15 May 2019

MBS Review Taskforce
Attention: Amanda Kennedy (Secretariat to the Specialist and Consultant Physicians Consultation Clinical Committee) in the Department of Health
MBSReviews@health.gov.au

Re: Feedback on the report from the Specialist and Consultant Physician Consultation Clinical Committee of the Medicare Benefits Scheme Taskforce

Thank you for the opportunity to review and provide feedback on the report from the Specialist and Consultant Physician Consultation Clinical Committee of the Medicare Benefits Scheme Taskforce (The Committee).

The Clinical Oncology Society of Australia (COSA) and Cancer Council submit this joint response, specific to **Recommendation 7 – A new framework for telehealth, recommendation b:** *The Committee recommends incrementally reducing derived fee for the nine telehealth loading items to zero* (page 49). The Committee cited the reason as: '…a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services.'

Benefits of Telehealth:

The survival rates for Australians diagnosed with cancer generally decrease as remoteness increases.[1] Geographic isolation, shortage of healthcare providers and poor access to specialist cancer care services are recognised as general contributing factors.[2,3] Telehealth is vital to extending the benefits of multidisciplinary care as it connects rural and remote patients to services not available locally (e.g. specialist consults and access to tumour-specific multidisciplinary teams via videoconference as well as telechemotherapy).[4]

Teleoncology models of care provide cancer care closer to home for patients living in rural and remote areas with high satisfaction among both patients and health workers. A study investigating the acceptability of a telehealth model found that 78% of patients preferred to have the first consultation via telehealth in Mt Isa rather than travelling to Townsville.[5] People in regional areas have embraced teleoncology as it saves them time, money and the inconvenience of travelling to face-to-face appointments in large, often unfamiliar towns or cities. Another Townsville study showed significant cost savings to the health system due to reduction in the travel and accommodation costs for patients, their carers and specialists.[6]

Our concern:

COSA and Cancer Council would like to alert the MBS Review Taskforce and Committee to an unintended consequence of the recommended incremental reduction of the loading entitlement to Items 99 and 112 to 0%.

The existing descriptors for Items 99 and 112 currently enable clinicians to claim an additional 50% loading on the corresponding service item. Clinicians delivering patient care using a telehealth model utilise this loading component to cover administrative costs of delivering telehealth, which are not claimable within the fee-for-service structure. The loss of loading could result in a loss of service relationships, limiting the ability to provide telehealth as an option to rural and regional patients.

Recommendation 8 within the report proposes savings generated would be re-directed to continue supporting telehealth through funding for activities to increase awareness of the benefits of telehealth. Although these are worthy activities, there is no support proposed to enable the development of telehealth services within a model of care.

a. *The removal of the loading claim will significantly reduce the ability of regional and rural clinicians, and metropolitan providers servicing these centres in a telehealth model to continue to:*

    i. *Provide a telehealth service*

    Regional and rural services do not have all services onsite which a cancer patient requires. Samples can be sent to clinical geneticists in metropolitan areas and follow up consultations with the patient conducted via videoconferencing. Similarly, patient consultations with specialist surgeons can occur remotely prior to required travel to have the surgery performed. Both examples enable patients to access care and avoid unnecessary travel. Since the release of the Committee's recommendation, metropolitan services within an existing telehealth model have expressed to rural and regional colleagues, their need to withdraw from this partnership if loading is removed.

    ii. *Provide a telehealth service at no charge to patients*

    The intent of the loading incentive within Medicare is to enable practices to take up telehealth and provide this free-of-charge. This additional financial support upon which to build a service and with the removal of the loading, clinicians will need to increase service fees to cover the additional expenses.

b. *The existing Medicare reimbursement structure, and the specific items for telehealth, does not reflect a patient-centred, model of care for telehealth in rural and regional areas.*

The delivery of telehealth requires the establishment of relationships between services, and recognition that additional work, not billable through Medicare, requires funding. The derived loading is intended to incentivise telehealth, and currently a percentage of this loading is paid back to the hospital to contribute to the administrative burden. If the loading is removed, services would need to absorb the administrative requirements of delivering telehealth, which would not be possible for many service arrangements. The MBS limits the ability to support telehealth as a model of care. Notably, MBS does not cover consultation time if a specialist's patient is admitted to hospital.

Service utilisation of telehealth models is increasing, however ongoing support is required to recognise telehealth as a standard care option.

COSA and Cancer Council recommend:

a. The Committee review and consider the impact of the incremental reduction and removal of 50% loading on Items 99 and 112 on the telehealth workforce, and the ability to support existing telehealth partnerships and the ability to establish future networks. Involvement of clinicians working within these services is essential to this investigation.

b. A model of care approach to telehealth to support service arrangements focusing on patient needs. Telehealth services could be built around the capacity to deliver a model of care. Centres could commit to delivering a defined model of care funded through a bundled payment arrangement, providing an incentive to support the model of care to establish telehealth as another part of their community care delivery.

   This approach could be linked to established Regional Cancer Centres or centres that frequently provide telehealth options. The Commonwealth Department of Health and Ageing funded the establishment of 24 regional cancer centres, including buildings, radiotherapy equipment, chemotherapy beds and patient accommodation. This significant investment in regional infrastructure requires additional resources to enable telehealth coordination, however it provides an existing infrastructure which can be leveraged.

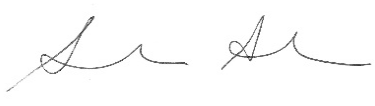
   The Townsville teleoncology model and Queensland Remote Chemotherapy Supervision (QReCS) model are two established models of telehealth that provide a guide for other networks to establish telehealth. The Townsville teleoncology model [7] enables medical oncologists from Townsville to provide their services to rural sites, using traditional video-conferencing technology or web-based systems. At larger rural centres, rurally based doctors, chemotherapy competent nurses and allied health workers accompany patients during teleconsultations. The QReCS model [8] enables rural generalist nurses to administer chemotherapy at rural sites with the support of the rural generalist doctors and pharmacists, under the supervision of medical oncologists and chemotherapy competent nurses from larger centres using telemedicine and tele-nursing respectively.[9,10] This multidisciplinary model enables the delivery of chemotherapy services in rural towns that do not have chemotherapy competent nurses and medical oncologists due to small patient volumes and workforce shortages. Because of collaboration between cancer centres in North Queensland, many rural sites have acquired the chemotherapy capabilities under direct supervision and many patients have avoided long distance travel and its social and emotional consequences.

COSA and Cancer Council look forward to contributing further to this discussion and following the outcomes from the MBS Review.

If you wish to contact either of the undersigned, please call (02) 8063-4100.

Kind regards,

Marie Malica
CEO COSA



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