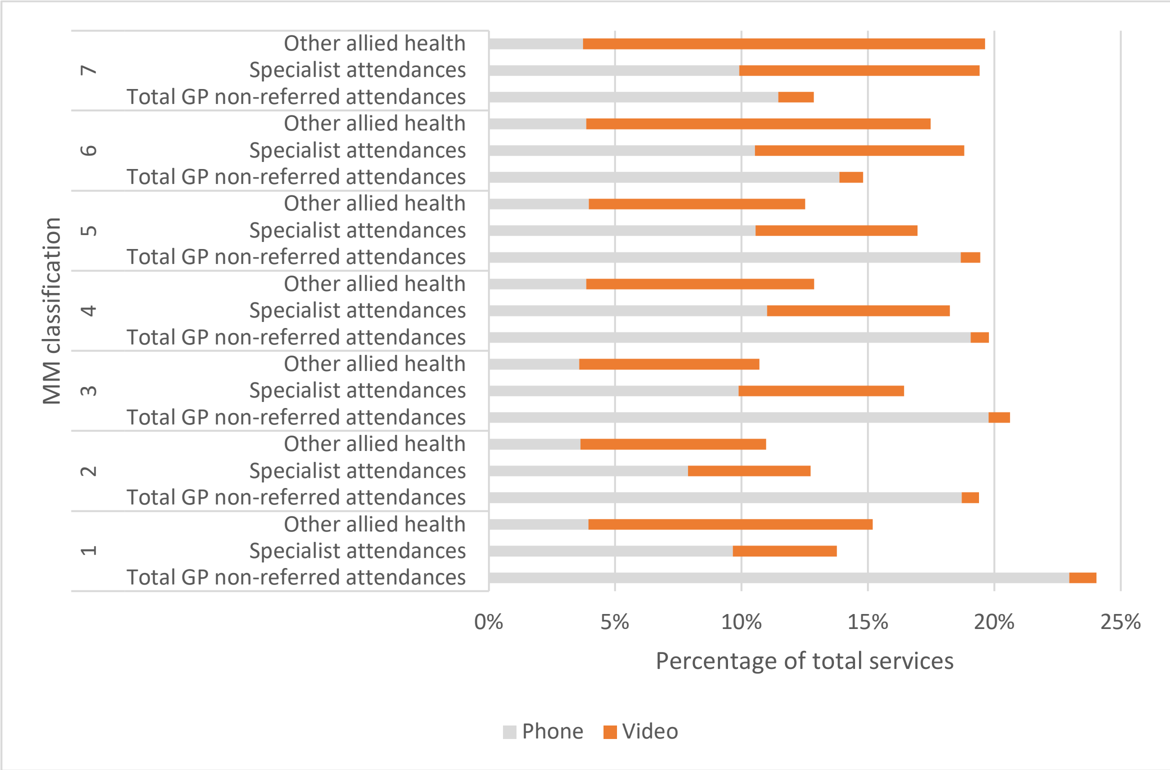

Figure 5 **Proportion of services by telehealth, by broad type of service and rurality (MM 1–7)**

Informed by the Health Lab's research (Health Design Lab, unpublished), the MRAC proposed several possible reasons for why GPs are not taking up video as readily as some of their colleagues, including:

- Clinicians may feel more comfortable using conventional, face-to-face consultations, especially for some conditions and some patients.
- Patients may be more comfortable using face-to-face consultations.
- GP appointments are relatively short (for example, compared to specialists and allied health appointments), making GPs reluctant to spend time dealing with potential technology issues.
- General practice clinics may not have been adequately supported in updating their telehealth capabilities. Some practices may have used telehealth during COVID-19, but did not have a strategy in place to continue using it after COVID-19 restrictions ended.
- General practice includes many patients who are older, and the over 70-years age group uses video telehealth less often than younger age groups.

- There are no guidelines outlining the available telehealth systems and how to make decisions regarding suitability for individual practices. Some clinicians and patients may lack digital literacy or internet access.
- There may be some confusion around Medicare claiming for telehealth items.

Patient use of telehealth services for primary health care

The MRAC noted that, during the first quarter of 2020 before the implementation of COVID-19 MBS telehealth on 13 March of 2020, the use of telehealth services increased substantially from pre-pandemic levels. Within weeks, telehealth transitioned from just over 1 million services to over 6 million services (see Figure 6). Since then, use of telehealth services has been declining, likely reflecting the removal of COVID-19-related social distancing restrictions and a return to conventional face-to-face consultations.

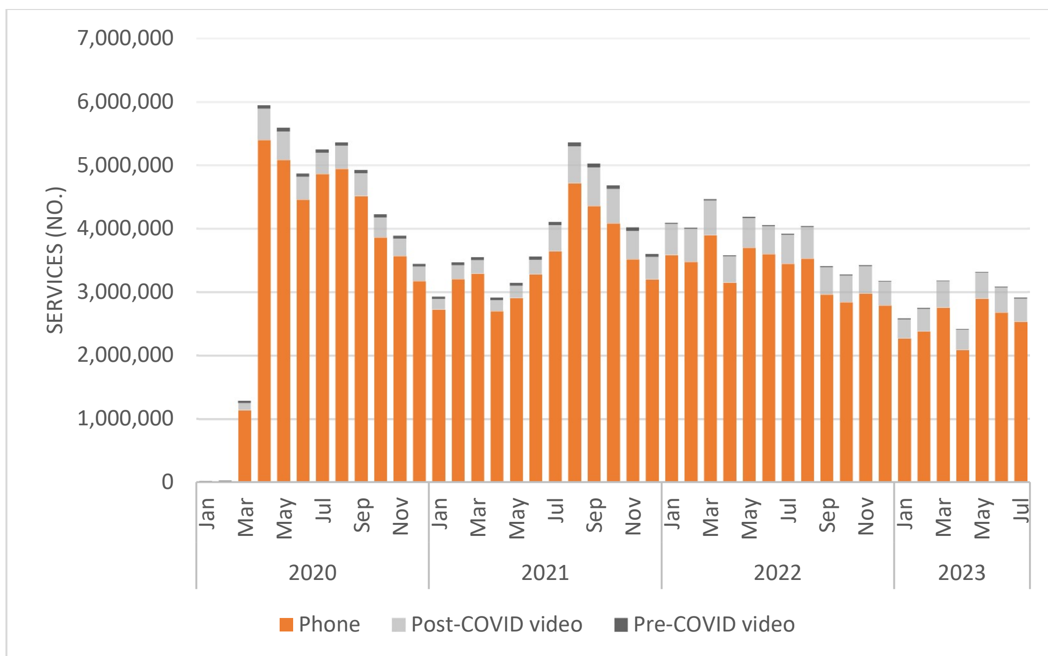

Figure 6 Patient use of telephone and video services, January 2020 – June 2023

The proportion of claimed GP telehealth services is stabilising at around 20% of all GP services in financial year 2022–23, but some analyses show telehealth use is lower among (Butler et al. 2023):

- older people
- males
- those with low education or low income
- those living in outer regional/remote areas
- those who are not proficient in English.

However, telehealth users who participated in the Australian Bureau of Statistics Patient Experiences in Australia survey were more likely to be middle aged or older, and older patients were more positive about their telehealth use than younger people (ABS 2021).

Patients have historically used telehealth differently outside major cities, and may have had more experience with video services, with access to most non-GP specialist consultations by video since 2011 (see Figure 5 in Clinician use of telehealth services).

There are also possible privacy issues, both in terms of patient access to a private space and the need for clinicians to ensure privacy in the conduct of a telehealth consultation. The MRAC also noted additional research being undertaken about culturally safe telehealth services (results not yet available).

Online-only telehealth models

The MRAC discussed the growth in online-only GP business models that offer telehealth services for medical certificates, prescriptions and referrals. These services are marketed as a convenient way to access health care where the outcomes are pre-determined and patient led. However, given they are generally provided as a quick once-off consultation, where the patient is unknown to the clinician and without access to the patient's medical records, they do not support safe, quality or continuous care. While these private services are not Medicare claimed, they may have downstream effects on the volume and clinical appropriateness of PBS prescriptions and MBS referrals (for example, for pathology, imaging or non-GP specialist review). In addition, a patient's care may be further fragmented as they do not have their regular GP or nurse practitioner coordinating this care.

Populations and services where access can be optimised with telehealth

The MRAC agreed that face-to-face consultation was still the preferred standard of health care, but also considered that telehealth could complement this care for some patients in certain circumstances. Specifically, telehealth could improve access for some patients, such as those with disability who are largely housebound, by providing access to an increased frequency of consultations and more timely access. However, the MRAC considered it important that patients with complex conditions are not relegated to telehealth-only consultations, as this could result in inferior care in the longer term.

The MRAC referred to its review of the MBS items for mental health, smoking cessation, and bloodborne virus and sexual and reproductive health (BBVSR) to frame its discussion and recommendations for improved access (see Eligibility requirements and exemptions).

Proponents of telehealth often cite equity of access for people in rural and remote regions as justification for the services. The MRAC agreed with this, but also noted that non-clinical barriers exist for those settings, including:

- technology and infrastructure limitations
- poor digital literacy for both patients and clinicians
- patient education on how to optimise their telehealth consultation
- previous poor experiences in using telehealth, for both patients and clinicians
- clinicians' understanding of the facilities available to the patient
- the lack of culturally appropriate health services for First Nations people.

The MRAC considered that some types of health care services and workflows likely conform to telehealth better than others. For example, a face-to-face consultation may be preferred for initial diagnoses and assessments, whereas telehealth may better suit treatment-based or follow-up consultations.

Considering the research presented to the committee, the MRAC suggested criteria for the assessment of new requests for telehealth items and exemptions to eligibility. Items that are exempt from the established clinical relationship should:

- represent situations where there is a relatively high acuity presentation or issue, where the immediacy of the service(s) is critical
- represent a clear public health advantage when providing 'unrestricted' access to care
- have a low likelihood of misuse by patients and providers
- refer to care where a single episode or consultation is sufficient and unlikely to adversely affect outcomes or fragment care.

In addition, several risks should be considered, including:

- overservicing and enabling adverse commercial models of care
- the efficacy of telehealth-only solutions
- privacy risks of sensitive or condition-specific items on patients' MBS claims records
- impacts to equity of access, including potential interactions with technology literacy and culturally and linguistically diverse groups, and people with vision or hearing impairments.

The MRAC noted that telehealth could help improve access to high-quality health care for some groups of people. The MRAC considered that telehealth items and exemptions could enable access for several populations or situations, such as:

- people with a health concern that needs urgent attention (although the MRAC noted that this may need to be defined, as 'urgent' may differ for different people)
- people in rural and remote settings where the health care workforce may be limited
- when delayed access may result in adverse health outcomes
- paediatric patients with behavioural issues that impede face-to-face consultations.

The MRAC considered situations involving care plans – for example, for patients with complex and chronic health conditions – and the importance of face-to-face consultations for ongoing care. However, the MRAC also considered that there may be situations where such patients benefit from telehealth, such as those in residential aged care or as part of the National Disability Insurance Scheme. The MRAC acknowledged that these are complex areas of health care. The MRAC advised that telehealth, in its current framework, is not fit for purpose for residents in aged care and requires further committee discussion.

Importantly, the MRAC acknowledged the importance of vulnerable patients receiving value-based health care, but also noted that exemptions should not result in

fragmentation of health care. The MRAC suggested 2 criteria that could be used to help identify vulnerable populations:

- where inequality of service is widely acknowledged
- where lack of access would be highly detrimental for the patient.

The MRAC considered it appropriate for the department to better support uptake of telehealth. The MRAC noted that while the department cannot promote certain systems or set-ups, accreditation requirements and standards for telehealth and associated technology would guide clinicians towards overall best practice as well as a telehealth system that best works for their practice and patients. MRAC pointed out that the Australian Digital Health Agency and the Australian Commission on Safety and Quality in Health have a role to play in accreditation, for both telehealth systems and for practices to meet standards around using telehealth.

MBS Telehealth Principles review

In 2020, the MBS Review Taskforce developed Telehealth Principles to guide future consideration of telehealth items in the MBS (MBS Taskforce 2020a).

As part of its post-implementation review, the MRAC reviewed these Principles and proposed updates, taking into account stakeholder feedback.

Principle 1

Original	Proposed revision
Should be patient-focused, and based on patient need, rather than geographical location.	Should be patient-focused and based on patient need, as determined by the clinician and the patient.

The MRAC discussed whether Principle 1 should be amended to refer exclusively to patient **clinical** need. However, the MRAC noted that patients' needs may be both clinical and non-clinical. For example, a patient may need to use telehealth for access-related reasons. Provided that telehealth is clinically appropriate (refer Principle 2), Principle 1 need not preclude consideration of non-clinical needs.

The MRAC considered that both the clinician and patient have a role in identifying the patient's needs. Acknowledgment of the patient's role could discourage inappropriate behaviour such as cold-calling patients to initiate consultations and generating MBS claims of limited clinical value. Patients would also benefit from education on how to optimise care when choosing telehealth, including joining from a quiet and private space, without distractions.

Principle 2

Original	Proposed revision
Must support and facilitate safe and quality services that demonstrate clinical efficacy for patients.	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.

Principle 2 emphasises that telehealth services must meet quality and safety standards. The MRAC considered that Principle 2 remains especially important in light of the emergence of new asynchronous telehealth models that do not deliver the same level of service and risk bypassing necessary clinical examination.

The MRAC considered that telehealth services must be clinically efficacious and align with the requirements of the equivalent face-to-face services. When scheduling telehealth appointments, clinicians should feel confident that these MBS item

descriptor criteria can be fulfilled (although it may become apparent during a telehealth consultation that a face-to-face consultation is needed).

The MRAC noted external feedback that Principle 2 should refer to ‘all aspects of safe and quality services’. However, the MRAC considered that this ‘absolutist’ phrasing was unhelpful.

Principle 3

Original	Proposed revision
Should be provided in the context of continuity of care between patient and clinician.	Should be provided in the context of coordinated and continuous care between patient and clinician.

Principle 3 supports continuity of care. The MRAC discussed whether the principle should focus exclusively on the relationship between the patient and their primary clinician, or if it should refer to effective clinical handover after episodes of care with another clinician.

The MRAC considered that an important purpose of the principle is to discourage opportunistic and aggressively commercial service models and those that offer telehealth-only consultations focused on a single disease or medicine. However, the MRAC also acknowledged the need for coordination where there are episodes of care (such as medical termination care) with a different clinician. The MRAC decided to largely retain the original wording, adding the concept of ‘coordinated’ care. Given that different clinicians are covered by different codes of conduct, the MRAC decided against referencing any specific code governing clinical handover. The MRAC noted that in relation to general practice, the introduction of MyMedicare has the potential to further improve continuity of care, and to replace and improve upon current arrangements through broader links to telehealth services.

Principle 4

Original	Proposed revision
Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.	[Retain without amendment]

The MRAC considered revising Principle 4 to designate telehealth as ‘complementary’ rather than as a ‘substitute’ for face-to-face consultations, and to identify face-to-face consultation as the preferred modality because it allows for comprehensive physical assessment. However, the MRAC noted that when comprehensive physical assessment is unnecessary, telehealth can be an effective substitute. The MRAC considered that more prescriptive wording risked devaluing and undermining telehealth.

The MRAC agreed to retain the original wording, noting that the intent of Principle 4 is to ensure that patients continue to have access to face-to-face care.

Principle 5

Original	Proposed revision
Should prefer video over phone, as video offers richer information transfer, with fewer limited exceptions being allowed over time.	Must offer both telephone and video along with face-to-face consultations, although the 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 clinician experience.

The intent of Principle 5 is to give guidance on which telehealth modality (video or telephone) is preferred. Principle 5 builds on Principles 1 and 2, which set out when telehealth is an acceptable alternative to face-to-face consultation.

The MRAC discussed whether practices using telehealth items (as well as face-to-face consultations) should be encouraged or even required to offer both telephone and video modalities to patients to discourage lack of investment in video capability. However, it was noted that such a requirement could have unintended consequences for practices that operate almost entirely face-to-face, complemented with occasional telephone consultations.

The MRAC acknowledged that video more closely approximates face-to-face consultation, giving the clinician access to both verbal and non-verbal information. However, the MRAC considered that the research evidence about any difference in clinical effectiveness was not strong enough to justify a blanket preference for video. The MRAC noted strong feedback from stakeholders that in many cases, there is no discernible difference in outcome between video or telephone consultations. Additionally, non-clinical issues (such as the patient’s access to and ability to use the technology) can mean telephone offers a better experience for the patient and/or provider in some circumstances. Therefore, the MRAC considered that clinicians should weigh factors and choose the most clinically appropriate modality for each consultation.

Principle 6

Original	Proposed revision
Support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation.	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.

The MRAC noted that the intent of Principle 6 was to expand and better recognise the engagement of clinicians that support the patient face-to-face during a telehealth consultation with another (remote) clinician. The MRAC considered that Principle 6 should be retained, with additional explanatory detail.

In Principle 6 (and others), the term 'clinician' includes allied health professionals and pharmacists.

Principle 7

Original	Proposed revision
Should be implemented and modified through time-limited transition arrangements.	Should provide sufficient notice of changes to MBS telehealth items for clinicians and patients to adjust to change.

Principle 7 signals the department's intention to give notice of changes to telehealth items. The principle was introduced in response to stakeholder feedback that during the MBS Review, practices had not been given enough time to adjust to item changes.

The MRAC noted stakeholder feedback that the wording of Principle 7 was confusing. The MRAC considered that the intent of the principle should be retained, but rewritten in plain language.

Principles 8, 9 and 10

Original	Proposed revision
Supports different funding models consistent with patients' need, clinical specialty and purpose.	[Remove]
Should take into account contemporary evidenced-based relevant guidelines and principles.	[Remove]
Require ongoing data collection, research and evaluation into outcomes and utility.	[Remove]

The MRAC noted that unlike the first 7 Principles, Principles 8, 9 and 10 apply to Medicare as a whole, rather than being specific to telehealth. The MRAC also noted that the overarching MBS rules apply equally to telehealth. While strongly supporting best practice and ongoing research, the MRAC therefore recommended the removal of Principles 8, 9 and 10.

Recommendation 1: Adopt the revised MBS Telehealth Principles.

Telehealth services review

Optimal telehealth care, and phone and video services

The MRAC recalled the evidence for comparing telehealth modalities (see Telehealth vs face-to-face consultations and Video vs telephone consultations). The MRAC considered that changes to telehealth services over time resulted in an increase of telehealth consultations by video, but it had potentially resulted in inequitable access to telehealth for some populations.

While taking into consideration more relevant research having been published on video-based telehealth, evidence from direct comparison of outcomes from video and telephone services remains scarce. Expert opinion and anecdotal evidence was noted, that suggested that video would be preferable to telephone and result in better care, especially when:

- diagnosing a condition with visual signs or if measurements need to be validated
- consulting about a condition where it is important to observe the patient (for example, a patient experiencing a psychotic episode or a patient who has an eating disorder)
- paediatric patients are involved.

Consistent with Principles 1 and 2, clinicians must balance patient needs and preferences with regulatory requirements, clinical safety and effectiveness when deciding whether to offer a telehealth consultation and which modality to use. For example, if a patient wanted a phone-based telehealth consultation for a certain condition but the clinician felt that this would risk the patient's safety, was clinically inappropriate or would likely result in an incomplete service ineligible for MBS claims, then the clinician would reserve the right to refuse to provide that type of service.

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 MRAC noted that, currently, the MBS only supports the synchronous delivery of telehealth services that are analogous to in-person consultations. These are synchronous (real-time) services for which the patient must be present for the clinician to bill Medicare. For many common items, it is the amount of time with the patient that determines the appropriate item to claim.

The MBS Review Taskforce and the Medical Services Advisory Committee (MSAC) have previously received submissions advocating for MBS items for asynchronous care, such as for time taken for correspondence, writing referrals, filling in forms, taking notes or reviewing reports. Rather than items for consultations, these types of activities may be more closely aligned with items for services that are outside the legal definition of professional attendance – for example, pathology and other specific diagnostic services, and case conferences or contributions to patients' care plans.

The MRAC determined it was difficult to make generalised recommendations on asynchronous services, as the scope of services provided by different specialities are so broad. In addition, renumeration for asynchronous services does not fit with the MBS framework of payment for services provided to a patient.

Overall, the MRAC considered it inappropriate for additional MBS items to be created to compensate for the administrative workload many clinicians are facing. The MRAC determined that it may be more appropriate to instead review the renumeration for some MBS items so that it better reflects current administration requirements. There was a perceived incompatibility with the intent of such items to be for payment of providers, while the MBS is foremost for the payment of patients. In the context of bulk billed services, such an approach had potential to introduce new risks of fraud to the MBS program.

The MRAC noted MSAC's decision in 2017 to not support an application for specialist dermatology services delivered by asynchronous store and forward technology, due to no benefits in safety, effectiveness or cost-effectiveness. The MRAC also considered that, to an extent, administrative tasks should be considered as part of the high-value care that clinicians are already providing to a patient as part of the initial service – for example, surgical fees that include the surgery and follow-up consultations.

However, the MRAC acknowledged that, for many clinicians, this administrative workload is increasing. The MRAC considered that longer time-tiered MBS items may be appropriate for complex patients that require substantial extra work, while some untimed but annual frequency-limited items such as chronic disease and mental health planning were already associated with higher fees for GPs.

The MRAC also recommended exploring other funding pathways that could renumerate clinicians for this type of work. The MRAC noted the opportunities MyMedicare may provide for recognising additional time that is often associated with managing complex patients in primary care. The following MBS services and incentives will be available to practices that are registered in MyMedicare:

- MBS-funded telephone calls and access to a triple bulk-billing incentive for longer MBS telehealth consultations for eligible patients
- blended funding payments for general practices to support people with complex, chronic conditions who are frequent hospital users
- General Practitioner Aged Care Access Incentive
- chronic disease management items non-exclusively linked to a patient's registration.

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.

Telehealth eligibility requirements and exemptions

Currently, GPs and other clinicians working in general practice can only provide MBS-rebated telehealth services if they have an existing and continuous relationship with a

patient (also known as the 12-month rule). This means that patients must have seen their GP or another clinician within the same practice face-to-face at least once in the previous 12 months. The rationale for these eligibility requirements is to prevent fragmentation of care, and to prevent patients from 'doctor shopping'.

At the start of the COVID-19 pandemic, temporary MBS items for GP consultation were introduced for nicotine cessation, BBVSR, pregnancy counselling and mental health that did not include the 12-month rule. The intention was to ensure access to these services when face-to-face consultations were not possible due to quarantine or social distancing restrictions.

The MRAC noted the lack of general support for disease/condition-specific MBS telehealth items from the Royal Australian College of General Practitioners and the Australian Medical Association. However, the MRAC considered that condition-specific telehealth items may improve access for some populations where access is a barrier to obtaining high-quality health care.

The MRAC referred to its conclusions (see Populations and services where access can be optimised with telehealth) when considering populations and services that may benefit from telehealth items to inform the following recommendations for ongoing eligibility requirements and exemptions.

Nicotine cessation temporary MBS items

The MRAC noted that condition-specific MBS telehealth items exempt from usual eligibility requirements could result in some more commercially oriented service models. There is some evidence of this in MBS data, with providers that appear to focus solely on telehealth nicotine cessation services. However, a typical 'episode of care' with the use of these MBS items was one consultation between a patient and provider, and this did not align with expectations of clinical management of nicotine dependence. The MRAC also noted that PBS data did not reveal any change in dispensing of PBS nicotine cessation therapies after the introduction of the specific GP telehealth items.

Acknowledging recently renewed commitments to prevention and reduction of nicotine dependence by all Australian states and territories, the MRAC noted that GPs were well trained in providing nicotine cessation services. The MRAC considered that these services would be available and more effective from patients' usual GPs using generic MBS items for consultations. In this context and with no evidence temporary GP nicotine cessation items improved access to evidence-based therapies, there was no need for these MBS items to continue beyond their scheduled expiry of 31 December 2023.

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

BBVSR temporary MBS items

A small number of approved prescribers for some medications and privacy concerns have been cited as reasons people may seek alternative providers to their regular GP for some sexual-health related consultations. The GP BBVSR services can be used to

provide time-critical treatment, including but not limited to medical termination and pre-exposure prophylaxis for human immunodeficiency virus.

The MRAC considered that access to BBVSR services served a more obviously unmet clinical need and services to a more vulnerable population, in contrast to telehealth nicotine cessation services. Overall, there was an ongoing role for specific BBVSR items and their exemption to existing clinical relationship requirements, and that these items were likely to improve access without being a high risk for misuse.

The MRAC noted stakeholder feedback suggesting that patient privacy could still be compromised when booking BBVSR telehealth services, but that this risk was the same for any telehealth booking, not just for BBVSR.

The MRAC also noted stakeholder feedback suggesting that removing the requirement for a GP referral for non-GP specialist BBVSR services, which began in 2021, would increase access to such specialised services. However, the general principle of GP referral remains important for avoiding fragmentation of care where possible, and that even in the case of episodes requiring specialist referral, joint care with a GP that may provide more frequent consultations with the patient was desirable.

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

Continuation of exemption for non-directive pregnancy counselling MBS items

The MRAC noted from MBS data that non-directive pregnancy counselling MBS items were accessed more than 30,000 times in the 2021–22 financial year, and just under 6,000 of these claims were via telehealth. Last year, in 2022–23 a total of 35,000 services were provided including a similar number by telehealth. The MRAC noted that some co-claiming occurs (about 35% of the time), with the most common combination being a face-to-face pregnancy counselling item followed by MBS items 23 or 36. The MRAC considered it unnecessary to continue the exemption for pregnancy counselling items, noting that many services may be superseded by making GP BBVSR items permanent, or may be provided as part of other GP telehealth services, including in relation to mental health where consideration may be given to perinatal depression. However, current BBVSR items may need to be updated to ensure they allow for all services currently provided under non-directive pregnancy counselling.

The long-term relevance of GP non-directive pregnancy items may also need to be considered in the context of concurrent or future reviews of mental health and GP MBS items.

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

Continuation of exemption for GP mental health MBS items

The MRAC considered that removing the exemption on mental health telehealth services may decrease access for some vulnerable populations that may not have an

ongoing relationship with a regular GP or general practice. Examples include young people, university students who have moved away from home, people in rural or remote areas, and those in domestic violence situations. In addition, the MRAC considered that many people with mental health conditions are disengaged from a regular practice. The MRAC noted the mental health statistics, including the suicide rates, in Australia and determined that ensuring equal access to mental health services was of paramount importance.

The MRAC noted that a GP referral is required to access psychological specialist services, and considered that timely referral and/or confident management by a GP specialising in mental health therapy was important. However, the MRAC was conscious of the unintended consequences of exemptions to access telehealth MBS items, such as encouraging online-only services that focus on quantity over quality, which may result in low-value, fragmented care. The MRAC was careful to acknowledge that not all online-only services result in low-value care, and some business models may be suitable. The MRAC queried whether there were opportunities to introduce rebates and incentives (and disincentives) to avoid undermining face-to-face services.

The MRAC considered different thresholds for patients' eligibility for MBS GP mental health services, and noted that MyMedicare, as it is proposed for MBS chronic disease items would be a suitable model for GP mental health planning and reviews of plans. This would introduce contemporary GP telehealth eligibility requirements which encourage continuity of care, and while no explicit requirement applies to GPs who provide mental health treatment plans to be the primary GP for the recipient of the plan, it was noted that planning was intended to be holistic and inclusive of biological, psychological and social factors (see MBS Note AN.0.57).

While MyMedicare could apply to planning and review items, it was essential that treatment services, including the 20+ minute GP mental health consultation and focused psychological strategies continued to be exempt from telehealth eligibility requirements. This approach ensured that GP mental health treatment services by phone and video were as accessible as allied mental health professionals and consultant psychiatrists.

The MRAC emphasised video as the preferred modality for mental health telehealth services, as it is often important to be able to observe the patient, and observed that for non-GP providers this was already the case. The MRAC referred to Principles 1 and 2; that patient preference must be considered and that clinicians must deliver a service that they determine to be safe and effective.

The MRAC noted that any mental health telehealth services should comply with the National Safety and Quality Digital Mental Health Standards, acknowledging that these are voluntary, as well as any MBS requirements. Initial findings from a trial of the National Safety and Quality Digital Mental Health Standards are anticipated in late 2023.

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.

Continuity of care and consistency of eligibility requirements

The MRAC discussed the eligibility requirements and how these exist to support the concept of continuity of care. The MRAC did not think these were applied consistently, and that some telehealth items for certain clinician groups did not currently have any eligibility requirements – such as nurse practitioners and allied health. The MRAC considered it appropriate to apply the existing relationship rule to nurse practitioner and midwifery telehealth items, as underpinned by Principles 1, 2 and 3. The MRAC also considered that this would be supported by the MyMedicare model, which does have the option to nominate a nurse practitioner, and noted that the model includes face-to-face requirements. 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. In addition, allied health services have caps associated with MBS claiming, and the MRAC considered that these caps make it unlikely that these services are misused.

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

Non-GP specialist attendances

The MRAC agreed that continuity of care and consistency in policy was important to implement across the broad range of MBS telehealth items. The MRAC noted that, currently, initial non-GP specialist consultations could be claimed via face-to-face or video consultation; however, the MRAC noted that this was inconsistent with GP requirements, which must fulfil the 1-in-12 rule. Therefore, the MRAC considered it appropriate to align the telehealth requirements across these non-GP specialist and other specialist groups.

The MRAC discussed the appropriateness of re-instating MBS item 116 for telephone consultations, and how the recent removal of this has negatively impacted some specialist services. The MRAC noted that many specialists are instead claiming MBS item 119 in place of item 116, as this item is available for telephone consultations, and some specialists are not billing for a follow-up telephone consultation at all. The MRAC considered that there are instances where clinicians could provide safe and effective care via telephone – for example, immediately after a face-to-face consultation, where patients may have travelled long distances for that initial consultation.

The requirement for an established clinical relationship for most GP telehealth consultations, but not currently required for other non-referred consultations, such as from nurse practitioners, was identified as an inconsistency. In recommending that the same eligibility requirements extend across non-referred attendances, MRAC suggested consideration also be given to new nurse practitioner MBS items that recognised

specialised services which are exempt from these rules, like GP consultations specific to mental health, sexual/reproductive health consultations by phone and video.

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.

Home visits and patient-end support services

The MRAC discussed the GP home visits as a service with declining annual volumes and which may be being superseded by telehealth in many circumstances. There are, however, patient populations at risk of perverse and unintended reductions in access to comprehensive consultations, if telehealth were their only option.

Acknowledging great diversity in practice models, including scenarios where home visits are routine, the MRAC heard that, for many GPs, these services are less commercially viable compared to alternative consultations.

The MRAC acknowledged that face-to-face services remained important for housebound patients requiring complex care, and discussed whether home visits should be better incentivised. While an amendment to relevant rebates is an option, the MRAC recommended an alternative approach harnessing patient-end support for telehealth consultation with the patient's GP. This would mean nurses or allied health providers under GP stewardship beside the patient to facilitate the service, and the MRAC noted that this was more consistent with earlier advice of the MBS Review Taskforce in relation to GP services (MBS Taskforce 2020b).

The MRAC suggested these facilitated GP telehealth consultations also would qualify patients for ongoing access to GP telehealth, for example, were there was a requirement for a face-to-face service within the previous 12-months.

The MRAC also noted stakeholder feedback that changes in 2022 to MBS items for GP/other clinician patient-end support for telehealth with private non-GP specialists and consultant physicians created inequity of access, particularly for some people living in rural and regional areas and for elderly patients. While such services continue to be available with nurses and Aboriginal Health Workers assisting the patient, increases in services by these providers have not overcome the reduction resulting from removal of the GP items. It was recommended that GP patient-end support items be reinstated, and the MRAC referred to Principles 1, 2 and 6 to support this recommendation.

The MRAC acknowledged that patient-end support in residential aged care and for telehealth consultation with GPs, and for patients of Aboriginal Community Controlled Health Organisations to consult with state-funded non-GP specialists and consultant physicians had potential too, but that these applications had potential implementation challenges and there was a need to identify optimal funding pathways. For example, MBS payments would not be suitable for patient-end supports already able to be funded in the context of residential aged care subsidies, other Commonwealth programs like the Indigenous Australian Health Program or Workforce Incentive Program, and state funding of its hospital and community-based specialist clinics.

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.

Consultation and feedback review process

Consultation with relevant and interested organisations, peak bodies and consumers is considered essential in the formulation of advice to government on recommended changes to MBS items. The MRAC and its working groups seek 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.

All feedback provided through consultation processes is considered.

Telehealth Principles

A targeted stakeholder survey was conducted in May–July 2023 about the 10 MBS Review Taskforce Telehealth Principles, seeking ratings of agreement with each principle (in its current form) from 1 to 5 stars. The survey also included opportunity for written feedback.

Feedback received from this process was considered by the MRAC and used to inform proposed revisions to these Principles.

Appendix A MBS Continuous Review and committee

Medicare Benefits Schedule Continuous Review

The Medicare Benefits Schedule (MBS) is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce (the Taskforce). From 2015 to 2020, the Taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Medicare Benefits Schedule Review Advisory Committee

The MRAC is an independent, clinician and consumer-led, non-statutory committee, established to advise government on publicly funded services listed on the MBS.

The MRAC aims to improve patient access to high-value care through consideration of the appropriateness of existing MBS services, in addition to wider health reform solutions which may include alternate funding models or means of service provision and the addition of new services where a health technology assessment (HTA) is not appropriate.

Through review processes, the MRAC examines how the MBS is used in practice and recommends improvements based on contemporary clinical evidence. It also allows for continuous monitoring of previously implemented changes and assists with identification of priority areas where targeted research, investment or support is required, through the assessment of cross-speciality items, to maximise system benefits.

The MRAC:

- undertakes thematic assessments across the MBS to examine issues including, but not limited to, consistency between items, methods of service delivery and multidisciplinary models of care
- considers changes in service delivery that may inform both MBS and non-MBS approaches (such as alternative funding models) to improving patient health outcomes and deliver high-value care to the community

- considers applications from the sector for MBS changes where the informed considerations of the MRAC do not require a new stand-alone HTA assessment
- identifies key areas for review as informed by patterns and trends in MBS data and other identified evidence and data sources
- undertakes a progressive schedule of work that builds upon the work of the MBS Review Taskforce and aligns with government and Department of Health and Aged Care priorities
- provides clinical and service delivery advice on policy issues identified by the department, relevant to the scope of the committee.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is available on the Department of Health and Aged Care's MRAC webpage.

MBS Continuous Review Guiding Principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
  - recognising the central role of general practice in coordinating care
  - facilitating communication through general practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
  - item descriptors and explanatory notes are designed to ensure clarity, consistency and appropriate use by health professionals
- promotes equity according to patient need
- ensures accountability to the patient and to the Australian community (taxpayer)
- is continuously evaluated and revised to provide high-value health care to the Australian community.

b) Service providers of the MBS:

- understand the purpose and requirements of the MBS
- utilise the MBS for evidence-based care
- ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
- utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.

c) Consumers of the MBS:

- are encouraged to become partners in their own care to the extent they choose

- are encouraged to participate in MBS reviews so patient health care needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that general practice general practitioners are specialists in their own right. Use of the term 'general practice', both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-health-care-system approach to its reviews.

Government consideration

If the Australian Government agrees to the implementation of recommendations, it will be communicated through government announcement.

Information will also be made available on the Department of Health and Aged Care websites, including MBS Online, and departmental newsletters.

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