RACGP Submission to the MRAC Telehealth Post-Implementation Review

October 2023

RACGP

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RACGP submission to the MRAC Telehealth post-implementation review draft report

1. About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

As a national peak body representing over 46,000 members working in or towards a career in general practice, our core commitment is to support GPs from across the entirety of general practice address the primary healthcare needs of the Australian population.

We cultivate a stronger profession by helping the GPs of today and tomorrow continue their professional development throughout their careers, from medical students and GPs in training to experienced GPs. We develop resources and guidelines to support GPs in providing their patients with world-class healthcare and help with the unique issues that affect their practices. We are a point of connection for GPs serving communities in every corner of the country.

Patient-centred care is at the heart of every Australian general practice, and at the heart of everything we do.

2. Overview

The RACGP welcomes the opportunity to provide a submission to the MBS Review Advisory Committee (MRAC) Telehealth post-implementation review. This review is a significant opportunity to develop a robust framework which ensures high-quality, safe and accessible telehealth consultations now and into the future.

The benefits of telehealth have been clearly demonstrated, with significant uptake and strong demand for continued flexibility from patients and GPs across the nation.[1,2,3]

The introduction of MBS telehealth items at the beginning of the COVID-19 pandemic demonstrated the utility and effectiveness of telehealth consultations. Around one-third of people had a telehealth consultation in 2021–22, with over 80% of these consultations occurring with a GP.[4] This reflects the widescale adoption of telehealth across Australia in 2021 and its permanent integration into the healthcare system during and post-pandemic.

3. Summary of RACGP recommendations

The RACGP:

- Supports the notion that to assess a patient's need is genuine and clinically appropriate for telehealth, a GP and patient must work in partnership to define this and to determine the most appropriate modality (phone/video) for their consultation.
- Recommends Medicare Benefits Schedule (MBS) funding should not distinguish telehealth (either via phone or video) consultations provided synchronously (in real-time).

- Cautions that enforcing or preferencing video use for telehealth is detrimental for several specific groups, including Aboriginal and Torres Strait Islander people, elderly people, people with disability, people experiencing financial disadvantage, and rural populations.
- Welcomes efforts to support GPs and other health professionals to deliver high-quality and safe telehealth consultations to their patients.
- Recommends that telehealth should support and preference continuity of care between patient and clinician, or with another clinician from the same practice (unless exemptions apply).
- Supports the provision of sufficient notice of changes to MBS telehealth items for clinicians and patients to be able to adjust appropriately.
- Recommends addressing unnecessary administrative burdens as critical, in addition to funding administration that is required as part of the delivery of high-quality care.
- Supports continuing exemptions to the established clinical relationship requirement for GP-provided bloodborne virus and sexual and reproductive (BBVSR) MBS telehealth items.
- Does not support the discontinuation of exemptions to GP telehealth eligibility requirements for GP non-directive pregnancy counselling services, as this will limit access to safe and affordable reproductive health and pregnancy care for women.
- Supports retaining eligibility exemptions for telehealth GP mental health MBS treatment items.
- Does not support MRAC's recommendation to 'make telehealth GP mental health care planning and review item non-exclusively linked to MyMedicare'.
- Recommends an additional principle to respond to the legislated privacy, safety, security and evidentiary standards, along with adhering to the medico-legal implications of patient data transfer.
- Supports further consumer education to improve patient digital literacy on telehealth.
- Does not support any telehealth model that results in fragmentation of care and risks patient safety.

4. Response to the MRAC Telehealth post implementation review draft report

4.1 Recommendation 1 – 'Adopt the revised MBS Telehealth Principles'.

4.1.1 MBS Telehealth Principle 1 (revised): Should be patient-focused and based on patient need, as determined by the clinician and the patient.

The RACGP similarly considers that both the clinician and patient have a role in identifying the needs of care and supports the revised principle that removes mention of geographical location. Telehealth helps facilitate a patient's access to their usual GP to easily receive high-quality, personalised health services when and where it suits them. It is a patient-centred approach based on their needs. To ensure a patient's need is genuine and clinically appropriate for telehealth, the health practitioner and the patient must work in partnership to define this.

While traditionally geographic location was the key driver for access, this is no longer best practice, and all patients must have access to patient-centred care when and where it is needed and deemed clinically appropriate.

The RACGP welcomes the suggestion of education to improve patient digital literacy, including the need for joining a telehealth consultation from a private and quiet space.

The RACGP **supports** the notion that to assess a patient's need is genuine and clinically appropriate for telehealth, a GP and patient must work in partnership to define this and to determine the most appropriate modality (phone/video) for their consultation.

The RACGP **supports** further consumer education to improve patient digital literacy on telehealth.

4.1.2 MBS Telehealth Principle 2 (revised): 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.

While telehealth is now an essential part of the healthcare landscape, face-to-face care is still the optimal mode of service delivery and provides greater opportunities to examine patients, diagnose and treat medical conditions. The RACGP considers telehealth to be complementary to, rather than a substitute for, face-to-face care.[5] The RACGP welcomes efforts to support and adequately remunerate GPs and other healthcare professionals to continue the delivery of high-quality and safe telehealth consultations to their patients[6]. We agree that clinical requirements are essential, however, we note some situations may differ in a telehealth environment from an in-person patient consultation. For example, a patient may take their own blood pressure during a telehealth consultation if they have access to a home blood pressure device.

We suggest amending this principle to '***aligning with clinical requirements and demonstrating clinical efficacy***' as telehealth consultations may differ from face-to-face consultations.

The RACGP welcomes efforts to support GPs and other health professionals to deliver high-quality and safe telehealth consultations to their patients. It is fundamental these consultations follow centralised, evidence-based and best practice principles to facilitate patient safety. The RACGP has produced the *Guide to providing telephone and video consultations in general practice* which provides advice on privacy and other considerations when undertaking telehealth consultations. In addition, the Medical Board of Australia has revised its *Telehealth guidelines* which will took effect on 1 September 2023, and offer new standards to 'close the gap between some online prescribing business models and good medical practice'.[7]

With data security breaches on the rise globally, including in Australia, clinicians have a fundamental role to play in protecting the privacy of patient health information. We suggest creating an additional principle regarding the use of technology to ensure it meets *'legislated privacy, safety, security and evidentiary standards, along with adhering to the medico-legal implications of patient data transfer'* or incorporating this within the existing principles. Privacy standards are fundamental to protecting patient safety as per the medico-legal implications of patient data transfer and adherence to the *MBS Privacy Checklist for Telehealth Services*.[8] For example, those providing telehealth services without adequate software protection, such as a firewall, may risk unauthorised access to information shared through a platform. The RACGP's resource *Privacy and managing health information in general practice* provides guidance based on the *Privacy Act 1988.* This includes examples to support the development of best practice systems and compliance with the 13 Australian Privacy Principles (APPs), as well as other relevant health records legislation within the general practice setting. Additionally, the RACGP's *Standards for general practices* outline privacy requirements as a benchmark for quality care and risk management in Australian general practices.

The RACGP **welcomes** efforts to support GPs and other health professionals to deliver high-quality and safe telehealth consultations to their patients.

The RACGP **recommends** an additional principle to respond to the legislated privacy, safety, security and evidentiary standards, along with adhering to the medico-legal implications of patient data transfer.

4.1.3 MBS Telehealth Principle 3 (revised): Should be provided in the context of coordinated and continuous care between patient and clinician.

Telehealth services should be provided by a patient's usual GP or general practice team wherever possible**Error! Bookmark not defined.**. The RACGP supports the 12-month established clinical relationship rule for MBS telehealth, with appropriate exemptions. This is to ensure the delivery of safe, necessary and appropriate care. GPs providing care to known patients have access to consultation notes, medical history and awareness of individual circumstances and needs.

We suggest alternate wording for Principle 3, '***Should support and preference continuity of care between patient and clinician, or with another clinician from the same practice where appropriate***'.

The addition of *'or another clinician from the same practice'* is important to note, as it is common for patients to have a regular practice, as opposed to a regular GP. This aligns with current Medicare rules. Under the existing relationship rule, the patient can see another GP or health professional at the same practice for a face-to-face consultation to qualify for telehealth rebates.

The RACGP **recommends** that telehealth should support and preference continuity of care between patient and clinician, or with another clinician from the same practice (unless exemptions apply).

4.1.4 MBS Telehealth Principle 4 (revised): Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.

There has been a surge in asynchronous, direct-to-consumer (DTC) profit-driven telehealth businesses that offer cursory medical services, both in-hours and after-hours. These types of telehealth services are typically not linked to a regular GP or general practice. Generalist whole-person care requires personal commitment and wise professional skills[9] to navigate complex patient concerns. The RACGP has raised concerns about opportunistic DTC telehealth providers as we believe these services have the potential to undermine the therapeutic relationship between a patient and their regular GP as well as providing a service that may put the patient at risk.

Additional unintended consequences created from DTC service models may include:

- compromised patient safety and quality of care, such as polypharmacy and off-label use of medications
- further fragmentation of care
- an increased risk of duplicate or unnecessary medical tests and investigations being ordered
- lack of regulation for training and qualifications of health professionals that provide DTC services.

The RACGP's *Vision for general practice and a sustainable healthcare system* highlights the importance of patients developing an ongoing therapeutic relationship with a usual GP to support continuity of care across their lifespan and prevent hospital presentations.

To address this issue, the RACGP suggests the inclusion of '***and do not undermine the therapeutic relationship between a patient and their regular clinician***' at the end of Principle 4.

The RACGP **does not support** any telehealth model that results in fragmentation of care and risks patient safety.

4.1.5 MBS Telehealth Principle 5 (revised): 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.

The RACGP agrees with the MRAC's consideration that 'clinicians should weigh up the factors and choose the most clinically appropriate modality for each consultation'[10]. Telehealth use in Australia is largely phone-based and we have seen a great uptake of telehealth in recent years, both during and since the COVID-19 pandemic. In 2021–22, most GP telehealth consultations took place via phone – 94% compared to only 6% via video over this time[11]. Given telehealth use in Australia is overwhelmingly phone-based, enabling continued access to MBS-subsidised phone-based care, including longer consultations, will improve access to care for many Australians.

As mentioned in our previous submission, although a video consultation is sometimes considered the 'gold standard' of telehealth due to the perceived benefits of having visual cues, research has found that health outcomes and patient satisfaction are generally comparable between video and telephone consultations.[12] However, unlike phone consultations, video consultations are associated with infrastructure and accessibility issues that make them unsuitable for many people, leading researchers to recommend that decision-makers refrain from requiring videoconferencing in mainstream healthcare until these issues are addressed.[13] For example, there is a significant 'digital divide' between metropolitan and regional areas. The gains achieved in improving patient access through telehealth must not be compromised by restricting access to a video-only telehealth model.

Allowing patients multiple ways to access their regular GP considers a person's preferences and life circumstances, including where they live, their level of comfort with technology, access to technological devices and data, and socioeconomic status.

Telephone is regarded as an easy and accessible platform. However, government policy continues to demonstrate a preference for video over phone, e.g. the introduction of the 30/20 rule for phone consultations which is designed to limit the number GPs can provide. The majority of those who responded to an RACGP survey on video consultations reported no added benefit when consulting via video. In some cases, patients did not have the equipment to support video consultations or reverted to a phone call after experiencing connection problems in an attempted video consultation.[14] General practice staff reported that patients often require considerable support setting up their devices and connecting to video appointments.[15] RACGP members also report that enforcing video use for telehealth is detrimental for several specific groups, including Aboriginal and Torres Strait Islander people, elderly people, people with disability, people experiencing financial disadvantage, and rural populations. For example:

- many people have pay-as-you-go data subscriptions and cannot afford data on their phone plans to support video consultations
- people living in crowded housing may have to sit in their car when on a video call
- people who have experienced violence may be unable to speak privately with a GP via videoconference inside their home.

We suggest removing the following wording: '*Video should be encouraged over phone where it will provide a better patient and/or provider experience*', as this is covered in Principle 1 whereby the clinician and patient work in partnership to determine the most appropriate modality (phone/video) for their consultation.

Future research is required on the benefit of telehealth video versus phone consultations[16], along with a commitment from the Australian Government to improve technology infrastructure in rural areas and the provision of robust digital health education and support for all patients.

The RACGP **recommends** Medicare Benefits Schedule (MBS) funding should not distinguish telehealth (either via phone or video) consultations provided synchronously (in real-time).

The RACGP **cautions** that enforcing or preferencing video use for telehealth is detrimental for several specific groups, including Aboriginal and Torres Strait Islander people, elderly people, people with disability, people experiencing financial disadvantage, and rural populations.

4.1.6 MBS Telehealth Principle 6 (revised): 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 RACGP supports the revised wording of Principle 6. GPs are stewards of the health system and provide effective care coordination for their patients across multidisciplinary teams, including with other specialists and hospitals, where third-party telehealth consultations provide enhanced healthcare access for patients. This is particularly important for those in rural and remote locations.

4.1.7 MBS Telehealth Principle 7 (revised): Should provide sufficient notice of changes to MBS telehealth items for clinicians and patients to adjust to change.

While the RACGP is generally supportive of the amendments to Principle 7, it is critical that robust consultation occurs with GPs prior to significantly changing MBS telehealth items. Addressing the root cause and working to simplify the requirements and reduce the administrative burden of modifications would reduce confusion and improve compliance. For example, the removal of separate MBS items that differentiate between phone and video and merging these into general telehealth item numbers could then allow GPs to determine whether the consultation is best conducted by phone or videoconference (as per Principles 1 and 5). We acknowledge that the introduction of MyMedicare may have implications for this example given certain telehealth items are available for enrolled patients only.

The RACGP **supports** the provision of sufficient notice of changes to MBS telehealth items for clinicians and patients to be able to adjust appropriately.

4.1.8 Removal of MBS Telehealth Principle 8, 9, 10.

Principle 10 *'Require ongoing data collection, and evaluation into outcomes and utility'* would benefit from rewording and re-inclusion to garner further evidence and evaluation on telehealth best practice principles. While telehealth is now an essential part of the healthcare landscape, further research is required to better understand best practice principles in an Australian context.

4.2 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 RACGP requests further clarification on Recommendation 2 regarding the reintroduction of '*some telephone services*' as this language is unclear.

The RACGP supports improved MBS-subsidised phone consultations into the future as phasing these out over time has the potential to create inequities in accessing healthcare. We have seen access removed to longer phone consultations

for most patients and the chronic disease management and mental health phone items are also limited. On 1 November 2023, MBS items for longer phone consultations will be reintroduced for patients enrolled in MyMedicare. The RACGP continues to support access to longer phone consultations through the MBS for all patients as needed, particularly vulnerable patients for whom videoconferencing is not an option. Deciding not to fund longer telephone consultations will likely end up costing more money in the long term, as prevention is better than cure in terms of both patient outcomes and healthcare costs. No other specialisation provides better preventive care than general practice.[17]

We strongly recommend MBS funding should not distinguish between telehealth consultations provided synchronously (in real-time), either via phone or video. As suggested in MRAC's Telehealth services review, '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'. While video consultations may be required in certain clinical circumstances, the clinician and patient work in partnership to determine the most appropriate modality (phone/video) for the consultation. Allowing patients multiple ways to access their regular GP ensures that further inequities in accessing healthcare are not imposed on certain population groups, including Aboriginal and Torres Strait Islander people, older people, people with disability and those located in rural and remote areas.

As suggested in our response to the revised MBS Telehealth Principle 5 (see above), further research must be conducted into the benefits of video versus phone consultations[18], along with a commitment from the Australian Government to improve technology infrastructure in rural areas and the provision of robust digital health education and support for all patients.

4.3 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.

The RACGP's *Vision for general practice and a sustainable healthcare system* supports the concept of voluntary patient registration (VPR) (also discussed as voluntary patient enrolment) as a strategy for strengthening general practice and improving continuity of care for patients within their preferred practice. However, this must remain voluntary and as a supplement to accessing MBS rebates for essential care provided by general practice.

MyMedicare has the potential to strengthen the relationship between GPs and their patients and create an environment where preventive comprehensive care is provided across the lifespan. However, the MyMedicare model requires some work to ensure it offers a sufficient incentive for registration for patients with low levels of ill health and patients who believe themselves to be in good health. It may take some time for MyMedicare to reach adequate levels of patient registration to sufficiently benefit them and result in improved health outcomes. It is also critical to ensure improved and continued MBS funding through the fee-for-service model given that priority and/or vulnerable cohorts may have difficulty understanding the scheme and will require additional resources, promotion, and support to become registered.

None of the proposed incentives or future ones should seek to replace fee-for-service as the primary basis of general practice funding. Fee-for-service is an essential mechanism that allows general practices to ensure their remuneration reflects the costs and value of the care being provided. Funding delivered through MyMedicare incentives should fill the gaps in funding where fee-for-service does not adequately provide for patients or general practices and complement existing fee-for-service funding systems. It is unclear whether this would be the most appropriate option to better remunerate GPs for the high administrative workload of highly complex patients who do not meet MyMedicare inclusion criteria. Many GPs are not adequately remunerated for the services they provide or are avoiding claiming certain patient rebates for fear of Medicare compliance ramifications. Further MyMedicare incentives would need to be considered and developed to support this.

The MRAC considered it 'appropriate to instead review the remuneration for some MBS items so that it better reflects current administration requirements' instead of creating additional MBS items. The Committee also noted that 'for many clinicians, this administrative workload is increasing'. We agree that increasing MBS rebates for current items is preferable to creating new MBS items. Creating new MBS items would increase MBS complexity. Increasing current MBS items is needed to support the increasing administrative burden placed on GPs, particularly when caring for complex patients. For example, GPs typically spend additional unremunerated time writing reports for patients applying

for the National Disability Insurance Scheme (NDIS). MBS items for GP consultations can only be billed if the patient is present at a face-to-face or telehealth appointment. Even though attending a consultation is an additional financial, access and time burden on a person living with a disability, MBS rebates are not available for paperwork completed in the patient's absence. There is no other avenue for GPs to be remunerated for their time and expertise unless they charge the patient a fee. Increasing patient rebates for MBS telehealth items will recognise and support high-quality care and improve patient outcomes. Any new MBS items for telehealth must be streamlined, not be disease-specific or further fragment MBS funding. Additionally, any changes must be clearly communicated to GPs well in advance to ensure compliance (as per MBS Telehealth revised Principle 7, see above).

We recommend more certainty in the wording of Recommendation 3, '***Find adequate and ongoing solutions to ensure clinicians are better remunerated directly for the additional administrative workload that is often associated with managing complex patients***'.

The RACGP **recommends** addressing unnecessary administrative burdens as critical, in addition to funding administration that is required as part of the delivery of high-quality care.

Direct-to-consumer asynchronous telehealth services

Australia has seen a rapid increase in the number of private telehealth organisations that provide virtual DTC asynchronous services as funded by patients.[6] Given these telehealth service models are commercially driven, it is unclear 'the extent to which patients are prioritised over profits, and how they contribute to the commercial determinants of health'[19]. **The RACGP does not support extending MBS telehealth rebates to these types of services**. These services have the potential to undermine the therapeutic relationship between a patient and their regular GP, often increase costs for patients as Medicare rebates may not be available, as well as providing a service that may put the patient at risk.

The RACGP supports telehealth services that provide continuity of care between a patient and their usual GP or general practice, including other members of general practice multidisciplinary teams. For example, follow-up appointments for patients who live in rural areas may be appropriately conducted via telehealth, and ideally as part of an established GP relationship. This issue of DTC telehealth services further highlights the importance of the established clinical relationship requirement. Please note that we support exemptions to the requirement for an established clinical relationship as per the MBS established clinical relationship rule for, certain population groups including people experiencing homelessness and infants and for highly specialised services including for mental health and sexual and reproductive healthcare. These services tend to offer highly specific care which patients may not be able to access from their usual GP.

Assignment of benefit for bulk billed telehealth consultations

Taking steps to reduce the administrative burden associated with telehealth is critical. The recent change to assignment of benefit requirements for bulk billed telehealth services, whereby the practitioner must document patient consent using an approved form and ensure they receive a copy, exemplifies the need to streamline administration requirements and ensure they are fit-for-purpose for a modern healthcare system.

When MBS telehealth items were introduced at the start of the COVID-19 pandemic, the Department of Health and Aged Care (the Department) advised consent for bulk billed telehealth services could be provided verbally and documented in a patient's clinical notes. Regrettably, on 21 September 2023 the Department advised, via an update to the Services Australia website, that this is no longer the case. While providers can still obtain verbal consent for telehealth

consultations, this must now be documented via one of two approved forms. This is an inefficient and cumbersome solution that runs counter to the efficiencies we are realising as our health system becomes increasingly digital.

The RACGP's preference is for verbal consent to remain available for bulk billed telehealth consultations permanently, with a solution to record consent for the assignment of benefit which minimises the administrative impact on GPs, practice teams and patients. A digital solution that is fully integrated with existing clinical information systems, utilises existing data and can be integrated to/supports clinical workflows from these systems is the way forward to modernise and avoid an overly burdensome administrative process. Having to repeat information when completing an approved form will take time away from delivering patient care.

There are concerns about compliance activities potentially being undertaken around the assignment of benefit. The regulatory burden facing GPs continues to grow, and the prospect of further compliance measures may lead to the introduction of private fees and reduce access to care.

The RACGP acknowledges the Department's willingness to engage with key stakeholders on the assignment of benefit issue, and we appreciate their responsiveness when we have provided feedback and asked questions.

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

The RACGP recognises smoking as a major risk factor for multiple health conditions and smoking cessation as one of the most effective and cost-effective preventive health interventions. We believe discussions and guidance around smoking cessation are best conducted during longer, general consultations as part of delivering holistic, comprehensive, and patient-centred care, rather than via specific MBS items. Holistic patient care is at the heart of general practice, and GPs seek to treat the whole person throughout their life rather than any single health issue in isolation. Unfortunately, Medicare in its current form is becoming increasingly fragmented and difficult for GPs to navigate. Patients are also struggling to identify and locate highly specific services delivered by different health professionals with less connection to their GP.

Many GPs find the growing number of MBS item numbers, including those specific to telehealth, difficult to navigate and are hesitant to claim unfamiliar items to avoid accidental, incorrect claims and potential compliance activity. In 2022 the RACGP found that 47% of GPs indicated that they had either avoided providing certain services or avoided claiming patent rebates despite providing certain services, due to fear of Medicare compliance ramifications[20].

The RACGP believes disease-specific MBS item numbers, such as the nicotine and smoking cessation, contribute to this fragmentation of care and the complexity of Medicare. At present, GPs discuss smoking and the need to quit with patients during standard consultations as part of whole of person care. For many GPs it is simpler to claim standard consultations for this care, however, current rebates make it difficult for GPs to have the longer consultations necessary to discuss preventive and lifestyle health while also bulk billing patients.

The RACGP believes GPs are best supported to assist patients in smoking cessation by increasing the rebate for Level C and D consultations for both face-to-face and telehealth MBS items (video and phone). This will incentivise longer consultations in which they can deliver more comprehensive care, including smoking cessation support. The RACGP acknowledges additional funding will become available for longer telehealth general practice consultations where a patient is registered with their GP through the MyMedicare model. However, all patients would benefit from further MBS funding, regardless of being registered with MyMedicare.

If the smoking cessation items are continued, the RACGP believes they should be subject to the same existing relationship requirements as other telehealth services to ensure these items encourage patients to maintain a continuous relationship with a regular GP. Patients who have continuity of care with a regular GP have lower mortality rates, lower rates of hospitalisation and are more likely to receive appropriate and patient-centred care.

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

The RACGP supports the continued exemption from the established clinical relationship requirement for GP-provided bloodborne virus and sexual and reproductive (BBVSR) MBS telehealth items. Unlike most GP telehealth items, these items do not require a patient to have an existing clinical relationship with the GP providing the service (i.e. the patient has had a face-to-face consultation in the past 12 months). The RACGP recommends these items be continued, as enabling access to sexual and reproductive health services via telehealth provides flexibility and choice for patients to consult with their GP (or an alternative GP) on sensitive health matters. Similarly, we recommend the temporary telehealth items for non-directive pregnancy support counselling be continued (as per our response to 0 below). These items are also exempt from the established clinical relationship requirement.

The RACGP **supports** continuing exemptions to the established clinical relationship requirement for GP-provided bloodborne virus and sexual and reproductive (BBVSR) MBS telehealth items.

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

The RACGP does not support the discontinuation of the exemption to GP telehealth eligibility requirements for GP non-directive pregnancy counselling services. We raise concerns that this will limit access to safe and affordable universal access to reproductive healthcare for women.

Earlier this year we welcomed Recommendation 19 from the Senate Community Affairs References Committee report *Ending the postcode lottery: Addressing Barriers to Sexual, maternity and reproductive healthcare in Australia*, which stated the Australian Government should continue MBS telehealth items for sexual and reproductive health and pregnancy care, as reflected in the RACGP's submission to the inquiry.

GPs are often the first point of contact for people seeking support regarding pregnancy and unplanned pregnancy. Pregnancy care encompasses the full spectrum of reproductive health from menstruation, contraception, unplanned pregnancy, preconception, antenatal care, intrapartum, postnatal care, menopause and termination options, with a focus on patient wellbeing, patient safety and joint decision-making. GPs play a vital role in the provision of care and provide patient counselling to help facilitate shared decision-making so people can make informed decisions. GP non-directive pregnancy counselling services offer a safe, confidential process that helps the patient explore concerns they have about a pregnancy, along with the provision of unbiased, evidence-based information about all options and services available to the patient.[21] Such discussions often require extended consultation times, with GPs playing a role in the coordination of these services.

In Australia, access to sexual and reproductive healthcare is often inhibited by poor funding and a lack of minimum service standards in public hospitals. Access to reproductive healthcare services, including non-directive pregnancy counselling, is improved by the wide distribution of GPs, availability of telehealth, expanded training of GPs and general practice teams that are supported by practice nurses. Improving access to GP services via telehealth has additional benefits to patients such as less care fragmentation and often reduced out-of-pocket costs in comparison to specialised services requiring additional support from hospitals and GPs. This is particularly critical for patients living in rural and remote areas who may experience barriers accessing in-person care from their GP.

We still have a long way to go before we see safe, affordable and accessible reproductive health and pregnancy care available to all people in Australia, irrespective of their geographical location. Access to sexual and reproductive health and pregnancy care is a fundamental human right and we must keep moving forward on this issue. Women must be able to easily access GP non-directive pregnancy counselling services that are exempt from telehealth eligibility requirements to ensure the best health outcomes for all patients, regardless of their location or socioeconomic position.

The RACGP **does not support** the discontinuation of exemptions to GP telehealth eligibility requirements for GP non-directive pregnancy counselling services, as this will limit access to safe and affordable reproductive health and pregnancy care for women.

4.7 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.

GPs plays a central role in the provision of mental health care in Australia. Easily accessed without a referral, people in distress frequently turn to their GP for help. General practice is key to providing equitable access to care for mental health issues.[22] People talk to their GP about mental health more than any other issue and the majority of mental health services in Australia are delivered by GPs[23]. However, as acknowledged by the MRAC in the draft report, 'some vulnerable populations may not have an ongoing relationship with a regular GP or general practice'.

Government support for telehealth services not only needs to remain but must also be strengthened to enable patients to access mental health care. For certain patients and population groups, telehealth can reduce the barriers of stigma, distance, service availability and cost which can affect patients and professionals, especially in rural and remote communities and disaster-affected areas.[22] The RACGP supports retaining the eligibility exemptions for telehealth GP mental health MBS treatment items to ensure all patients have access to timely, holistic and comprehensive quality healthcare.

The RACGP does not support MRAC's recommendation to 'make telehealth GP mental health care planning and review item non-exclusively linked to MyMedicare'. As discussed in our response to Recommendation 3 (see above), continued provision of mental health care planning and review items is essential to ensure equity of access to mental health care regardless of whether a patient is registered with MyMedicare, including development of a GP Mental Health Treatment Plan (GPMHTP) along with general mental health services and Focussed Psychological Strategies (FPS). It is important any proposed approach ensures that GP mental health treatment services by phone and video are just as accessible as similar services provided by allied mental health professionals and consultant psychiatrists, and that these services also support the safe and effective use of telehealth (via phone or video) as determined by the GP and their patient in partnership.

The RACGP **supports** retaining eligibility exemptions for telehealth GP mental health MBS treatment items.

However, the RACGP **does not support** MRAC's recommendation to 'make telehealth GP mental health care planning and review item non-exclusively linked to MyMedicare'.

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

No comment.

4.9 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.

No comment.

4.10 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.

Overall, we note the wording of this recommendation is ambiguous and does not mention home visits as discussed by the MRAC in the draft report.

Telehealth offers house-bound patients flexible access to high-quality care when and where it suits them, as based on their needs. Patients value an ongoing relationship with their GP, even when their needs change. The *RACGP Standards for general practice (5th edition)* indicate as per mandatory criterion GP1.2A that patients must be able to access home and other visits when safe and reasonable to ensure access to care. However, when a home or other visit is neither safe nor reasonable, a practice may utilise an alternative source of care such as telehealth consultations. The Standards also discuss patient safety and clinical needs, along with the location of the practice as considerations for whether telehealth is an appropriate option. Supporting patient-end support services via telehealth could also remain an option when it is not viable or reasonable for a patient to attend face-to-face to enable access to continuous care from a GP who knows them best. We caution the wording of 'exploring funding possibilities' as we do not recommend introducing further fragmentation and complexity for MBS funding.

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