RACGP
Royal Australian College *of* General Practitioners

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23 December 2019

Professor Bruce Robinson
Chair, Medicare Benefits Review Taskforce

Email: MBSReviews@health.gov.au

Dear Professor Robinson

Re: Draft report from the Medicare Benefits Review Taskforce - Ophthalmology Clinical Committee

The Royal Australian College of General Practitioners (RACGP) thanks the Ophthalmology Clinical Committee of the Medicare Benefits Schedule (MBS) Review for the opportunity to provide feedback on the committee's draft report.

The RACGP makes the following comments in response to the report.

1. The role of general practice

- While comprehensive, the report fails to recognise the key role general practitioners (GPs) play in service provision, as both 'gate keepers' in the referral network and as providers of follow-up care to patients who have been treated in specialist services. This is particularly relevant for those in remote and rural areas, who rely on primary care as the first point of contact for care and for ongoing management of these conditions.
- The report's focus on non-primary care treatment pathways and specialist care means that it does not take into consideration the needs of primary care, including:
    - the provision of imrpoved screening services at a GP-level for conditions such as glaucoma
    - the skills required by GPs to provide follow-up care for their patients. The RACGP is concerned that de-skilling in primary care, in particular the loss of GP specialisation in ophthalmologic conditions, is fostered by this report.

2. Aboriginal and Torres Strait Islander health

- The report does not review the specific needs of Aboriginal and Torres Strait Islander people, which are compounded by issues of remote and rural locations. Aboriginal and Torres Strait Islander people are nearly three times as likely to suffer vision impairment or blindness compared with non-Indigenous Australians.[1]
- Improving the capacity for cataract surgery in the public system is crucial. In 2015, only 61% of Indigenous Australians who needed cataract surgery had had the surgery (compared with 88% of non-Indigenous Australians).[2] The Committee's draft report lists the median waiting time for cataract surgery as 73 days; the median wait time for Indigenous patients is almost double, at 141 days.[1] Long waits make cataract surgery more difficult and mean patients are unable to work, are at higher risk of falls, and so more likely to be admitted to hospital or develop other medical problems – simply because of the lack of capacity to perform what the report says is a "mature procedure with well-documented outcomes and impacts".
- Changing telehealth items as described would be helpful, but the RACGP recommends the items be more flexible about the referring or attending health care practitioner. Many Aboriginal medical services may not have an optometrist, and services may be provided by a well-trained Aboriginal health worker, a remote area nurse, a nurse practitioner, or a GP, and possibly even a practice nurse. Other telehealth items are claimable on Medicare with a GP or a nurse attending with the patient, and this should be possible for ophthalmology telehealth consultations too, and should include Aboriginal health workers.

- The review does not consider how to incorporate the Aboriginal medical services that support these communities, and there are no recommendations about including Aboriginal and Torres Strait Islander health practitioners in the clinical team, or incentives to include them in care. The RACGP recommends the Committee considers this to help create culturally safe health services.

3. Specific items

- Item 42738: intravitreal injection – there are some restrictions because of concerns of over and under servicing. The rebate amount should be reviewed in line with the costs of providing the service now that they have become frequent, routine, outpatient services provided under topical anaesthesia. The RACGP proposes a re-evaluation of the rebate on the basis of equipment requirements and time required to perform the task.
- Item 42702: cataract surgery – there is tremendous variation from region to region, greater than explained by distribution of ophthalmologists. The RACGP recommends that clinical indications be established for referral for cataract surgery that take into account quality of life, quality of vision and visual acuity. Given the risks and harms, cataract surgery should be offered to those with the most to gain.
- The RACGP commends the committee for identifying that the effective hourly rebate rate for cataract surgery exceeds other types of surgery. The RACGP recommends that surgical fees be considered on the basis of their effective hourly rate and costs, rather than historical precedence.

Thank you again for the opportunity to provide feedback on this report. Please contact Mr Stephan Groombridge, Manager, eHealth and Quality Care on (03) 8669 0544 or at stephan.groombridge@racgp.org.au if you have any further queries.

Yours sincerely

Dr Harry Nespolon
President

References

[1] Australian Institute of Health and Welfare 2019. Indigenous eye health measures 2018: In-brief. Cat. no. IHW 221. Canberra: AIHW. https://www.aihw.gov.au/reports/indigenous-australians/indigenous-eye-health-measures-2018-in-brief/formats
[2] Foreman J et al. *National Eye Health Survey Report 2016.* Centre for Eye Research Australia and Vision 2020 Australia; 2016. Available from: https://www.vision2020australia.org.au/resources/national-eye-health-survey-report/