RACGP

Royal Australian College *of* General Practitioners

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RACGP submission

Australian National Audit Office: Expansion of telehealth services

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1. Executive summary

The introduction of COVID-19 Medicare Benefits Schedule (MBS) telehealth items continues to be a critical enabler for patients accessing high-quality and timely general practice services.

Prior to the introduction of these items, the MBS only supported access to care delivered via telehealth in very limited circumstances. Although face-to-face remains the gold standard for general practice consultations,[1,2,3] telehealth is an invaluable tool for patients and general practitioners (GPs). The Royal Australian College of General Practitioners (RACGP) is pleased that Medicare will support access to appropriate care delivered via telehealth on a permanent basis.

Given the significant logistical task of creating new MBS item numbers and descriptors for a range of services, the swift introduction of COVID-19 telehealth items after strong RACGP advocacy was welcomed by our members and their patients. It was pleasing to see the need for telehealth recognised so quickly in response to the pandemic, as GPs noted that funding for MBS telehealth items in general practice was long overdue. The RACGP has been a vocal advocate for the introduction of alternative models of care for patients who are unable to attend a practice in-person.[4]

Telehealth is not a leap into the future or the unknown. Governments have been slow to provide funding for the use of communication technologies in the primary healthcare sector, despite other industries being early adopters of innovative digital platforms for their customers (eg the banking sector). GPs communicated remotely with their patients long before the onset of the pandemic. Failure to support this type of care, until recently, clearly demonstrates limitations to the MBS in ensuring patient accessibility to timely healthcare.

By allowing communication and collaboration remotely, telehealth was key to the prompt adoption of COVID-19 suppression strategies. In addition to allowing business to be conducted as usual, telehealth ensures people can access care in a way that reduces their potential exposure to infection, while maintaining continuity of care. It mitigates the infection risk for key healthcare workers who are at the frontline of the pandemic.[5] Telehealth also allows patient data to move efficiently between healthcare providers, resulting in more coordinated care.

However, throughout the past two years there have been several issues associated with the telehealth expansion, which are outlined in detail in this submission. The Department of Health's (the Department) responsiveness to feedback from the health sector helped to address some challenges with the MBS telehealth items in a timely manner. Despite this, several significant issues remain unresolved.

The RACGP welcomes the opportunity to work closely with the Department and the new government to identify solutions to these issues and ensure key learnings are used to inform future policy decisions.

2. Introduction

The RACGP is Australia's largest professional general practice organisation, representing more than 43,000 members working in or towards a career in general practice including four out of five GPs in rural Australia.

The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline. As a national peak body, our core commitment is to support GPs to address the primary healthcare needs of the Australian population.

The RACGP welcomes the opportunity to provide a submission to the Australian National Audit Office's (ANAO) audit of the expansion of telehealth services and understands that the objective of the audit is to assess whether the Department has efficiently managed the expansion of telehealth services during and post the COVID-19 pandemic.

2.1 Submission overview

In summary, this submission highlights that:

- both GPs and their patients rapidly embraced telehealth when MBS items were introduced in March 2020, and it has remained a popular form of service delivery as the COVID-19 pandemic has progressed
- changing rules and requirements have created confusion and resulted in a significant amount of additional administrative work for GPs and practice teams
- the Department has shown a willingness to engage with the RACGP and other key stakeholders, however key learnings from the telehealth expansion have not always been adopted
- there have been significant policy challenges associated with the expansion of telehealth services, primarily:
    - mandatory bulk billing of MBS telehealth items
    - the removal of rebates for most MBS phone items in July 2021
    - the existing relationship requirement for telehealth services provided by GPs
    - the Department's 2021 telehealth compliance campaign, which saw many GPs receive targeted compliance letters despite providing services in good faith during a pandemic
- there are opportunities to improve the delivery of telehealth services in general practice, including removing barriers to telehealth access and expanding the range of MBS items available.

3. Background

3.1 Uptake of telehealth and COVID-19 vaccines in general practice

The RACGP conducted a survey of GPs on telehealth in April 2020, with 99% of respondents advising their practice was currently offering patients consultations via telehealth (phone or video).[6]

Telehealth is not a replacement for face-to-face care, however it provided greater flexibility during a time when GPs saw their workloads increase dramatically. GPs have continued to provide in-person care to their patients during the pandemic and have often had to source personal protective equipment (PPE) themselves.[7]

Practices across Australia have been under enormous pressure delivering COVID-19 vaccines and boosters, treating patients who have delayed or avoided screenings and consultations during the pandemic and helping people with mental health issues, all while continuing to provide routine care.

The COVID-19 vaccine rollout has precipitated new learnings and workflows, with GPs having administered almost 30 million vaccine doses – around half the total number of doses in Australia.[8]

3.1.1 Medicare statistics

The last decade has seen steady annual increases in general practice services. This continued throughout the COVID-19 pandemic, with non-referred GP consultations billed to Medicare increasing from 160.77 million in 2019 to 166.31 million in 2020, and to 186.74 million in 2021.[9] The significant role of GPs throughout the pandemic, including the delivery of COVID-19 vaccines, contributed to this ongoing rise, particularly in 2021.

Proportion of overall GP non-referred attendances[9]

Telehealth as a share of total GP non-referred attendances now accounts for more than a fifth of services annually.

	2019–20	2020–21	2021–22 (year to date Jul–Dec)
Phone services	8.5%	22.2%	20.8%

Video services	0.3%	0.4%	1.3%
Face-to-face services	91.1%	77.4%	77.8%

Overall GP telehealth services – Breakdown of phone vs video[9]

This table shows that telephone services are considerably more popular than video.

While there has been a slight rise in video consultations in 2021-22, this can be attributed to reduced phone options for patients following the removal of most MBS phone items in July 2021. Despite this, phone services still account for well over 90% of all GP telehealth consultations.

	2019–20	**2020–21**	**2021–22 (year to date Jul–Dec)**
Phone services	96.5%	98%	94%
Video services	3.5%	2%	6%

3.1.2 Patient sentiment

Two in three of those surveyed in the *nbn Covid-19 Behavioural Change Survey* reported that they would be open to continuing to use telehealth after the pandemic.[10] Patients report multiple reasons for being in favour of using telehealth, including:

- convenience (eg easier appointment times and no travel)
- improved accessibility
- personal safety by avoiding time in the waiting room with other sick people.[11]

In the 2021 *Australian Health Consumer Sentiment Survey*, most respondents reported having one or two telehealth consultations in the previous 12 months. Regarding their most recent appointment, most reported consulting a GP (75%) or a non-GP specialist (19%). Over half of respondents who had used telehealth rated the quality of their most recent appointment as about the same as in-person, and 17.1% rated the appointment as better than in-person. However, almost 30% felt that the appointment was not as good as in-person.[12]

3.2 Practice viability

The rapid rollout of telehealth consultations has had a negative impact on many practices' profitability. The 2021 *CommBank GP Insights Report* is based on a quantitative survey of 223 decision-makers and influencers at general practices across Australia and 1021 patients who had consulted a general practice within three months prior to completing the survey. Of the practices responding to the CommBank survey, 35% said that telehealth is reducing profits versus 32% indicating that profits are up.[13]

While a net 3% of regional practices report that telehealth is lifting profits, a net 6% of metropolitan practices report a negative impact on profits.[13]

Half of practice owners (50%) who completed the RACGP's 2021 Health of the Nation survey reported being concerned about the long-term viability of their practice,[14] an increase from 37% in 2020.[5] However, the proportion of owners concerned about the short-term viability of their practice is just 4%[14] – a marked drop from 20% in the 2020 survey,[5] completed during the early COVID-19 lockdown.

RACGP members reported that COVID-19 has placed additional financial pressure on practices. These include increased overheads relating to providing telehealth services (additional administrative time, higher phone bills, the cost of infrastructure upgrades, and more).[14]

The impact of Australia's first COVID-19 lockdown, mandated bulk billing of new telehealth MBS item numbers and the temporary decrease in patient presentations resulted in a more immediate concern over viability of practices in April 2020. That concern remained in 2021, but its immediacy has abated.[14]

While the introduction of telehealth allowed some GPs to maintain their income above the threshold for JobKeeper payments, expenses increased dramatically when the COVID-19 vaccine rollout commenced, due to the increased costs associated with vaccine provision. Our members report this resulted in significantly reduced profits. The effects of this period of overwork and increased expenses continues.

3.3 Changing rules and requirements

While the RACGP recognises the need for telehealth to be flexible and adaptable in a rapidly changing pandemic environment, abrupt changes in MBS item numbers, descriptors and interpretation have been a persistent feature of the telehealth expansion. This has resulted in widespread confusion and additional administrative work for GPs and practice teams whose workload increased significantly during the pandemic.

One solution to simplify the requirements and reduce the administrative burden may be to remove separate MBS items that differentiate between phone and video and merge these items into general telehealth item numbers. GPs would then determine whether the consultation is best conducted by phone or videoconference.

3.3.1 Examples of changing rules

Date	Details
13 March 2020	When MBS telehealth items were first introduced, they were available only to health professionals and patients at risk of COVID-19. This was defined as having been diagnosed with COVID-19 or required to isolate, or – in the case of patients only – being more susceptible to the virus.[15] This included patients aged over 70 (over 50 for Aboriginal and Torres Strait Islander patients), those who are pregnant, parents of children aged under 12 months, and people with a chronic health condition or who are immunocompromised. Patients considered more susceptible to the virus needed to have an existing relationship with the GP providing the service to access telehealth rebates.
16 March 2020	The existing relationship requirement was changed to include the patient's regular practice as well as GP.[15]
23 March 2020	All vulnerable GPs became eligible to use telehealth for all consultations with all their patients.[15]
30 March 2020	Telehealth rebates were made available for all patients eligible for Medicare (whole of population telehealth). An expanded range of telehealth items also became available.[16]
6 April 2020	GPs were no longer required to bulk bill all telehealth patients, however the bulk billing requirement remained in place for concession card holders, children under 16 and patients more vulnerable to COVID-19.[17]
20 April 2020	The bulk billing requirement was removed completely for all non-GP specialists and allied health professionals.[18]
1 July 2020	It became a requirement for telehealth services provided by GPs to be linked to a patient's regular GP or practice.[19] The changes promote patients receiving continuous care from their regular GP or medical practice, reflecting requirements in place when telehealth was first made available in March 2020. Feedback on the existing relationship requirement is outlined below in section 5.3.2.

Date	Details
1 October 2020	The bulk billing requirement was removed for GP services.[20] Feedback on this requirement is outlined below in section 5.1.
1 July 2021	The majority of MBS items for GP phone services were removed.[21] This included items for Level C and D standard attendances, chronic disease management and mental health services. Rebates for Level C GP attendances via phone were temporarily reinstated in July 2021[21] and again in January 2022.[22] Feedback on the removal of phone items is outlined below in section 5.2.
16 July 2021	The test for exempting patients from the existing relationship requirement whose movement was restricted by a state or territory public health order was replaced with three separate criteria: • the patient is in COVID-19 isolation because of a state or territory public health order • the patient is in COVID-19 quarantine because of a state or territory public health order • the patient is located in a COVID-19 hotspot as declared by the Commonwealth Chief Medical Officer.[23] This change meant that being in lockdown did not necessarily exempt a patient from the existing relationship requirement, as was the case previously.
21 July 2021	The requirement for patients to have an existing relationship with their medical practitioner to access a general practice telehealth item related to mental health support services, including services provided under the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative (Better Access) and eating disorder services, was removed.[21]
1 January 2022	MBS telehealth services were added to the calculation of Standardised Whole Patient Equivalents (SWPEs) for Practice Incentives Program (PIP) payments. The SWPE value is a calculation of practice size based on MBS billed care provided by all GPs in the practice.[24] Given the rapid uptake of telehealth, the decision not to include these services in SWPEs meant that GPs were missing out on incentive payments because telehealth was not considered equivalent to face-to-face care. However, the Department's view was that the reduction in funding through the PIP was not entirely due to telehealth and could be attributed to changing patient presentations during the pandemic. The RACGP is pleased this has been rectified, with telehealth now included in the calculation of SWPEs.

3.3.2 Member feedback on the staged rollout of telehealth services

RACGP members have reported the staged introduction of the MBS telehealth item numbers was an unnecessarily overcomplicated and confusing process. 'Whole of population' telehealth services should have been introduced when funding for telehealth was first announced.

Members have advised the staged approach to the COVID-19 telehealth items:

- significantly increased costs to practices as a result of having to:
    - frequently adjust billing systems
    - provide education and training to staff on the new items – particularly which patients can access telehealth and whether they must be bulk billed
    - educate and inform patients regarding service options and fees

- resulted in loss of income due to software vendors being unable to keep up with changes to the items
- created disruptions for practices and made it difficult to create stable workflows, largely due to time spent educating staff about the changes
- was unnecessarily complex in comparison to other medical service fee structures (eg workers' compensation schemes)
- enhanced the possibility of errors being made when billing the items
- forced GPs to review and adapt their business models repeatedly during a time of crisis
- resulted in reception staff having to answer more questions about billing from confused patients.

Members also reported some initial requirements were inconsistent with the intent of the telehealth items, such as the need for a physical signature to be provided by a patient who is bulk billed to assign their benefit as full payment for the service.

4. Engagement and communication

4.1 Engagement with the Department of Health

The RACGP acknowledges the Department's willingness to engage with the RACGP throughout the rollout of telehealth services and as changes to MBS items were implemented. As the pandemic has progressed the RACGP has remained an important stakeholder and has provided extensive feedback to the Department on the topics and issues raised in this submission. The RACGP has engaged frequently with staff from the Benefits Integrity and Digital Health and Medical Benefits divisions of the Department.

While we appreciate the Department's efforts to consult with stakeholders, the expansion of telehealth services has been defined by an inability to implement key learnings as the COVID-19 situation has evolved. This is particularly evident in the case of major policy decisions such as mandatory bulk billing of telehealth items, the removal of MBS phone items and the existing relationship requirement for telehealth. These decisions have had a profound impact on GPs and general practices, and the communities they serve, across Australia. Despite this, change has been slow or in some cases, not forthcoming at all. Telehealth is a major reform that should have been agile in response to the changing pandemic environment and needs of patients, however this has not always been the case.

One of the key issues during the pandemic has been the lack of information on whether telehealth items would be extended when they were scheduled to expire. Until telehealth was made permanent on 1 January 2022, telehealth items were available on a temporary basis and extended incrementally. Often the RACGP was not advised whether the items would continue until just days before they were due to expire. This meant that GPs were unable to confidently book telehealth appointments with patients, particularly those who require care on a regular basis.

4.2 Dissemination of MBS telehealth information

The quality and timeliness of information about MBS telehealth items has been variable. Fact sheets on MBS Online have been regularly updated in response to telehealth changes and have helped to answer questions about telehealth billing rules. However, clear information around the existing relationship requirement has been extremely difficult to attain.

A great deal of ambiguity around exceptions to this requirement were evident in 2020. The RACGP found it difficult to obtain clear answers from the Department around situations where exceptions would apply, with the definition of a 'COVID-19 impacted area' particularly confusing. It was not until December 2020 – five months after the change was introduced – that the Department issued guidance around the existing relationship requirement via an AskMBS Advisory. This document was only developed following persistent questions from the RACGP to the Department, and scenarios included in the document were suggested by the RACGP.

The Department published a *COVID-19 Telehealth Items Guide* in August 2020, which the RACGP provided feedback on. It appears this document was not regularly updated, as the most recent version was last updated in December 2020

and clearly does not reflect current telehealth arrangements. This is disappointing as an up-to-date Q+A document would have been a useful resource for GPs and practice staff. Such a document should be regularly updated, clearly dated and available via a single webpage. Old versions also need to be removed when changes are made.

See **Appendix A** for a list of examples of telehealth queries submitted by the RACGP to the Department.

5. Key policy challenges

5.1 Mandatory bulk billing of MBS telehealth services

5.1.1 Background

Initially, it was compulsory for GPs to bulk bill all patients when using the new COVID-19 MBS telehealth items. The bulk billing requirement was partially relaxed on 6 April 2020. However, the legislative requirement that telehealth services provided by GPs be bulk billed for Commonwealth concession card holders, children under 16 years old and patients who are more vulnerable to COVID-19 remained in place until 1 October 2020. From 20 April 2020, other medical specialists and allied health professionals were permitted to privately bill all COVID-19 telehealth consultations.

The RACGP questions the legality of mandated bulk billing and has received numerous enquiries from concerned GPs and practice staff who described mandated bulk billing as inequitable and detrimental to the viability of their practices, impacting their ability to provide care for their patients.

5.1.2 RACGP position

The RACGP recognises millions of people across Australia have been affected financially by the pandemic. We fully support access to frontline healthcare for patients, particularly those who are vulnerable and at greater risk of COVID-19 complications.

However, it is unacceptable that the bulk billing requirement was applied to particular health professionals and not others. During these challenging times, GPs should have been trusted to apply their usual billing practices and exercise discretion where necessary (eg if patients are clearly unable to afford a gap fee).

The bulk billing requirement threatened the financial viability of practices because GPs were unable to charge a fee for a large percentage of patient consultations. Members have observed practices that charge private fees cost the government less money per hour due to their capacity to offer longer, more comprehensive consultations, including discussions regarding preventive health, mental health and self-management.

At the time the bulk billing requirement was introduced, the viability of many practices across Australia had already been impacted because of the longstanding impacts of the Medicare rebate freeze and natural disasters such as the 2019-20 summer bushfire season. Practices affected by the bushfires provided vital support to devastated communities in a time of severe adversity and are needed to support these communities as the recovery process continues in the months and years post the event. Rebates for telehealth were also equivalent to rebates for face-to-face services, meaning they were set at an artificially low level due to years of inadequate indexation.

In recognition of the restrictions placed on GPs during this time, the former government temporarily doubled bulk billing incentive payments for vulnerable patients receiving care in-person and via telehealth. However, RACGP members reported these were not sufficient to cover their expenses and were far below the gap fee they would usually charge when billing privately. Many practices rely on private billing to cross-subsidise the patients they bulk bill, as this is their only way of funding high-quality care.

Given the questionable legality of these measures and the ongoing impact of mandated bulk billing on practice viability, mandated bulk billing must be removed from government measures.

5.1.3 Consequences of the bulk billing requirement

Member feedback indicates the bulk billing requirement:

- contributed to significant loss of practice viability, with most practices reporting between 10–60% loss in revenue compared to the same time in 2019[25], particularly for smaller, privately owned clinics
- left GPs struggling to cover essential and increased practice costs
- reduced the capacity of GPs to spend more time with patients and provide preventive care
- resulted in some GPs essentially being required to bulk bill every patient they see due to the prevalence of chronic disease within the general population. This was due to the wide application of the 'chronic health condition' criteria
- forced GPs to bulk bill patients who can afford to pay for healthcare and expect to be charged in line with pre-COVID-19 billing arrangements
- created uncertainty for privately billing practices that have established fixed costs in line with an expectation that they can charge private fees
- impacted negatively on the mental health and wellbeing of GPs and practice teams
- further lowered morale in the profession, with GPs feeling inadequately valued at a time they were providing critical frontline care
- created questions about the integrity of Medicare
- prompted GPs to question whether general practice will be a viable future career option
- further contributed to the pressures and low morale GPs are already facing, that has resulted in a large drop in the number of medical students and graduates wanting to become GPs.

RACGP survey: Bulk billing requirements for the COVID-19 telehealth items

The RACGP sought feedback from members on the impact of the telehealth bulk billing requirement on the viability of their practice via an online survey.[25] Almost 1000 responses were received. The survey results revealed:

- nearly 60% of respondents either strongly agreed or agreed that the bulk billing requirement had affected the viability of their practice
- 56% were required to bulk bill 80–100% of COVID-19 MBS telehealth consultations due to mandatory bulk billing, while a further 24% were required to bulk bill 60–80% of telehealth consultations
- over 70% of respondents were bulk billing more patients than usual
- 42% experienced a 10–30% decrease in revenue compared to the same time last year, while 27% experienced a 30–60% decrease
- 50% of respondents thought removing the bulk billing requirement would help improve the sustainability and viability of their practice.

5.1.4 Ongoing implications

Despite the removal of the bulk billing requirement for GP services in October 2020, phone and video consultations continue to be bulk billed at exceptionally high rates. In 2021-22 (year to date Jul–Dec), MBS phone services have been bulk billed at a rate of 95.6%, and video services at 89.3%. This compares with a bulk billing rate of 84% for face-to-face services, not including COVID-19 vaccinations.[9]

The decision to impose mandatory bulk billing has inflated bulk billing figures for GP attendances. In 2020-21 bulk billing was at 88.8%[9] – a statistic which is clearly misleading given GP billing practices have been dictated to a large extent by government policy. Mandatory bulk billing of COVID-19 vaccinations also contributed to record bulk billing rates frequently touted by the previous government.[26]

Many GPs and practices continued bulk billing telehealth consultations, even after the mandate was lifted, because patients had grown accustomed to being bulk billed in the early stages of the pandemic. Although GPs can now apply

their usual billing practices, altering billing arrangements and imposing fees can be a difficult process to manage within a practice, despite ongoing concerns around practice sustainability.

5.2 Removal of Medicare rebates for telephone consultations

5.2.1 Background

Telehealth use in Australia is largely phone-based. In 2020-21, video consultations comprised just 2% of GP telehealth services, whereas phone consultations comprised 98%.[9] On 1 July 2021, most MBS items for GP telephone consultations were removed. This decision is not underpinned by solid evidence and will effectively remove telehealth access for many Australians. We acknowledge that this is an emerging space and there is literature that highlights the benefits of video consultations.[27,28] There is a dearth of literature comparing video and phone consultations and more research is needed.

RACGP members have consistently raised concerns about how the removal of rebates for longer phone consultations increases access issues and health gaps for specific groups, including Aboriginal and Torres Strait Islander people, elderly people, people with disability, and rural populations. Many patients in these groups have poorer health outcomes than the general population and want to avoid visiting a practice in-person where possible to protect themselves from COVID-19 and other illnesses. They are also more likely to be bulk billed, placing GPs at a financial disadvantage by restricting them to claiming lower rebates for complex care.

Phone is seen as an easy and accessible platform. 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 staff and patients reverted to a phone call after experiencing connection problems in an attempted video consultation.[29] Staff have reported that patients needed considerable support setting up their devices and connecting to video appointments.[30] Furthermore, GPs often work in buildings and rooms without windows, resulting in poor reception when on a video call.

Our members report that enforcing video use is detrimental for many disadvantaged groups. 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
- videoconferencing equipment is expensive and unaffordable for many
- patients have described feeling intruded upon in some cases as they did not want their GP to see inside their home.

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.[31] 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 rolling out videoconferencing in mainstream healthcare until these issues are addressed.[3] There is a significant ‘digital divide’ between metropolitan and regional areas,[32] and older patients and those from ethnic minority groups are less likely to use video.[33,34]

RACGP survey: Telehealth video consultations

The RACGP conducted a survey of members on video consultations in general practice in June and July 2020.[29] The results revealed:

- 45% of respondents had not undertaken any consultations with a video component
- by comparison, 97% had undertaken telehealth consultations using telephone (audio-only)
- the top reasons why GPs had not conducted video consultations were because they felt telephone consultations were satisfactory and video would not add any benefit (25%), they did not have the hardware/software to enable video (25%), and patients did not want to use video (15%)
- 65% would be willing to start using video for telehealth consultations if these issues were addressed
- when asked what would need to change to start using video for telehealth consultations, the top responses were patient requests for video consultations (21%), access to hardware/software (18%), better remuneration for consulting via video (16%), hands on training on the use of video platforms (14%), and reliable internet (12%)
- the most popular consultations conducted via video were standard consultations (34%), follow-up consultations, prescriptions and referrals (21%), and mental health (21%).

5.2.2 RACGP position

It is vital that the gains achieved in improving patient access through telehealth are not compromised by restricting access to a limited 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, their access to technological devices and their socioeconomic status.

The RACGP's President, Adj. Professor Karen Price, has noted the disproportionate impact of the decision to remove phone items on female GPs and their patients. Female GPs on average provide longer consultations than their male counterparts and earn less per hour.[35]

The former government's preference for video consultations has been evident since the start of the pandemic. Providers were advised they could deliver audio-only services via phone if video is not available, which fails to consider patients' overwhelming preference for phone services.

The newly elected federal government can support every Australian to continue to access telehealth as part of their ongoing general practice care by:

- reinstituting Medicare rebates for phone consultations for Level C and D standard attendances, mental health care and chronic disease management (GP Management Plans and Team Care Arrangements) as part of the permanent telehealth model.

To support safe, high-quality care for all Australians, these consultations must be:

- available for all GP consultation lengths and types
- valued at the same level as face-to-face and video items
- linked to a patient's usual GP, with some exceptions for services provided by GPs with special interests upon usual GP referral.

5.2.3 Bond University research

The Department commissioned the Institute for Evidence-Based Healthcare at Bond University to conduct a systematic review of telehealth in primary care.[36] The final report was completed in February 2021.

The Department has referred to the report on multiple occasions as evidence that video is a superior modality to phone. However, the key findings from the Bond report are as follows:

- Telehealth – **by either video consultation or phone consultation** – appears to provide equivalent clinical outcomes for many types of clinical encounters, particularly for ongoing clinical care.
- For initial diagnosis, telehealth has some limitations, particularly where physical examination is required as part of the diagnostic process.
- While some physical examination can be carried out via video consultation, this appears generally less satisfactory, reliable and accurate than conducting the examination face-to-face.
- For continuing care for management of an established diagnoses, telehealth appears equivalent for most clinical outcomes, has similar cost to health services, and increases convenience and access for patients.

A number of key themes are evident in the research referenced in the report, including a lack of available evidence for phone consultations, the limitations of telehealth generally when compared with face-to-face consultations (eg for diagnosis/physical examination), and the fact that video may not be a suitable medium for all patients given connectivity/usability issues. The Bond report acknowledges that most studies have examined video consultation rather than phone consultation alone, with a few exceptions.

The Department appears to have interpreted this to mean that phone consultations are less effective than video. In reality, more research is needed to fully understand the benefits of phone consultations for patients. In addition, the Bond report does not endorse video as a superior mechanism, but rather explicitly states that video is not always suitable for physically examining the patient despite the visual element.

The Department's assumption that video is more effective than phone has been evident for some time now. For example, the report on telehealth released as part of the federal government's MBS Review states that video 'is the preferred mode of delivery for MBS telehealth because of the richer information transfer'.[37] The report does not reference any evidence to support this and was in fact published before the Bond report was finalised. Australia's Primary Health Care 10 Year Plan 2022–2032 also states that as access to and useability of technology improves, the government would expect increased use of video to deliver GP telehealth services.[38]

5.2.4 Temporary reinstatement of Level C phone item

Following the decision to remove GP phone items, an MBS item for a Level C GP consultation (20–40 minutes) via phone was temporarily reinstated for patients in Commonwealth declared COVID-19 hotspots on 16 July 2021. Patients in COVID-19 isolation or quarantine because of a state or territory public health order were also able to access rebates for longer phone consultations with their GP.

Following the commencement of permanent telehealth arrangements in January 2022, the former government once again temporarily reinstated Level C MBS phone consultation items for attendances lasting longer than 20 minutes until 30 June 2022. All Medicare-eligible patients can receive these services based on normal telehealth eligibility requirements and exemptions.

On 17 June 2022, the Prime Minister announced at National Cabinet that current COVID-19 health funding arrangements would be extended until the end of the year.[39] The RACGP understands that this includes extending the temporary Level C phone item for a further six months. We will continue to advocate for patient rebates for longer phone consultations to be available on a permanent basis, as there are clear benefits in terms of minimising the risk of COVID-19 infection in general practices.

5.2.5 Increasing video consultations in general practice

Major improvements are needed if the number of video consultations in general practice is to increase, including:

- ensuring the user interface at both ends is simple and easy to use
- improving internet speeds and reliability
- providing education to both doctors and patients (eg how to optimise video applications for business rather than personal use)
- addressing health equity issues that restrict access to technology and create privacy concerns (eg overcrowded housing, needing to use a computer in a public space).

The Good Things Foundation Australia suggests that 'Digital Health Navigators' could help to improve health literacy and build stronger connections between healthcare professionals and consumers.[40]

Our members suggest funding is required to train GPs, practice nurses and administrative staff (eg receptionists) to assist patients to use digital technologies. Having digital health champions in practices will increase uptake of these systems. In recent years there has been an increase in online systems such as the Australian Immunisation Register, My Health Record and online Medicare claiming, however many people are unable to use them or are not even aware they exist.

5.3 Linking telehealth to a patient's regular GP/practice

5.3.1 On demand telehealth services

The expansion of MBS telehealth items resulted in a surge in telehealth models and businesses that operate models of care that are often profit-driven and may compromise patient safety. Concerns have been raised about opportunistic telehealth providers. There is a risk these providers may divert funding from usual care providers, further reducing the viability of comprehensive general practice.[41]

The RACGP has significant concerns about on demand telehealth services that do not provide a link to a patient's usual general practice, which is essential for continuity of care. Many of these services are not eligible for accreditation against the RACGP's *Standards for general practices*, meaning there is no way of assuring their quality of service. There are additional concerns with privacy and, at times, the inappropriate and unapproved use of patient data, both during and after a consultation. Research shows that the risks and limitations of telehealth are reduced when there is an existing relationship between the clinician and the patient.[42,43]

Some of these services have taken advantage of understandable anxieties in the community about contracting COVID-19 and expanded their business models with public funding through the MBS. This poses considerable risks to the health and wellbeing of the community and the viability and reputation of high-quality and patient-focussed general practice care.

Telehealth services should be provided by a patient's usual GP or practice wherever possible.[44] This is to ensure the delivery of safe, necessary and appropriate care. GPs providing care to known patients have access to a patient's notes and history and awareness of individual circumstances and needs.

Telehealth provides an opportunity for remote monitoring and the management of chronic conditions, providing flexibility, improving convenience and potentially reducing costs for both patients and GPs. The RACGP's *Vision for general practice and a sustainable healthcare system* highlights the importance of developing an ongoing therapeutic relationship with a usual GP to support continuity of care across a patient's lifespan and prevent hospital presentations and admissions. In the future, voluntary patient enrolment – whereby a patient nominates to enrol with their usual general practice – is a mechanism to ensure telehealth use is available only for the patient's usual GP or practice.

5.3.2 Existing relationship requirement

On 10 July 2020 the Minister for Health, Hon Greg Hunt MP, announced changes to the telehealth MBS items introduced in response to COVID-19, effective 20 July 2020.[45] The changes promote patients receiving continuous care from their regular GP or medical practice, reflecting requirements in place when telehealth was first made available in March 2020.

These changes restricted the ability of GPs to provide MBS-subsidised telehealth services where the patient has not been seen by that GP or another medical or health professional at the same practice face-to-face at least once in the 12 months prior to the date of the telehealth consultation. The requirement is ongoing and applies to every telehealth consultation – not just the first telehealth appointment that a patient attends.

A valid service for satisfying the requirement for an existing clinical relationship in order to access telehealth is a service defined by the *Health Insurance Act*. Therefore, a face-to-face attendance with a GP that is not billed to Medicare (i.e. a completely private service where no rebate is claimed) would not qualify as an eligible service. Previous telehealth consultations also do not count towards this criterion. Our members advise that the Department's dismissal of services where no Medicare rebate was claimed is problematic, as GPs provide a broad range of services that extend beyond the MBS (eg workers' compensation).

The RACGP was supportive of establishing the existing relationship requirement to enable access to MBS telehealth services and to ensure continuous, high-quality primary healthcare. The initial intention of the rule was to restrict virtual clinics exploiting the telehealth MBS items at the expense of long-term patient care, while at the same time supporting GPs to provide care to ongoing patients of their practice.

Over time, the RACGP recognised that some amendments to the requirement would be needed to better support GPs who were at risk of contracting COVID-19 and/or who were furloughed and unable to deliver patient care. In February 2022, the RACGP wrote an open letter to the Department to request an exemption to the 12-month rule for immunocompromised GPs and GPs in isolation to allow them to continue treating patients. Unfortunately, this proposal was not adopted.

We recommend the impact of the existing relationship requirement on vulnerable patients, such as refugees and victims of domestic violence, be regularly reviewed. Consideration must be given to ways to facilitate access to telehealth for patients who are known to their GP/practice but have not been seen face-to-face in the past 12 months. We acknowledge that there are several exemptions currently in place, including for patients of practitioners at an Aboriginal Medical Service (AMS) or an Aboriginal Community Controlled Health Service (ACCHS), as well as particular services such as mental health and eating disorders.

5.4 2021 telehealth compliance campaign

5.4.1 Background

In February 2021, the Department wrote to the RACGP advising of an imminent compliance campaign related to COVID-19 telehealth items. The compliance activity was initiated in March 2021, examining billing between July 2020 and January 2021.

While the Department initially identified close to 30,000 GPs engaged in potentially non-compliant activity, the scope of the compliance activity was scaled down. The campaign directly targeted approximately 500 GPs through targeted letters and audits.

5.4.2 Key issues

The RACGP had significant concerns with the telehealth compliance campaign and its impacts on GPs and practice teams. We communicated these concerns to the Department in emails, letters and during meetings over several months in 2021. The key issues are outlined below.

Key issue	RACGP commentary
Timing of the campaign	The compliance campaign was rolled out at a time when GPs were continuing to care for their patients in a rapidly changing pandemic environment, and as the COVID-19 vaccination program was being established. In early 2021, the COVID-19 vaccine rollout was in its infancy, and COVID-19 outbreaks and border closures were still commonplace. GPs were – and remain –

Key issue	RACGP commentary
	central to the vaccination rollout, with the public seeking information about and quick access to the vaccine. Many GPs offered out-of-hours services to accommodate usual business and COVID-19 and influenza vaccinations. The mass compliance campaign was very disruptive and placed undue pressure on GPs, owing to the time involved in preparing the relevant documentation for the compliance activity. However, it also had effects for the broader profession, causing significant distress and disengagement and potentially promoting behaviour change amongst GPs to avoid scrutiny. The Department further embedded its focus on telehealth and vaccine administration as compliance priorities in its *Health Provider Compliance Strategy 2021–22*, released in August 2021. The RACGP again questions the timing of this announcement, as at this stage GPs were still having to manage periodic outbreaks and continual changes to vaccine eligibility.
Inconsistent and confusing rules	As noted above in section 4.2, implementation of the existing relationship rule has been inconsistent and confusing. Ambiguity around exceptions to this requirement were evident in 2020, constant changes to the rules because of intermittent lockdowns and border closures generated confusion and it took providers time to adapt. The level of misunderstanding became more evident when GPs received targeted compliance letters.[46] The RACGP received enquiries from several Victorian-based members, who advised that telehealth services provided during the state's 2020 lockdown (from July to October, during the second wave of COVID-19 infections) were not excluded from the list of claims they were asked to review. This was despite patients being exempt from the existing relationship rule during this time, and therefore able to access telehealth from any GP or practice. As a result, GPs had to work out various lockdown dates themselves to assess whether their claims were compliant. The RACGP was also made aware of claims being included for review where the patient had been seen by another medical/health professional at the same practice, meaning they were eligible for telehealth rebates. Although the Department did make educational materials available, they were not always accurate. Responses to enquiries around situations where exceptions would apply were neither prompt nor consistent, with the definition of a 'COVID-19 impacted area' particularly confusing. It was only in December 2020, approximately five months after the rule was introduced, that the Department issued guidance around the existing relationship requirement via an AskMBS Advisory. Yet subsequent to this, an RACGP member identified in May 2021 that the Department's *COVID-19 Telehealth Items Guide* did not specify that the service provided in the past 12 months for the purpose of establishing a relationship needed to be a face-to-face service. As recently as March 2022, communications are still being circulated to clarify the changing rules in regard to the relationship requirement following telehealth items being made permanent in January 2022 and further changes to COVID-19 'hotspot' status.

Key issue	RACGP commentary
	Another area of confusion related to the expected response from GPs who received a targeted compliance letter. Several members contacted the RACGP seeking clarification about whether they were required to respond to the letters or repay funds. It took considerable time to get confirmation from the Department that GPs were not required to respond, although it was preferred. The delay caused considerable stress for GPs, who were unsure how to proceed.
Data integrity	The RACGP was particularly concerned about the way in which GPs were identified for the compliance campaign and the timeframes applied to the data collection. Initially, the Department identified almost 30,000 GPs who had potentially breached MBS telehealth rules and intended to undertake a tiered compliance campaign that would have affected over 10,000 GPs: • Targeted awareness raising letter (9,470 providers identified, who had engaged in 10–74 potentially non-compliant services) • Targeted compliance letter (737 providers identified, who had engaged in 75–300 potentially non-compliant services) • Audit program (33 providers identified, who had engaged in 300+ potentially non-compliant services). The criteria the Department used in the data extraction was unclear, despite the RACGP's calls for greater clarity. The timeframe indicated for the data integrity was also questionable. There was considerable ambiguity and uncertainty about exemptions over the identified period of review, with regular changes because of intermittent lockdowns and border closures. As outlined above, the Department did not provide formal advice on this until December 2020 via an AskMBS Advisory, yet the decision to pursue these compliance activities suggests there was an expectation that GPs would be able to bill these items correctly without formal advice or guidance. The RACGP acknowledges that the Department accepted feedback on the nature and approach to data analysis. As a result, the compliance campaign was adapted to focus on broader awareness raising and the number of GPs who received targeted letters or were audited was scaled down. While this was a positive outcome, it did not address the fundamental issues with the approach to data collection and analysis.
Punitive nature of the compliance activities	The RACGP has repeatedly stressed to the Department that increased compliance activities should be balanced with corresponding educational activities. Where reasonable, health professionals must be given an opportunity to adapt their billing practices prior to being subject to an audit. On several occasions the RACGP sought to communicate our concerns to the Department – see for example this media release. The RACGP has been contacted by numerous GPs concerned about this compliance activity. GPs noted that: • they were providing care to their usual patients but were caught out by a technicality, and wrongful claiming was never their intention • they were told to repay any incorrect claims to the Department despite having met the intent of the existing relationship rule • they believed the existing relationship rule only applied to the 12 months preceding the commencement of telehealth, and a usual patient of the

Key issue	RACGP commentary
	practice would be able to continue to access telehealth from their practice after meeting the initial threshold requirement. The RACGP sought and received assurances that GPs who had genuinely misunderstood the rules and provided services in good faith to long-term patients of their practice would be considered on a case-by-case basis. GP feedback suggested this was not the reality of their experience, as GPs were made to repay Medicare funding for providing telehealth services to ongoing patients of their practice who did not technically meet the rule of existing relationship. Given the circumstances GPs found themselves in during the review period for the compliance campaign, these principles should have been considered prior to launching the activity. Although the Department willingly worked with the RACGP on the scale and scope of the campaign, we were disappointed that flexibility was not applied. Clearly, there is precedent for this, as the Department did commit to excluding GPs in flood-affected areas in New South Wales and South East Queensland from telehealth compliance activities until a later date.

We acknowledge and welcome the Department's commitment to exploring opportunities with the RACGP to increase education and awareness raising activities to complement the broader compliance program. The Department noted this education may be best delivered through a combination of government and profession-led approaches.

6. Opportunities

6.1 Disaster response

Enabling rapid access to telehealth during an emergency or disaster situation can assist people who are unable to access healthcare in-person. This may require consideration of expanding clinical situations where telehealth is considered an appropriate means of service delivery.

Since 22 February 2022, patients in flood-affected areas have been exempt from the requirement to have seen the GP in the last 12 months to access telehealth.[47] The RACGP has since been advised that the exemption will soon be expanded to include areas affected by natural disasters more broadly, and this exemption category will be permanent. Determination of eligibility rests with states' and territories' declaration of an affected local government area (LGA).

The RACGP welcomes this decision. We recommend patients living in LGAs that are declared disaster zones – including both natural and non-natural disasters – by a state/territory or federal government be automatically exempt from telehealth rules from the date of the disaster declaration. The exemption should continue for as long as access to healthcare in an affected LGA is impacted because of the disaster.

6.2 Telehealth with third parties

Our members suggest there needs to be recognition that telehealth consultations often occur with third parties who are representing the patient (eg parents of young children). Some consultations do not require the physical presence of the child, and the efficiency gains of telehealth should recognise this. Allowing greater flexibility would prevent children needing to take time off school for GP consultations with their parents about referrals, prescriptions and test results. Other examples include patients with dementia, learning difficulties and other disabilities that make verbal communication difficult or impossible.

One of the most common settings where GPs engage in video/phone calls without the patient being present is residential aged care, as outlined below.

6.2.1 Telehealth in residential aged care

Currently, patients in residential aged care facilities (RACFs) must be present when receiving an MBS service by video or telephone. Nurses and other health practitioners cannot represent a patient in a consultation with a doctor without the patient being present.

This requirement creates a barrier for patients to access care from their GP via telehealth. It is not uncommon for GPs to discuss a resident's condition with nursing staff at a RACF without the patient being present during the consultation, on request of nursing staff for advice and support. Under current Medicare rules, patient rebates are unavailable for this type of care, despite it being clinically necessary, part of the GP's ongoing treatment of the patient and in line with the GP's duty of care for the patient. Adherence to care plans developed by medical practitioners has previously been identified as a concern by our members. Improved GP/nurse liaison is crucial to ensuring that plans are followed and the appropriate care is delivered.

The proposal for Medicare to fund GP consultations via telehealth without the patient being present is not intended to disempower aged care residents. The RACGP considers this to be necessary to enable residents to receive the right care when they need it and prevent their condition from deteriorating.

The current Medicare system with respect to aged care services is clearly not fit for purpose and is placing vulnerable residents at risk. The RACGP has identified a number of issues with the current rules, as outlined below.

- Given the frailty of many elderly residents, not all are able to communicate with the GP during a consultation and instead may rely on a nurse to discuss their health needs. Many residents suffer from vision and hearing loss, speech impediments or dementia, making it virtually impossible for them to participate in a telehealth consultation. Communication between a GP and nurse enables residents to receive the care and support they need in a timely manner.
- The COVID-19 pandemic has resulted in many RACFs being placed into full lockdown, including restrictions on internal movements, to stop the spread of infection. Telehealth is therefore an invaluable tool to enable GPs to deliver timely care to residents, provided there is flexibility allowed when communication is a problem, or resident safety may be compromised by moving through the facility and/or being in close contact with another person. Removing barriers to telehealth for aged care residents would in many cases prevent or delay an escalation of care to already overstretched hospital emergency departments.

The RACGP suggests issues around aged care residents being prevented from accessing the care they need via telehealth could be resolved by considering the following options:

- Introducing separate MBS items for GP services provided via telehealth to residents of RACFs, including medication reviews and health assessments, and ensuring that they attract incentive payments to support GPs to deliver this type of care. These items should be able to be used without patients being present – for example, if a patient's ability to communicate effectively is clearly impaired and/or when their safety cannot be guaranteed throughout the facility.
- Undertaking extensive consultation with key stakeholders around development of a voluntary patient enrolment model for aged care residents, whereby a fixed amount would be paid to the GP/practice to support the delivery of additional and more comprehensive services. These additional services would be agreed between the GP and patient (or their guardian) and could include telehealth consultations between a GP and a nurse without the patient present.

6.3 Additional telehealth items for general practice services

The RACGP welcomes the range of COVID-19 MBS telehealth items available for use by GPs, with the majority of non-procedural attendance items covered. However, there is a need for equivalent telehealth items to be created for a range of other services. See **Appendix B** for a list of suggested additions.

6.4 Telehealth research

The COVID-19 pandemic has highlighted the willingness of patients and health practitioners to embrace new models of service delivery. Telehealth offers numerous benefits and has demonstrated that care can be equally effective when delivered remotely, challenging traditional conceptions of the doctor-patient relationship.

Despite this, decreases to the number of face-to-face services in the future could potentially reduce the quality of care provided to patients. There is also a lack of evidence around the impact of telehealth on healthcare costs, use and outcomes.[48]

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.[49]

To support optimal delivery of health services via telehealth now and into the future, the RACGP recommends funding be provided for research into:

- how to ensure the provision of high-quality care via telehealth for the treatment and management of a range of health conditions
- the impacts of a large-scale adoption of telehealth on general practices (during and post-pandemic) to assist with the allocation of future funding
- the experiences of GPs and patients using video and phone consultations during COVID-19
- the role of telehealth in Aboriginal and Torres Strait Islander primary healthcare.

7. Social impacts of telehealth

7.1 Telehealth impact on Aboriginal and Torres Strait Islander health

Aboriginal and Torres Strait Islander people experience poorer health outcomes than the rest of the population. They are at higher risk of contracting COVID-19 and developing severe illness due to a range of social factors.[50] Ensuring that telehealth did not contribute to worsening this gap was essential. Telehealth was a key initiative that allowed care to continue to be provided to Aboriginal and Torres Strait Islander patients.[51]

Patients of medical practitioners at an AMS or an ACCHS are exempt from the requirement to have seen the practitioner in-person in the last 12 months to access telehealth rebates. This likely enabled access to telehealth for patients who would otherwise have missed out.

Enabling telehealth access to a health assessment (equivalent to MBS item 715) likely enabled remote communities to access health assessments during the pandemic by allowing onsite Remote Area Nurses and Aboriginal and Torres Strait Islander Health Practitioners to perform a face-to-face component of the assessment. This could be completed and billed by a GP supporting the community by telehealth and is a good example of how telehealth extended the primary care available to remote communities.

7.2 Telehealth and health equity

There has been lower uptake of telehealth by patients with lower socioeconomic status.[52] While the reasons for this are not entirely clear, these patients have been more affected by COVID-19 and have higher rates of chronic disease and disability. Poverty tends to cluster in communities, and general practices in these communities are more likely to bulk bill as patients cannot afford fees. Unless telehealth policy actively seeks to address health equity issues, it runs the risk of exacerbating health inequalities. Removing Medicare rebates for longer telehealth consultations will inevitably have this effect.

While GPs should retain the right to privately bill patients, health inequalities will worsen if it is left to patients to make up the deficit between the cost of providing care and the Medicare rebate. General practices in disadvantaged areas are systematically underfunded by Medicare with no way of making up the shortfall, meaning they will become unviable.

Applying a socioeconomic lens to telehealth will also have implications for practices in Aboriginal and Torres Strait Islander communities, rural and remote communities, and communities with significant numbers of people from non-English speaking backgrounds.

8. Conclusion

The benefits of telehealth in Australia have been clearly demonstrated, with significant acceptance and uptake and strong demand for this continued flexibility from providers and patients. Telehealth helps facilitate a person's access to their usual GP, meaning people can more easily receive high-quality, personalised health services when and where it suits them. Telehealth is beneficial for all Australians, but particularly important for patients with compromised mobility, such as older people or people with disability. Telehealth complements face-to-face care, with GPs and their patients deciding how best to meet their needs.

The RACGP's foremost priority is the reinstatement of MBS phone consultation items for longer GP attendances, chronic disease management and mental health care. Patients with complex care needs need and deserve flexible and affordable access to healthcare.

The RACGP looks forward to engaging with the newly elected federal government and the Department of Health around telehealth. Having now entered a new phase of the COVID-19 pandemic where lockdowns are a last resort, we hope that any future changes to MBS telehealth items will be easier for GPs to understand and implement.

Please note our President, CEO and others involved in developing this submission are willing to discuss these matters in-person if you think that would be beneficial.

Should you have any queries or comments regarding the RACGP's submission, please contact Michelle Gonsalvez, National Manager – Policy and Advocacy on (03) 8699 0490 or via michelle.gonsalvez@racgp.org.au.

Appendix A: Examples of telehealth queries

Examples of telehealth related queries submitted by the RACGP to the Department are listed below. This is not an exhaustive list.

While many of these were submitted to the AskMBS email advisory service (askmbs@health.gov.au), others were forwarded to the RACGP's contacts within the Department – most often if a response from AskMBS was not forthcoming. While many of these queries have now been resolved and the Department's responses alleviated member concerns, the list gives the ANAO an idea of the complexity of telehealth arrangements over the past two years. The MBS is already highly complex and the RACGP is a strong advocate for a simplified rebate structure that makes it easier for GPs to meet their compliance obligations.

- *Can you advise what happens if a video call drops out midway through or if a person just can't connect to video at all? Would the GP/patient be able to use a phone in this scenario and still claim the video item (i.e. for a longer consultation), or would they have to revert to a shorter phone attendance item?*
- *What are the rules around co-claiming the new telehealth items for sexual and reproductive health services with other telehealth items (eg standard attendances)? There doesn't seem to be any mention of this in the relevant fact sheet.*
- *Is there any further information about the particular services covered by 'blood borne viruses, sexual or reproductive health' beyond what is in the fact sheet? Is there an explanatory note on MBS Online?*

- *Can you please advise if a home visit is a valid service for establishing a clinical relationship for the purpose of accessing MBS telehealth services from a GP?*
- *Are patients in regional Victoria still exempt from the requirement to have had a face-to-face attendance in the last 12 months in order to access GP telehealth services? Regional Victoria has now moved to step 3 of the state's roadmap to reopening.* ***Update:*** *Given the recent easing of restrictions across Victoria, can you advise what the exemption status is of both Melbourne and regional Victoria? Will this change once the 25 km travel limit in Melbourne and the ring of steel between Melbourne and regional Victoria are removed?*
- *Are patients with COVID-19 symptoms who have not yet been tested exempt from the requirement to have had a face-to-face attendance in the last 12 months in order to access GP telehealth services?*
- *If a patient has a face-to-face attendance with a GP that is not billed to Medicare (i.e. a completely private service where no rebate is claimed), would this count as an eligible face-to-face attendance for the purposes of telehealth? In other words, would the patient be able to access MBS funded telehealth services given they have seen the GP face-to-face in the last 12 months?*
- *If a patient is referred to a GP by a non-GP specialist for a telehealth service, are they exempt from the requirement to have had a face-to-face service with the GP in the past 12 months?*
- *Are we correct in surmising that a face-to-face visit in a residential aged care facility would satisfy the existing relationship requirement for access to telehealth?*
- *Can I confirm that items 91853 and 91858 (antenatal attendance) are also exempt from the 20 July changes?*
- *I also wanted to check whether the obstetric items and practice nurse/Aboriginal and Torres Strait Islander health practitioner items are also exempt from the requirement for telehealth services to be bulk billed by GPs.*
- *Can you please advise if the COVID-19 MBS telehealth items can be used for services provided to private hospital patients?*
- *What chronic health conditions are considered to result in increased risk from coronavirus infection? Does 'being treated for a chronic health condition' mean the patient has a GP Management Plan, or is it at the discretion of the treating GP to determine if they have a chronic health condition?*
- *How does the Department define 'immune compromised'?*
- *Do patients at risk of COVID-19 now also qualify for the doubled bulk billing incentive? The descriptors for items 10990 and 10991 still state that the incentive only applies if the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder.*
- *Are you able to advise what specific arrangements GPs are required to have in place to ensure their patients can access face-to-face care? For instance, if a practice is closed and is now only offering services via telehealth, can they simply refer a patient to a practice or GP that is providing face-to-face care, or do they need to have an arrangement in writing to satisfy this requirement? If so, what are the specifications of such an arrangement?*
- *RACGP members have expressed concern that there are no equivalent COVID-19 MBS telehealth items for existing items 90020, 90035, 90043 and 90051 (professional attendances at a residential aged care facility). Can you please advise why these items have been omitted, and if the Department has any plans to introduce equivalent telehealth items at a later date?*

Appendix B: Suggested additional MBS telehealth items

Item category	Details
Health assessments	• Telehealth items would be equivalent to existing items 701, 703, 705 and 707. • While a comprehensive and appropriate assessment may not be fully realisable via telehealth, delays in assessment affect timely identification, planning and management. • Additional health assessment items are needed, particularly for older people and those in RACFs. The RACGP has recommended that existing health assessment items for people 75 years and older be expanded to include patients 65–74 years and 50–74 for Aboriginal and Torres Strait Islander Australians. • If the intent of telehealth is to support access to GPs for vulnerable people, enabling GPs to undertake a health assessment via telehealth for older people and those living in RACFs fits within this framework. • Without the items, people who are vulnerable are forced to attend a practice for a face-to-face consultation for this service. • Older people, who are among the most susceptible to COVID-19 complications, will likely miss out on their annual health assessment. These assessments provide an invaluable opportunity for GPs to consider the needs of their patients and evaluate current care. • Patient access to geriatrician health assessments is supported via telehealth. • Telehealth items equivalent to MBS item 715 (Aboriginal and Torres Strait Islander peoples' health assessment) were introduced.
After-hours care for urgent and non-urgent GP attendances	• Telehealth items would be equivalent to existing items 585, 5000, 5020, 5040 and 5060. • Members have reported a loss of income as a result of this omission. • Providers have been advised the general telehealth item numbers can be used to provide after-hours care, however the rebates are far lower and do not recognise the added impost of providing care on weekends or during the evening. • There is currently only one videoconference item available for the provision of urgent after-hours care during unsociable hours – item 92210, which is equivalent to item 599. • Recognising that opportunistic stand-alone and entrepreneurial telehealth providers may look to capitalise on the availability of after-hours telehealth items, we recommend that strict parameters be monitored and enforced to support the patient's relationship with their usual GP. Any new after-hours items should only be available to GPs providing both in-hours after-hours care – not dedicated after-hours services such as Medical Deputising Services (MDSs).
Professional attendances at a RACF	• Telehealth items would be equivalent to existing items 90020, 90035, 90043 and 90051. • Providers have been advised the general telehealth item numbers can be used to provide care to patients in RACFs. However, these items do not qualify for the Aged Care Access Incentive through the PIP.[53] • Managing the complex needs of residents will often require GPs to undertake unremunerated work, for instance by providing detailed notes and instructions to RACF staff, completing forms and consulting or following up with other service providers, families and carers. • This omission also affects the ability to report on and analyse service use in aged care facilities.

Item category	Details
Home and residential medication reviews	• Telehealth items would be equivalent to existing items 900 and 903. • As of 21 April 2020, pharmacists can deliver medication reviews to eligible patients via telehealth. This includes Home Medicines Reviews, Residential Medication Management Reviews, MedsChecks and Diabetes MedsChecks.[54] • This enables pharmacists to deliver medication management consultations for those in home isolation and vulnerable patients wishing to limit their potential exposure to COVID-19, and also limit the potential exposure of pharmacists to COVID-19. • The same provisions have not been made for GPs to provide medication reviews.
In-depth patient assessment for COVID-19 vaccines	• Telehealth item would be equivalent to existing item 10660. • The RACGP recommends GPs be able to bill Medicare for vaccine counselling if the service is provided via telehealth. • This would allow patients to have a conversation with their GP remotely and take some time to make an informed decision about whether they want to be vaccinated. • Vaccine counselling provided by GPs is equally as valuable to the patient and the health system whether provided in-person or via telehealth.

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