



A joint submission to the Medicare Benefits Schedule Review Advisory Committee (MRAC) Draft Report: Post implementation of telehealth MBS items

3rd November 2023

This submission has been prepared jointly between Cancer Council Australia, and the Clinical Oncology Society of Australia.

Cancer Council Australia (Cancer Council) is Australia's peak national non-government cancer control organisation and advises the Australian Government and other bodies on evidence-based practices and policies to help prevent, detect and treat cancer.

The Clinical Oncology Society of Australia (COSA) is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients.

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Cancer Council Australia and COSA welcome the opportunity to address the recommendations made within the Draft Report: Post implementation of telehealth MBS items (the Report) and the evidence informing them. Our organisations are concerned about the impact of *Recommendation 4: Discontinue temporary nicotine cessation MBS items with exemptions after 31*

December 2023 and 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 on patient care. The impact of these recommendations on people affected by cancer has not been fully considered or explored and we strongly recommend the continuation of telehealth options for both nicotine cessation support and initial consultations with non-GP specialists.

We support 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.

Telehealth has enabled localised cancer care delivery for people living far from specialist options for many years. More recently the expansion of telehealth Medicare Benefits Scheme (MBS) items during the COVID-19 pandemic has broadened access, connecting more people to best cancer care options regardless of where they live. Providing cancer care remotely (either via telephone or videoconferencing), for treatment that isn't required in person or can be delivered via local health professionals connected into specialist sites, has become a standard option for people affected by cancer. Several advantages for patients include reduced time to travel to treatment and time away from family and work, greater access to a range of cancer support services and treatment options and receiving care within their community.

General feedback on the report

Differentiating between general practitioner and non-general practitioner specialist roles.

The Report makes several references implying that general practitioners (GPs) and non-GP specialists provide the same care. However, GPs and non-GP specialists offer different care to people affected by cancer, and the scenarios for the safe and effective use of telehealth differs. For people living in regional and remote areas, and people diagnosed with a rare or less common cancer, the right person to treat their condition may not be available locally, requiring them to travel significant distances to access appropriate treatment.

Telehealth enables people to seek non-GP specialist care across Australia. The existing telehealth MBS item numbers enable people to discuss their condition and any test results with the non-GP specialist to identify their care options before deciding, and travelling, for interventional treatment/s requiring face-to-face contact.

Maintaining flexibility in modalities for cancer care delivery.

The Report presents telehealth as an inferior method of care delivery to face-to-face care and bases the recommendations on limited evidence. Telehealth delivers safe and effective cancer care and provides additional benefits to people limited by distance to treatment services. Following the implementation of the Townsville Teleoncology Model, quality improvement measures were implemented to improve the scope of practice of the local site (Mt Isa). All new patients were seen initially via videoconferencing and, patients were not required to travel to

Townsville for their care unless requested by the clinical team¹. This resulted in all patients who required urgent reviews with medical oncologists being seen via videoconferencing and managed in Mt Isa with the support of local doctors¹. This model is acceptable to patients, rurally based health professionals and provided quality cancer care¹.

Retaining MBS items to enable both GP and non-GP specialist telehealth consultations provides flexibility in the delivery of cancer care and puts the needs of cancer patients at the centre of care delivery. This flexibility should extend to providing telehealth either via telephone or videoconferencing and based on clinical judgement **and** patient preference or feasibility. The Report suggests a preference for videoconferencing however, this is not an option for all people. The availability of telecommunications infrastructure, affordability of technology and data access, or the digital literacy to facilitate video consultations can be a barrier to videoconferencing. Decisions regarding the availability of MBS items enabling cancer care, whether for telehealth or face-to-face care, must consider the implications for communities with poor cancer outcomes, including Aboriginal and Torres Strait Islander peoples, people living in regional and remote areas, and people from lower socioeconomic areas, and aim to reduce the existing equity issues.

The data presented may not represent the value of telehealth.

The recommendations within the Report are made in the absence of or with limited evidence. The lack of available evidence does not indicate no benefit. In addition, data showing that a small number of people access an MBS item number does not mean that the MBS item is not necessary. It may be representative of the population who need the support that it enables. For example, populations from outer regional/remote areas are likely to have lower rates of engagement with healthcare services overall, consequently uptake of telehealth could be seen as low in the overall population, and further reduced by the requirements for 12-month care connection with the general practice.

Critically, the recommendations in the Report do not address some of the gaps identified in the data presented (e.g. lower rates of telehealth use by older males, people of lower socioeconomic status and rural/remote populations). Rather than limiting telehealth, real time data reflecting implementation experiences should be collected, analysed, and disseminated to build the evidence base to make informed changes and recommendations to MBS item numbers in the future.

Feedback on the recommendations

Recommendation 1: Adopt the revised MBS Telehealth Principles.

Principle 1: Should be patient-focused and based on patient need, as determined by the clinician and the patient, and Principle 4: Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care do not support Recommendation 9 in the Report (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.)

¹ Sabesan et. al. 2014. Quality Improvement Report. Timely access to specialist medical oncology services closer to home for rural patients: Experiences from the Townsville Teleoncology Model. Aust. J. Rural Health 22, 156-159.

Recommending that all initial consultations with a non-GP specialist be face-to-face is not patient-focused or considers the patient's needs. It will lead to people foregoing care due to the burden of travel and the associated financial cost. In the case of cancer care, it is not always clinically necessary for the patient to attend a face-to-face consultation with the non-GP specialist, especially as the initial consultation often discusses treatment options without providing the intervention.

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

The Report states that “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.” (p.27) However, research conducted by the Tobacco Free Program at the Australian National University highlights that Australians who smoke/vape are trying to quit and utilising telehealth services to change their behaviours (*publication-in-press*). Of the 94,862 nicotine and smoking cessation MBS service claims made between July 2021 and May 2023, approximately 37,371 were telehealth cessation claims (*publication-in-press*). Ensuring equitable access to evidence-based smoking cessation interventions to quit requires the continuation of telehealth MBS items.

Evidence based brief interventions and tailored supports from health professionals, people working in primary care and others, can effectively and efficiently support successful quit attempts. To reach the National Tobacco Strategy targets ($\leq 27\%$ Indigenous daily smoking prevalence and $\leq 5\%$ among the Australian population) by 2030, smoking and nicotine cessation MBS items are critical to supporting smoke and nicotine free behaviours and will help lead to significant health improvements (*publication-in-press*). Smoking cessation support does not require face-to-face consultation therefore, the adoption of Recommendation 4 in the Report would discourage people to seek evidence-based options, supported by a qualified health professional, to quit smoking. This could add to commercial companies playing a greater role in providing, and profiting from, individuals seeking smoking cessation options without consulting a healthcare professional. In addition to continuing the exemption for nicotine cessation MBS items, education campaigns explaining the importance of accessing smoking cessation support through qualified health professionals, could help to redirect interest and provide greater access to evidence-based interventions.

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.

MBS items supporting telehealth as an option for initial and subsequent consultations with a non-GP specialist must continue. Telehealth consultations improve access to high quality, safe and timely cancer care, and removing the telehealth option for initial consultations for non-GP specialists, will negatively impact access to best cancer care. Accessing the right service and the right specialist quickly affects cancer outcomes. For example, the Reporting for Better Cancer Outcomes program by the Cancer Institute NSW demonstrates variation in 5-year survival by regional location and socioeconomic status, with poorer outcomes for those living in out-

regional areas compared to metropolitan areas. Telehealth options are also safe, high quality and considered standard care in cancer care for allied health services.

The Report states several times that while telehealth enables improved access to care, it is at the detriment to quality and safety. This is inaccurate.

“Telehealth may appear to improve access, but there is risk of decreased quality and safety associated with non-face-to-face consultations.” (p11)

“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.” (p14)

Travelling to their nearest non-GP specialist or allied health care providers can stop people attending appointments and receiving cancer care. Travelling hours to receive a referral to diagnostic services or to discuss treatment options is a significant burden for people, particularly people not living locally to treatment. In many instances, this initial consultation is used to discuss treatment options such as whether treatment at a metropolitan hospital or via a clinical trial. If Recommendation 9 is adopted, people will be required to travel unnecessarily for these conversations. For people seeking second opinions, or who are referred to a different provider, or require additional services, including radiotherapy or allied health, each of these new services would also require an initial face-to-face consultation.

Traveling for cancer treatment incurs financial costs. These expenses such as travel or petrol, accommodation, and time away from work, can be financially straining. This is further felt when a person does not qualify for the state-based patient assisted travel scheme or the program doesn’t adequately cover their expenses. Accessing telehealth appointments creates less disturbance to family life and work and has lower costs to the patient. As an example, telehealth has enabled patients in Western Australia to avoid travelling 2-3 days for a 30-minute consultation with their oncologist.

Reliability on referral relationships between metropolitan and regional non-GP specialists requires telehealth options for initial consultations. Genomic services, including genetic counsellors, are available in metropolitan areas but less so in regional and remote areas. Regional doctors rely on the ability to refer patients to these metropolitan services via telehealth to inform accurate treatment delivery, including eligibility for funded medicines, and support for their patients.

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.

Our organisations support the recommendation to extend MBS items enabling patient-end support to nurse and allied health. Telehealth models of care are successful if patient-end support is available and for cancer care. Best cancer care can be appropriately delivered by nurse and allied health with support from health professionals in specialist centres.