



MBS Review Advisory Committee

**Telehealth
Post-Implementation Review**

**FINAL
REPORT**

March 2024

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Summary

The Medicare Benefits Schedule (MBS) Review Advisory Committee (MRAC) is an independent, non-statutory committee. Its role is to advise the Australian Government and the Department of Health and Aged Care (the department) on publicly funded services listed on the MBS. The MRAC members include clinicians, health system experts, and consumers.

In 2022, the Australian Government's Minister for Health and Aged Care asked the MRAC to review MBS telehealth services. MRAC was asked to:

- review and update the MBS Taskforce Telehealth Principles, which will provide a framework to consider all MBS-funded telehealth services in the future
- advise on the right balance between access, quality and safety for current video and telephone consultations
- make recommendations on patient eligibility and exemptions for MBS telehealth items.

The MRAC aimed to provide evidence-based recommendations for telehealth. Therefore, the MRAC considered data from independent research (literature and systematic reviews), stakeholder interviews and workshops with general practice clinicians and managers, and MBS claims data about different aspects of telehealth.

The MRAC published the [Telehealth Post-Implementation Review Draft Report in September 2023](#) for public consultation (see [Consultation on the draft report and recommendations](#)). In addition, the Consumers Health Forum of Australia (CHF) held workshops on behalf of the department to better understand consumers' views on telehealth (see [Consumer Health Forum workshops](#)). The MRAC considered the feedback from these consultations and workshops when finalising its recommendations.

Telehealth services in Australia

Over the past few years, the role of MBS telehealth services has changed in Australia. MBS telehealth items have existed since 2002 but were expanded during the COVID-19 pandemic and more patients and clinicians used them. Before COVID-19, telehealth was mostly used for non-general practitioner (GP) specialist video services to patients living outside of major cities. During COVID-19, new temporary MBS telehealth items were created to ensure people could access health care amid lockdowns and social distancing requirements. These changes allowed more clinicians and patients to use telehealth, and some services were able to be done by phone instead of video. Most of the temporary MBS telehealth items introduced during the pandemic are now permanent.

Telehealth use peaked in March–June 2020. Although it declined when social distancing requirements became less strict, telehealth is still widely used. According to the Department of Health and Aged Care's analysis of MBS data the proportion of services by telehealth in 2022–23 was 20% for GPs, 11% for non-GP specialists, 12% for allied health and 3% for other clinicians including nurse practitioners and midwives.

Clinician uptake

Since the COVID-19 telehealth items were introduced, GPs have been the largest group of telehealth providers, accounting for approximately 6 out of every 7 telehealth services.

The proportion of video consultations compared to telephone consultations is increasing; however, not all clinicians use video equally. Allied health and non-GP specialists are the highest users of video, making up 75% and 48% of all telehealth consultations in 2022–23, respectively within these groups. GPs are using video the least, rising to 5% of GP telehealth consultations in 2022–23. This could reflect different reasons, including:

- the communication requirements in primary care build upon continuity of care, making visual assessments less critical
- additional time needed to set up the videoconferencing technology
- lack of guidance and support for using video
- the preferences, capabilities and technological access of both clinicians and patients.

Patient uptake

Patients' use of telehealth is also variable. According to analysis of linked Australian Government data on health, education, government payments, personal income tax, and population demographics from 2020 (Butler et al. 2023), telehealth is used less (as a proportion of all services) by people who:

- are male
- aged over 70
- of lower socioeconomic status
- live in outer regional and remote areas
- have low English proficiency.

While older patients had a lower proportion of their care provided by telehealth, the likelihood that patients had at least one GP telehealth consultation increased with age and was highest for people aged over 70. This could reflect that older patients use health services more in absolute terms, and their lower proportion of telehealth is in the context of other care received.

Large self-report surveys in 2021-22 and 2022-23 by the Australian Bureau of Statistics (ABS) complement some of the research findings. While telehealth was a lower proportion of services for people aged over 70, the ABS reports that older patients were more positive about their telehealth use than younger people (ABS 2023). Alternatively, older patients are more likely to have chronic conditions, and as such, a continuing relationship with a provider. Therefore, telehealth may be viewed more positively because it is used for monitoring an existing condition.

Historically patients have used telehealth differently outside of major cities and may have had more experience with video services due to the availability of most types of non-GP specialist consultations by video since 2011.

Telehealth business models

Online-only GP business models that offer telehealth services for medical certificates, prescriptions and referrals have been growing. These services are marketed as a convenient way to access health care for services such as getting prescriptions and referrals where the outcomes are pre-determined and patient led. However, these consultations are generally quick and once-off, lacking a prior patient–clinician relationship or access to the patient's medical history. As a result, these services do not support integrated, safe and high-quality care.

An increasing concern in relation to these models relates to businesses built around access to specific medicines and treatments. Even if private telehealth services are not MBS-eligible, they may affect the volume and appropriateness of Pharmaceutical Benefits Scheme (PBS) prescriptions and MBS referrals (for example, for pathology, imaging or non-GP specialist review). In addition, a patient's care may be further fragmented as they do not have their regular clinician or practice coordinating this care.

Balancing access, quality and safety

Face-to-face consultation is still the preferred standard of health care for many and must remain accessible to patients. At the same time, telehealth can improve access to health care for some people in some circumstances and can assist clinicians to provide a timely service during after-hours or in aged care settings for example. The MRAC therefore considers it appropriate that the Australian Government continues to support the safe and high-quality use of telehealth.

To determine when telehealth services can improve appropriate access while meeting quality and safety standards, the MRAC considered the available data including stakeholder feedback, consumer workshop feedback, primary Australian research, available MBS data, and systematic reviews of evidence.

Comparing telehealth to face-to-face health care

The research comparing telehealth to face-to-face care is limited, including where there is little evidence for face-to-face consultations as the comparator. There are also challenges with generalising some telehealth research findings to Australia and the MBS. But the research that is available suggests that telehealth can be as good as face-to-face care for managing known conditions of known patients.

For some patients, such as those who are house bound, a telehealth consultation can mean the difference between accessing health care or not. Options to enable access to telehealth as part of comprehensive and ongoing care has been a consideration of MRAC (see [Recommendation 10](#))

Consumers in the CHF workshops agreed that telehealth was suitable when they were seeing a clinician that they already knew, and for a condition that they already had. Some felt that a new diagnosis using telehealth was also sometimes suitable. However, consumers also flagged that receiving confronting test results may be better during a face-to-face appointment.

However, telehealth is not suitable when hands-on clinical assessment is needed. Telehealth is less likely to be effective for new diagnoses, particularly in cases where the clinician requires a lot of different information or needs to assess complex factors to make a diagnosis.

Video vs telephone

A literature review found no major differences between video and telephone consultations in patient satisfaction, clinical effectiveness or cost-effectiveness. Similarly, stakeholders gave strong feedback from different clinical practices that, in many cases, there is no notable difference in outcomes between video and telephone consultations. However, there are major gaps and limitations in the existing research. While evidence-based comparisons are emerging (Caffery et al 2024), more studies with longer follow-ups are needed before the MRAC can make any firm, evidence-based recommendations.

Despite these research limitations, the MRAC considered it self-evident that video consultations more closely resemble face-to-face consultations than telephone consultations, as they give clinicians access to both verbal and non-verbal information. This makes video preferable or necessary in some circumstances, such as with paediatric patients, when diagnosing conditions with visual signs, and whenever observation of the patient is relevant.

However, it should be noted that some patients and providers experience difficulties with video consultations due to issues such as connectivity, access to appropriate technology and devices, and digital literacy.

MRAC agreed that overall, clinicians must balance patient needs and preferences with clinical safety and effectiveness, and give clear guidance to practice managers and staff who assist with patients' bookings about when to offer a telehealth consultation and which modality to use. As such, both video and phone modalities should be available to the clinician, and the technology should be readily set up and accessible.

Telehealth in the MBS

MBS Telehealth Principles

The MBS Telehealth Principles provide a framework to ensure appropriate access, safety and quality are maintained when future changes to telehealth MBS items and policies are considered. In line with its discussions about access, quality and safety, the MRAC proposed revisions to the existing Principles (see [Recommendation 1](#)).

Appropriate types of telehealth services

Overall, clinicians must balance patient needs and preferences with clinical safety and effectiveness. The practice manager and staff must also be well informed about when to offer a telehealth consultation to patients when booking, and which modality to use (noting the cost implications if telehealth proves unsuitable and a subsequent face to face consultation is required). There are instances where telehealth may be inappropriate, and this should be communicated to patients. Conversely, patients should be able to access telehealth if it is their preference and it is appropriate.

The MRAC acknowledged telephone consultations are appropriate for the following services and should be reintroduced (see [Recommendation 2](#)):

- GP Chronic Disease Management plans and reviews
- subsequent consultations for consultant physicians as part of ongoing care.

Asynchronous telehealth

Currently, the MBS only supports the synchronous (real-time) delivery of telehealth services that are the same as in-person consultations. This means the clinician must be providing care to a patient who is present at that time of a telehealth consultation. Some stakeholders have advocated for MBS items to be created for asynchronous care, such as writing referrals, filling out forms or reviewing reports, when the patient is not there.

The MRAC acknowledged that many clinicians' administrative workloads are increasing. However, the MRAC did not support creating new items for asynchronous telehealth services (see [Recommendation 3](#)). Other options could be explored instead, such as:

- reviewing the fees for some MBS items

- instituting longer items for patients to allow for appointments of varying lengths
- considering other non-MBS funding pathways to compensate clinicians for administrative work.

Eligibility requirements and exemptions for telehealth services

Currently, GPs and clinicians working in general practice can only provide MBS-rebated telehealth services if they have an existing and continuous relationship with the patient. This means that the clinician must have seen the patient in-person at least once in the past 12 months, known as the ‘12-month rule’ or ‘1 in 12 rule’. Some items and services are exempt from this requirement.

The MRAC concurred that there are some instances where telehealth items should be exempt from the 12-month rule, and advised on when this may be of value:

- For presentations and issues that are relatively acute and immediate care is time critical.
- When ‘unrestricted’ access has a clear public health advantage.
- If a single consultation or episode of care is sufficient and unlikely to fragment care or negatively affect health outcomes.

As well as agreeing to these general principles, the MRAC considered specific temporary telehealth items that are currently exempt from the 12-month rule, but for which the exemption is due to expire. The MRAC recommended that telehealth bloodborne virus and sexual and reproductive health (BBVSR) and GP mental health treatment items remain exempt from the 12-month rule, citing (among other things) the need to ensure continued access for vulnerable populations (see [Recommendations 4–7](#)).

MRAC also examined MyMedicare registration as an alternative eligibility measure for patients in a general practice setting. MyMedicare registration reinforces continuity of care and could exempt registered patients from the 12-month rule for MBS telehealth items that require it (also [Recommendation 7](#)).

At present, the 12-month rule does not apply to nurse practitioners and participating midwives. To support equality in how telehealth works for nurse practitioners and GPs, continuity of care and alignment with the Telehealth Principles, the MRAC considered it appropriate to apply the 12-month rule to nurse practitioner MBS telehealth items with exemptions (as nurse practitioner telehealth should work the same way that GP telehealth does). Overall, continuous care is important for telehealth provided by nurse practitioners and midwives, although the current specification of the 12-month rule is less relevant for midwives whose services are based on pregnancies (see).

Currently, MBS items for non-GP specialist consultations do not have the 12-month rule or other eligibility requirements based on prior face-to-face services.

The MRAC acknowledged stakeholder feedback that a draft recommendation for initial non-GP specialist consultations to be in-person only could disadvantage many patients, especially those who need to travel long distances to see a non-GP specialist. The MRAC acknowledged that there are circumstances where patient care would not be negatively affected by a telehealth service with a non-GP specialist for an initial consultation.

Thus, the MRAC recommended that the current eligibility and exemptions not be changed for non-GP specialists (see). To address any disadvantage the patients may experience, the MRAC strongly recommended the reintroduction of patient-end support for telehealth consultations with non-GP specialists with no geographical limitations.

Strengthening access to patient-end support

The MRAC recommended the reintroduction of MBS patient-end support services by GPs for non-GP specialist telehealth consultations. Members discussed how the MBS could be used to provide patient-end support for telehealth consultations with other clinicians to further support high quality consultations (as they provide the opportunity for a trusted clinician to support engagement with a remote clinician and opportunities for coordinated team care). It was noted that this is how MBS GP patient end support worked prior to 2022. The MRAC also recommended that MBS patient-end support services be extended to nurse practitioners and allied health clinicians to facilitate GP consultations, and that additional patient-end support services should be available in residential aged care settings (see Recommendation 10).

Recommendations

Recommendation 1

Adopt the revised MBS Telehealth Principles

The MBS Telehealth Principles (the Principles) are intended to guide the development and implementation of MBS telehealth policy, including the creation and amendment of MBS items. The Principles were developed under the premise that telehealth should not completely replace face to face consultations, which remain the preferred standard of care. Consultations provided in-person present greater opportunities for more comprehensive investigations and are likely to be more beneficial for patients and providers. However, there are many scenarios where telehealth – both video and phone – can have equivalent outcomes to in-person care and has potential to add value with increased flexibility and frequency of care.

Adherence to these Principles is expected to achieve a necessary balance between facilitating access to care while ensuring that the quality of care and patient safety are not compromised. The current range of MBS telehealth services have been created as equivalent substitutes for in-person consultation, including in relation to their fees and rebates. The best available evidence for telehealth in this context relates to its use as part of continuous care – to known patients for known health conditions. This is critical for maintaining the safety and value of MBS telehealth services.

MBS Telehealth Principles

Telehealth items in the MBS should consider the following:

1. Should be patient-focused and based on patient need, as determined by shared decision making between the clinician and the patient.
2. Must support safe, private and quality services for patients, aligning with the clinical requirements of the equivalent face-to-face service and demonstrating clinical efficacy.
3. Should be provided in the context of coordinated and continuous care between patient and clinician.
4. Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.
5. Options of telephone, video and face-to-face consultations must be offered to patients, though the type of 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.
6. Should support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation, if appropriate, enabling rebates for support by both the treating clinician and patient-end clinician.
7. Amendments to MBS telehealth should follow sufficient advance notice of changes to MBS items for clinicians and patients to adjust.

Recommendation 2

Reintroduce:

- a) GP telephone services with a known clinician

b) Subsequent consultant clinician telephone services as options for patients receiving continuing care.

Recommendation 3

Consider how MyMedicare and other non-MBS funding options could better remunerate clinicians directly for the asynchronous and non-contact work that is often associated with managing patients.

Recommendation 4

Discontinue temporary nicotine cessation MBS items with exemptions after 31 December 2023.
(*Note: implemented 1 January 2024.*)

Recommendation 5

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

Recommendation 6

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

Recommendation 7

- a) Retain eligibility exemptions for MBS GP telehealth mental health treatment items.
- b) Make GP mental health care planning and review telehealth items non-exclusively linked to MyMedicare.

Recommendation 8

Introduce eligibility requirements and exemptions to nurse practitioner and midwifery MBS telehealth items, including selected services which have no established clinical relationship requirement.

Recommendation 9

Maintain current telehealth policies for MBS video telehealth items that are for initial consultations with non-GP specialists.

Recommendation 10

Expand patient-end support by:

- a) Reintroducing GP patient-end support for telehealth with a non-GP specialist and extend it to include nurse practitioners.
- b) Extend patient end support to include nurse practitioners, allied health, and Aboriginal and Torres Strait Islander Health Practitioner patient-end support for telehealth with a GP.
- c) Introducing a support type service for GP telehealth in a residential aged care setting, when GPs advise patients' carers or a registered nurse in lieu of the patient (in circumstances where the patient lacks capacity).

If the MBS is not a suitable funding pathway for patient-end support services, explore other funding possibilities (such as MyMedicare, practice incentives, Primary Health Networks, or a new funding initiative).

Acronyms, abbreviations and definitions

ANU	Australian National University
BBVSR	bloodborne virus and sexual and reproductive health
GP	general practitioner
MBS	Medicare Benefits Schedule
MM	Modified Monash
MRAC	MBS Review Advisory Committee
PBS	Pharmaceutical Benefits Scheme

Clinician is any healthcare provider. In this report, it includes GPs, non-GP specialists, nurses and allied health professionals.

Telehealth is defined broadly by many sources as “the use of technology to deliver healthcare services at a distance”. The structural requirements of MBS items necessitate a real-time video and audio (video), or audio-only (telephone) consultation with a patient. In this report, telehealth can refer to both video and phone, with some matters identified as specific to video or phone.

Introduction

MBS items for telehealth services have been available since 2002, but were restricted to patients in eligible areas, patients of Aboriginal Community Controlled Health Organisations, and patients in aged care facilities. However, due to natural disasters and public health emergencies (drought, bushfires and the COVID-19 pandemic), additional MBS items were created to ensure that people could still access health care when a conventional face-to-face consultation was not possible. The most significant changes were in 2020 in response to the COVID-19 pandemic. At this time MBS items for telehealth services for providers and patients were broadened and services by phone were introduced.

Most of the telehealth items introduced in response to the COVID-19 pandemic were made permanent on 1 January 2022, superseding many items that had been part of an iterative expansion since 2002, and were accompanied by several additional temporary items.

The COVID-19 MBS telehealth items have changed the approach to delivering Medicare services in Australia, shifting from almost entirely face-to-face services to an increased number of non-face-to-face services. This has also permitted more widespread use of telephone consultations without a video element, use of telehealth by people living in metropolitan areas, and direct phone and video services by general practitioners (GPs) and other primary care clinicians that had not previously offered either service.

Telehealth has potential to improve access, but there is risk of decreased quality and safety associated with non-face-to-face consultations. Also, commercialisation of online-only telehealth services may threaten continuity of care by providing one-off transactional episodes or low-value health care. These online-only services may also increase the number of subsequent inappropriate referrals, consultations and prescriptions.

Minister's request for this review

On 14 November 2022, the Minister for Health and Aged Care, the Hon Mark Butler MP, requested that the MRAC conduct a post-implementation review of telehealth services, to:

- advise on the appropriateness of current settings for video and telephone consultations to ensure the right balance between access, quality and safety
- review, and update if necessary, the MBS Review Taskforce Telehealth Principles (first published in the Taskforce's [Telehealth Recommendations 2020](#)) to provide a framework for future consideration of MBS-funded telehealth
- advise on current patient eligibility settings and related exemptions, noting that this work will be informed by the [Strengthening Medicare Taskforce](#).

Information about the MBS Continuous Review and the MRAC is in [Appendix A](#).

Balancing access, quality and safety

Telehealth services must balance improved access with high-quality and safe health care. Further, telehealth services should assist with continuity of care to deliver the best health outcomes for patients.

Research and systematic literature reviews

To inform its deliberations and recommendations, the MRAC was presented with data from:

- independent research, including
 - systematic literature reviews from Bond University (Scott et al. 2021, 2023a, 2023b; Scott & Glasziou 2023)
 - case study and linked data research from the Australian National University (ANU) (Butler et al. 2023) investigating telehealth in primary care
- Australian Government Department of Health and Aged Care (the department) research conducted by the Health Design Lab and the Medicare Benefits Division (Health Design Lab, unpublished), including stakeholder interviews and workshops with general practice clinicians and managers
- consumer feedback from workshops conducted by the [Consumers Health Forum \(CHF\)](#) on behalf of the department
- MBS data, collated and presented by the department.

Limitations of the research

The MRAC noted the limited availability and diversity of high-quality evidence comparing telehealth modalities and comparing telehealth to face-to-face consultations. Most studies to date focus on immediate or short-term clinical aspects of care, with little research into patient views on telehealth services. Further research is needed.

The MRAC considered the available evidence while deliberating but acknowledged that the gaps in evidence made it challenging to make strong, evidence-based recommendations. For example, evidence about the comparison of telehealth modalities (telephone vs video) in primary care remains limited. There is also limited peer-reviewed evidence about patients' understanding of risks and benefits, and drivers of choices regarding telehealth. However, the CHF workshops did provide certain insights from a range of consumer perspectives.

The MRAC's deliberations and recommendations were informed by the best possible data available to the committee at the time. It is incumbent upon policy makers and those seeking to amend the MBS to maintain a current understanding of relevant and emerging research.

Telehealth as a substitute for in-person care

The MRAC noted from the research that no new relevant evidence had been found since a 2021 systematic review (Scott et al. 2021) which informed the transition from temporary to permanent telehealth from 1 January 2022. Overall, telehealth and face-to-face consultations could have equal efficacy for ongoing management of known conditions for a known patient (Scott et al. 2023a). It is acknowledged that the latest systematic review did not yield as much new research as anticipated. Also, several studies were subject to bias, had small sample sizes and were conducted overseas.

The MRAC noted Bond University’s research conclusions that, ‘while history taking and verbal assessments can be done acceptably by telehealth, only some elements of physical examination are sufficiently reliable and valid’ (Scott et al. 2023a). When hands-on clinical assessment was necessary for diagnosis, and especially for a new diagnosis, telehealth was unlikely to be suitable and a face-to-face consultation was highly preferred (Scott et al. 2023a). Further, the MRAC noted that it is more difficult to diagnose via telehealth when the information requirements for that diagnosis increase – for example, additional information from pathology or imaging tests.

Even if telehealth has potential to increase patients’ access, there were perceived risks of both lower quality of care and lower value services when telehealth is not used optimally. Most research comparing telehealth to in-person care employs pre-planned assessments. Some patient assessments relying on verbal assessment tools, such as for neurocognitive and mental health conditions were equivalent to in-person services. In contrast, other telehealth assessments and diagnoses dependent on physical observations or arising from unplanned or unstructured assessments often had only moderate or poor agreement, or moderate disagreement with assessments in-person (Scott et al. 2023a). While acknowledging this is an emerging area of research, the findings to date emphasise an optimal role for telehealth for ongoing care rather than ad-hoc or acute consultations.

Some published observations following the expansion of MBS telehealth in 2020 also reported differences in between telehealth and face-to-face consultations, with telehealth resulting in reduced prescribing (Wabe et al, 2022) and pathology referrals (Hardie et al, 2022). Understanding the factors behind these differences may inform how telehealth is being appropriately chosen to substitute for face-to-face consultations, or if these observations represent a potential risk of missed opportunities for intervention.

The MRAC identified an option for further research that was not possible in the time of this review to evaluate whether there are differences in the clinical notes taken by service providers for telehealth and in-person consultations, and to investigate whether differences in the reason for the consultation informs the modality of the consultation.

Comparing video and telephone consultations

The MRAC noted through Bond University’s systematic review that studies comparing video consultations to telephone consultations revealed no major differences in patient satisfaction, clinical effectiveness or health care use (cost-effectiveness) (Scott & Glasziou 2023). However, these studies in the systematic review had several limitations, including:

- lack of currency (half of the studies were conducted prior to 2012 before widespread availability of smartphones and ‘used special video call devices installed in patients’ homes, which would pose a challenge for scalability of the intervention’ [Scott et al. 2023a])
- a medium to high risk of bias
- none reported on patient safety or adverse events
- none reported on diagnosis or initiating new treatment
- none were set in primary care that directly compared video to telephone consultation.

Overall, the MRAC agreed with the authors that this is an emerging area of study that requires more research. While evidence is emerging (Caffery et al. 2024), at present it is insufficient to restrict the modality when telehealth is deemed appropriate by the clinician and patient.

Clinician use of telehealth services

Telehealth was rapidly adopted by most health service providers in the context of the pandemic. More than half of all telehealth providers provided their first video or telephone consultation within a month of the items commencing of telehealth services (Figure 1). Since the beginning of COVID-19 telehealth items, GPs have been the largest group of telehealth providers, accounting for approximately 6 out of every 7 services (Figure 2).

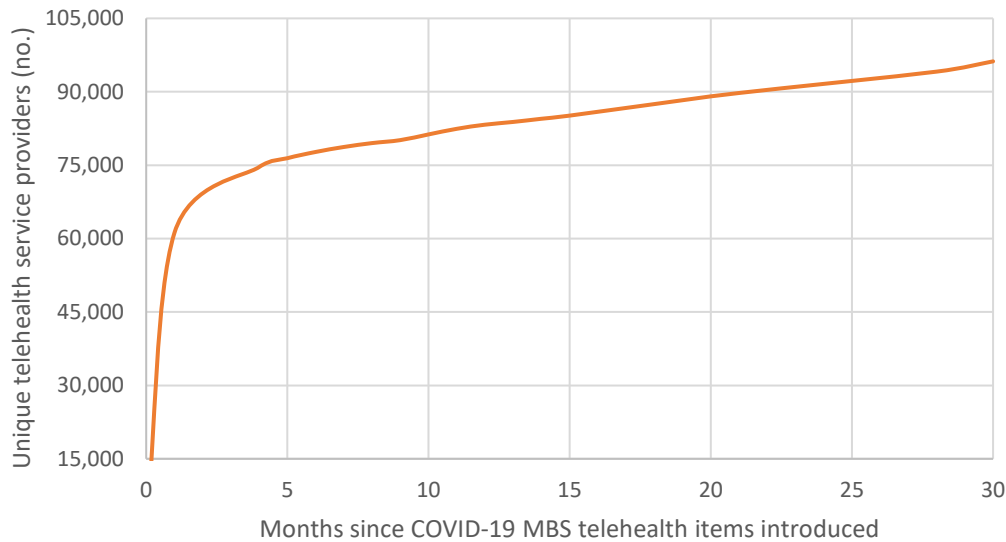


Figure 1 Department of Health and Aged Care analysis of MBS data - Cumulative uptake of MBS COVID-19 telehealth services (unique service providers)

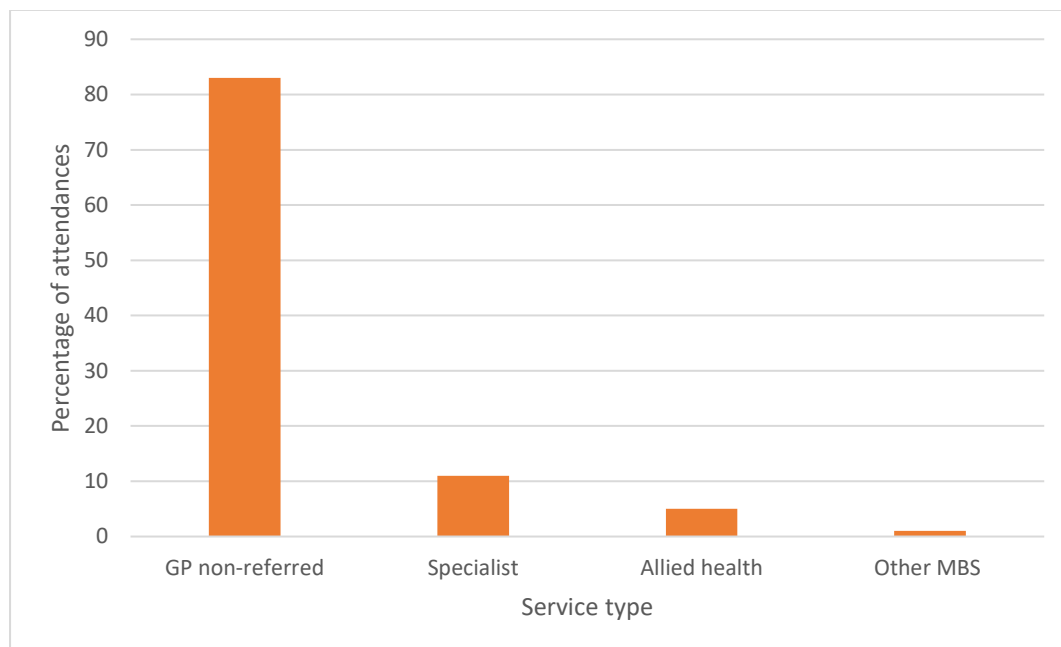


Figure 2 Department of Health and Aged Care analysis of MBS data - Proportion of telehealth consultations by MBS broad type of service, April 2020 – June 2023

The proportion of services by telehealth in 2022–23 was 20% for GPs, 11% for non-GP specialists, 12% for allied health and 3% for other providers including nurse practitioners and midwives (Figure 3).

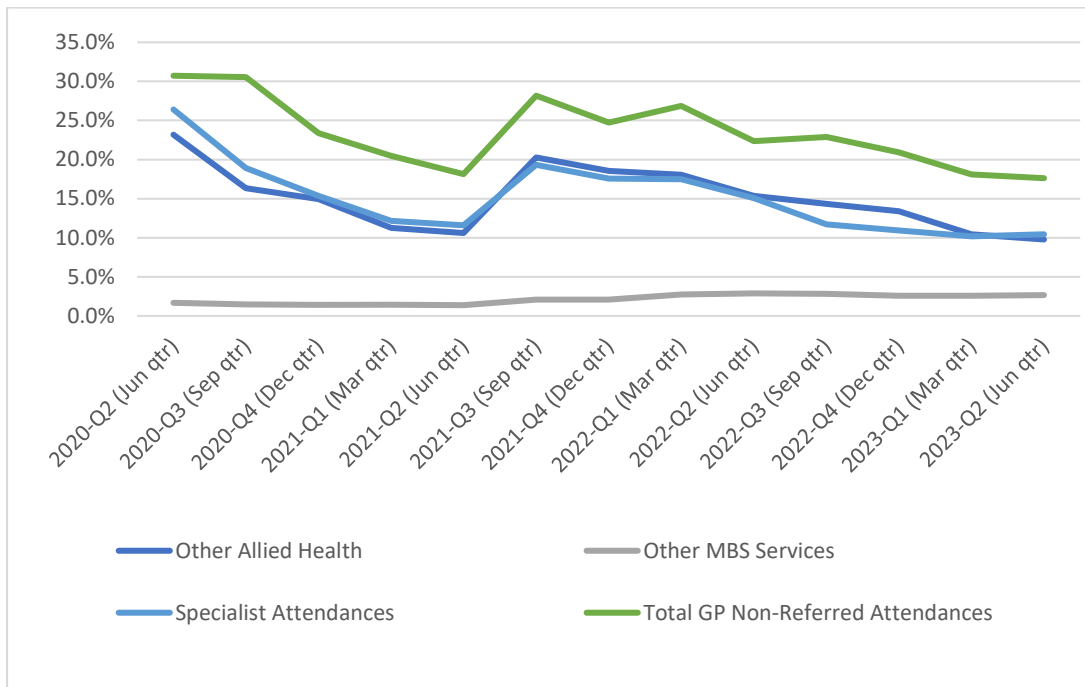


Figure 3 Department of Health and Aged Care analysis of MBS data - MBS broad type of services, proportion of services by telehealth (phone and video), 1 April 2020 – 30 June 2023

The MRAC noted that GPs on average are using video the least of all clinician types, at less than 5% of all telehealth consultations claimed in 2022–23 (see Figure 4).

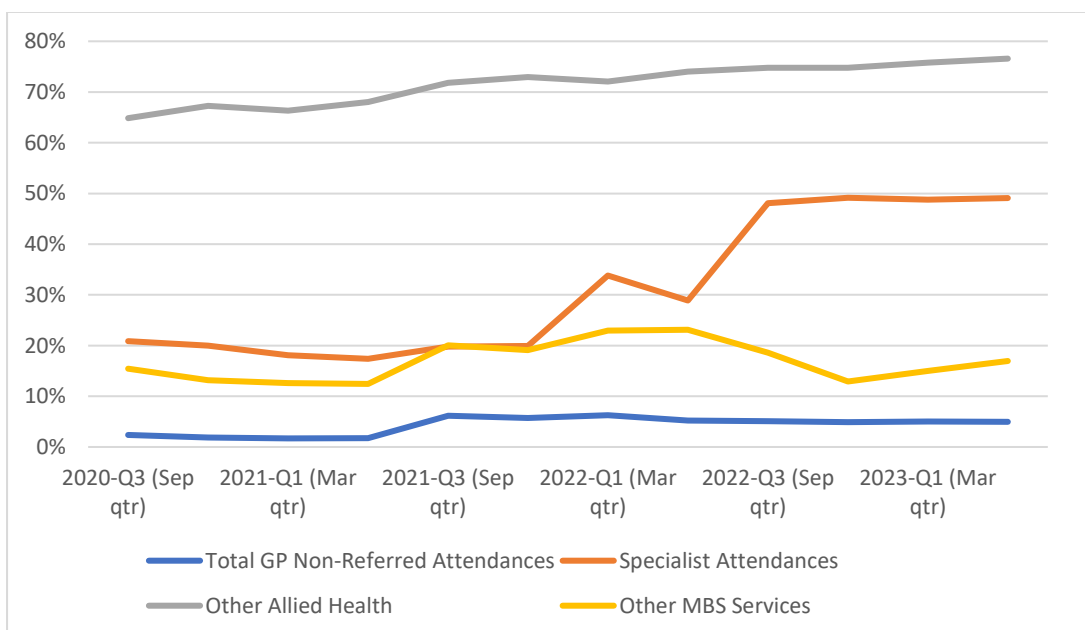


Figure 4 Department of Health and Aged Care analysis of MBS data - Percentage of video telehealth consultations, by clinician, 1 July 2020 – 31 March 2023

Referring to the [Modified Monash \(MM\) Model](#) for rurality, the MRAC noted from MBS data that, since July 2021, most users of telehealth services and the highest proportion of services are in major cities (MM 1), and most of these consultations are for GP services. As rurality increases (MM 2–7), telehealth GP services decrease, but non-GP telehealth and allied health services both increase (see Figure 5).

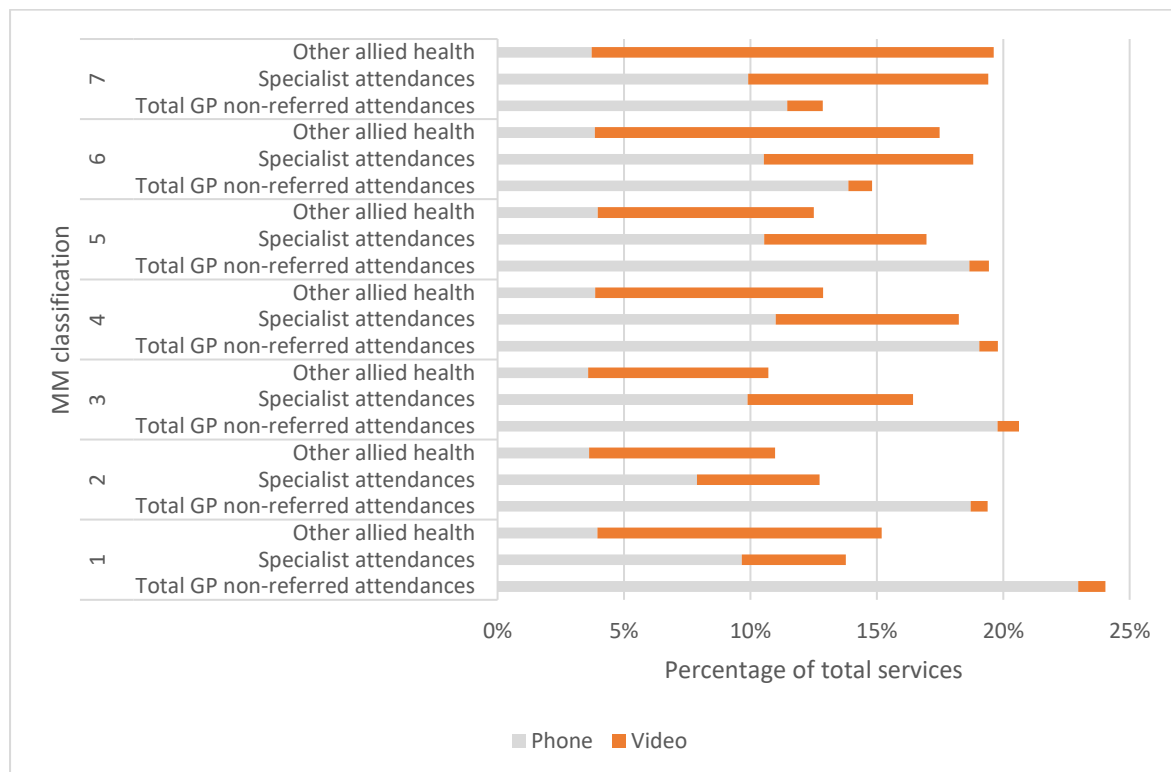


Figure 5 Department of Health and Aged Care analysis of MBS data - Proportion of services by telehealth, by broad type of service and rurality (MM 1–7), since July 2021

Informed by the Health Lab’s research that involved 22 primary care site visits and over 55 hours of interviews with GPs, practice managers, nurses, specialists and community health workers (Health Design Lab, unpublished), the MRAC considered the following reasons for why GPs are not taking up video as readily as some of their colleagues, including:

- Clinicians and patients are more likely to escalate to a face-to-face if telephone is inappropriate, rather than attempt video.
- GP appointments are relatively short (for example, compared to specialists and allied health appointments), making GPs reluctant to spend time dealing with potential technology issues.
- General practice clinics may not have been adequately supported in updating their telehealth capabilities. Some practices may have used telehealth during COVID-19, but did not have a strategy in place to continue using it after COVID-19 restrictions ended.
- General practice includes many patients who are older, and the over 70-years age group uses video telehealth less often than younger age groups.

- There are no guidelines outlining the available telehealth systems and how to make decisions regarding suitability for individual practices. Some clinicians and patients lack relevant digital literacy or internet access.
- There may be some confusion around Medicare claiming for telehealth items.

In acknowledging these reasons, the MRAC also noted that other provider groups (such as allied health and non-GP specialists) have variably overcome these challenges, and that in many instances this has been without the kinds of incentives and grant payments directed to general practices to obtain current technology and develop relevant skills.

Patient use of telehealth services for primary health care

The MRAC noted that, during the first quarter of 2020 before the implementation of COVID-19 MBS telehealth on 13 March of 2020, the use of telehealth services increased substantially from pre-pandemic levels. Within weeks, telehealth transitioned from just over 1 million services to nearly 6 million services (see Figure 6). Since then, use of telehealth services has been declining, likely reflecting the removal of COVID-19-related social distancing restrictions and a return to conventional face-to-face consultations.

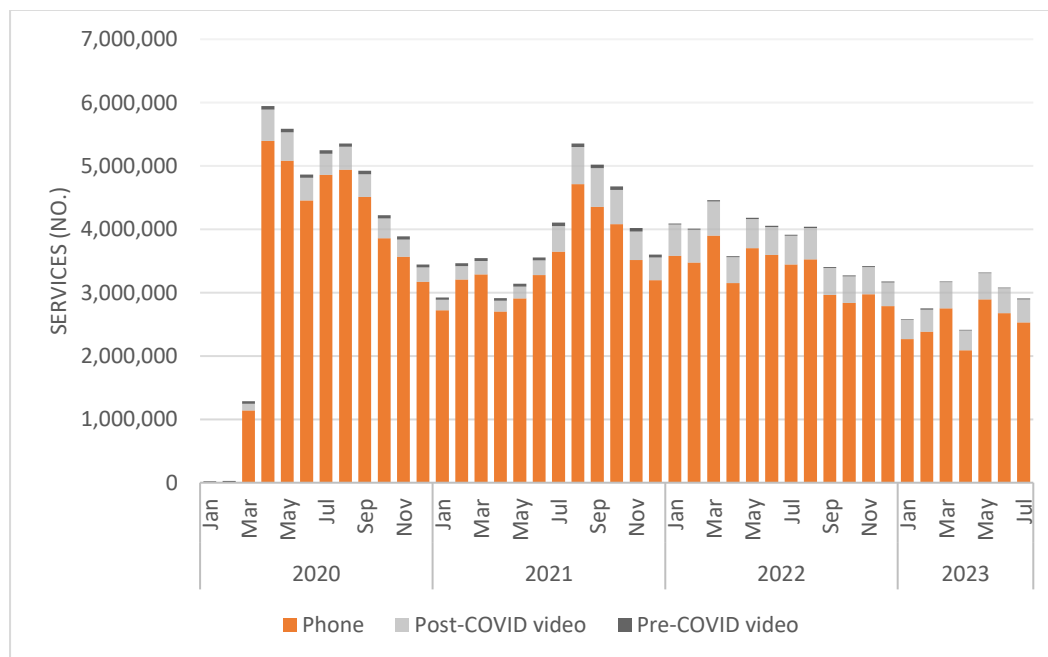


Figure 6 Department of Health and Aged Care analysis of MBS data - Patient use of telephone and video services, January 2020 – June 2023

Patients’ use of telehealth is also variable. According to analysis of linked Australian Government data on health, education, government payments, personal income tax, and population demographics from 2020, (Butler et al. 2023) telehealth is used less (as a proportion of all services) by :

- older people
- males
- those with low education or low income
- those living in outer regional/remote areas

- those who are not proficient in English.

The proportion of claimed GP telehealth services is stabilising at around 20% of all GP services in financial year 2022–23. Large self-report surveys in 2021-22 and 2022-23 by the Australian Bureau of Statistics (ABS) complement some of the research findings. While telehealth was a lower proportion of services for people aged over 70, the ABS reports that older patients were more positive about their telehealth use than younger people (ABS 2023). This could reflect that older patients use health services more in absolute terms, and their lower proportion of telehealth is in the context of other care received. Alternatively, older patients are more likely to have chronic conditions, and as such, a continuing relationship with a provider. Therefore telehealth may be viewed more positively because it is used for monitoring an existing condition.

Patients have historically used telehealth differently outside major cities, and may have had more experience with video services, with access to most non-GP specialist consultations by video since 2011 (see Figure 5).

The MRAC also noted that use of telehealth requires consideration of privacy in a different way compared to services in-person, in consulting rooms. This relates to both the online environment and ensuring that technology solutions are secure, and the physical environments of the patient and practitioner respectively. Telehealth improves the flexibility of accessing care with respect to patient and provider locations, but it is critical that consultation participants are aware of their surroundings and consider whether non-participants can hear or view their private consultation. This is also referenced in the updated telehealth guidelines from the Medical Board of Australia. The MRAC also noted additional research being undertaken about culturally safe telehealth services (results not yet available).

Initial telehealth consultations for non-GP Specialists

The MRAC noted from MBS data that in 2022-23, more than 8.5 million individual patients across Australia received non-GP specialist consultations (See Figure 7). Most of these patients received either face to face (6.7 million; 79%) or a mixed care with face to face and telehealth (1.5 million; 18%). In comparison, a relatively smaller group of patients received these services exclusively through telehealth (308,453, 4%). The use of telehealth increased with rurality as did the proportion that received telehealth exclusively (see Table 1).

Figure 7: Department of Health and Aged Care analysis of MBS data - Overall patient use of total non-GP specialist services by delivery type and rurality.

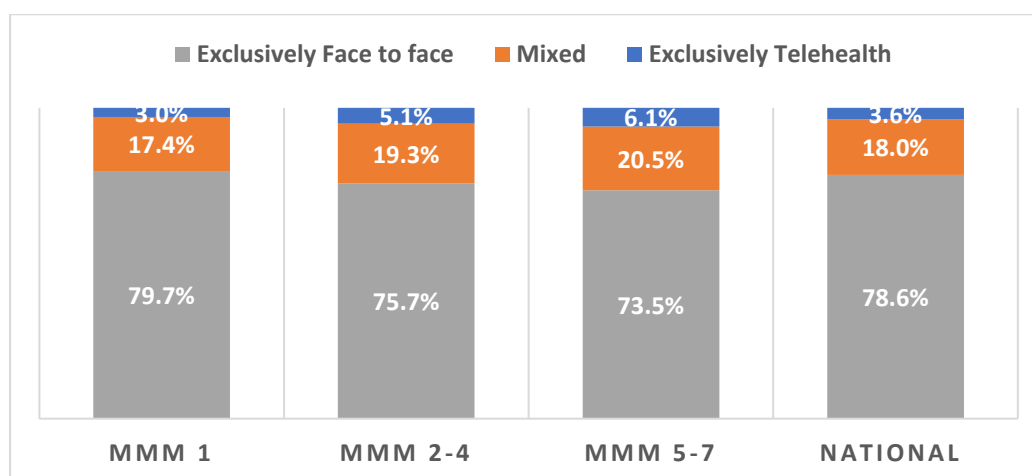


Table 1: Number of non-GP Specialist patients’ use of services by rurality and modality

NUMBER OF PATIENTS	MMM1	MMM2-4	MMM5-7
FACE TO FACE ONLY	4,972,405	1,246,510	489,420
MIXED	1,085,626	317,789	136,677
TELEHEALTH-ONLY	186,359	83,282	40,318

Of these 8.5 million patients in 2022-23, rural patients were more likely to have an initial consultation by telehealth, although in all regions face-to-face accounted for the majority of initial consultations. The average annual services were highest for patients that used both face-to-face and telehealth, consistent with broader trends that patients who use more services are more likely to use telehealth for some of their care. Most (71%) patients who received an initial consultation via telehealth received follow-up within 12-months. Patients who used more services and a mix of service types (telehealth and in-person) generally were more likely to see different providers. Continuity of care for patients who commenced with telehealth was higher when subsequent services were also by telehealth, compared to either a subsequent mix of telehealth and face-to-face or by face-to-face only. The transition from telehealth to face-to-face was a scenario most likely to result in subsequent services with a different provider.

Telehealth consultations for nurse practitioners and midwives

MRAC noted that MBS data from 2022-23, 374,476 Australians received a total 1,025,929 MBS nurse practitioner services, delivered by 854 providers. Of these services, 27% of total Nurse Practitioner services were by telehealth (video and telephone). Claiming patterns during this timeframe show that 15% of total Nurse Practitioner services were telehealth consultations provided to patients that only received telehealth from their Nurse Practitioner. Nearly a third (33%) of Nurse Practitioners’ MBS services went to patients that received a mix of telehealth and face-to-face, and 54% were face-to-face only.

There were 221,357 MBS participating midwifery items claimed, delivered to 43,114 patients by 641 providers for the same period. Of these services, 18% were by telehealth. Approximately 5% of all midwifery MBS services were delivered as telehealth to patients that only received telehealth from their midwife, while 53% were face-to-face only, and 42% of services were provided to patients as a mix of both telehealth and face to face consultations.

Online-only telehealth models

The MRAC discussed the growth in online-only GP business models that offer telehealth services for medical certificates, prescriptions and referrals. These services are marketed as a convenient way to access health care where the outcomes are pre-determined and patient-led. However, given they are generally provided as a quick once-off consultation, where the patient is unknown to the clinician and without access to the patient's medical records, they do not support safe, quality or continuous care.

While these private services are not Medicare claimed, they may have downstream effects on the volume and clinical appropriateness of PBS prescriptions and MBS referrals (for example, for pathology, imaging or non-GP specialist review) and implications for patient safety. In addition, a patient's care may be further fragmented as they do not have their regular GP or nurse practitioner coordinating this care.

Populations and services where access can be optimised with telehealth

The MRAC agreed that face-to-face consultation was still the preferred standard of health care, but also considered that telehealth could complement this care for some patients in certain circumstances. Specifically, telehealth could improve access for some patients, such as those with disability who are largely housebound, by providing access to an increased frequency of consultations and more timely access. However, the MRAC considered it important that patients with complex conditions are not relegated to telehealth-only consultations, as this could result in inferior care in the longer term.

The MRAC referred to its review of the MBS items for mental health, smoking cessation, and bloodborne virus and sexual and reproductive health (BBVSR) to frame its discussion and recommendations for improved access (see [Eligibility requirements and exemptions](#) for recommendations regarding these MBS items).

Proponents of telehealth often cite equity of access for people in rural and remote regions as justification for the services. The MRAC agreed with the importance of equity of appropriate access, but also noted that non-clinical barriers exist for those settings, including:

- technology and infrastructure limitations
- poor digital literacy for both patients and clinicians
- patient education on how to optimise their telehealth consultation
- previous poor experiences in using telehealth, for both patients and clinicians
- clinicians' understanding of the facilities available to the patient
- the lack of culturally appropriate health services for First Nations people.

The MRAC considered that some types of health care services and workflows likely conform to telehealth better than others. For example, a face-to-face consultation may be preferred for initial diagnoses and assessments, whereas telehealth may better suit treatment-based or follow-up consultations.

Considering the research presented to the committee, the MRAC suggested criteria for the assessment of new requests for telehealth items and exemptions to eligibility. Items that are exempt from the established clinical relationship should:

- represent situations where there is a relatively high acuity presentation or issue, where the immediacy of the service(s) is critical
- represent a clear public health advantage when providing 'unrestricted' access to care
- have a low likelihood of misuse by patients and providers
- refer to care where a single episode or consultation is sufficient and unlikely to adversely affect outcomes or fragment care.

In addition, several risks should be considered, including:

- overservicing and enabling adverse commercial models of care
- the efficacy of telehealth-only solutions
- privacy risks of sensitive or condition-specific items on patients' MBS claims records
- impacts to equity of access, including potential interactions with technology literacy and culturally and linguistically diverse groups, and people with vision or hearing impairments.

The MRAC noted that telehealth could help improve access to high-quality health care for some groups of people. The MRAC considered that telehealth items and exemptions could enable access for several populations or situations, such as:

- people with a health concern that needs urgent attention (although the MRAC noted that this may need to be defined, as 'urgent' may differ for different people)
- people in rural and remote settings where the health care workforce may be limited
- when delayed access may result in adverse health outcomes
- paediatric patients with behavioural issues that impede face-to-face consultations.

The MRAC considered situations involving care plans – for example, for patients with complex and chronic health conditions – and the importance of face-to-face consultations for ongoing care. However, the MRAC also considered that there may be situations where such patients benefit from telehealth, such as those in residential aged care facilities or as part of the National Disability Insurance Scheme. The MRAC acknowledged that these are complex areas of health care. The MRAC advised that telehealth, in its current framework, is not fit for purpose for residents in aged care and requires further committee discussion.

Importantly, the MRAC acknowledged the importance of vulnerable patients receiving value-based health care, but also noted that exemptions should not result in fragmentation of health care. The MRAC suggested two criteria that could be used to help identify vulnerable populations:

- where inequality of service is widely acknowledged
- where lack of access would be highly detrimental for the patient.

The MRAC considered it appropriate for the department to better support uptake of telehealth. The MRAC noted that while the department cannot promote certain systems or set-ups, accreditation requirements and standards for telehealth and associated technology would guide clinicians towards overall best practice as well as a telehealth system that best works for their practice and patients. MRAC pointed out that the Australian Digital Health Agency and the Australian Commission on

Safety and Quality in Health Care may have a role to play in the development of telehealth standards that support best practice, noting that neither agency is a regulator.

MBS Telehealth Principles review

In 2020, the MBS Review Taskforce developed Telehealth Principles to guide future consideration of telehealth items in the MBS (MBS Taskforce 2020a).

As part of its post-implementation review, the MRAC reviewed these Principles and proposed updates, taking into account stakeholder feedback (see [Consultation and feedback review process](#)).

Preamble

The MBS Telehealth Principles (the Principles) are intended to guide the development and implementation of MBS telehealth policy, including the creation and amendment of MBS items. The Principles were developed under the premise that telehealth should not completely replace face to face consultations, which remain the preferred standard of care. Consultations provided in-person present greater opportunities for more comprehensive investigations and are likely to be more satisfactory for patients and providers. However, there are many scenarios where telehealth – both video and phone – can be equivalent to in-person care and has potential to add value with increased flexibility and frequency of care.

Adherence to these Principles is expected to achieve a necessary balance between facilitating access to care while ensuring that the quality of care and patient safety are not compromised. The current range of MBS telehealth services have been created as equivalent substitutes for in-person consultation, including in relation to their fees and rebates. The best available evidence for telehealth in this context relates to its use as part of continuous care – to known patients for known health conditions. This is critical for maintaining the safety and value of MBS telehealth services.

Principle 1

Original	Revision
Should be patient-focused, and based on patient need, rather than geographical location.	Should be patient-focused and based on patient need, as determined by shared decision making between the clinician and the patient.

The MRAC discussed whether Principle 1 should be amended to refer exclusively to patient **clinical** need. However, the MRAC noted that patients' needs may be both clinical and non-clinical. For example, a patient may need to use telehealth for access-related reasons. Provided that telehealth is clinically appropriate (refer Principle 2), Principle 1 need not preclude consideration of non-clinical needs.

The MRAC considered that both the clinician and patient have a role in identifying the patient's needs. Acknowledgment of the patient's role could discourage inappropriate behaviour such as cold-calling patients to initiate consultations and generating MBS claims of limited clinical value. Patients would also benefit from education on how to optimise care when choosing telehealth, including joining from a quiet and private space, without distractions.

Principle 2

Original	Revision
Must support and facilitate safe and quality services that demonstrate clinical efficacy for patients.	Must support safe, private, and quality services for patients, aligning with the clinical requirements of the equivalent face-to-face service, and demonstrating clinical efficacy.

Principle 2 emphasises that telehealth services must meet quality and safety standards. The MRAC considered that Principle 2 remains especially important in light of the emergence of new asynchronous telehealth models that do not deliver the same level of service and risk bypassing necessary clinical examination.

The MRAC considered that telehealth services must be clinically efficacious and align with the requirements of the equivalent face-to-face services. When scheduling telehealth appointments, clinicians should feel confident that these MBS item descriptor criteria can be fulfilled (although it may become apparent during a telehealth consultation that a face-to-face consultation is needed).

The MRAC noted external feedback that Principle 2 should refer to ‘all aspects of safe and quality services’. However, the MRAC considered that this ‘absolutist’ phrasing was unhelpful.

Principle 3

Original	Revision
Should be provided in the context of continuity of care between patient and clinician.	Should be provided in the context of coordinated and continuous care between patient and clinician.

Principle 3 supports continuity of care. The MRAC discussed whether the principle should focus exclusively on the relationship between the patient and their primary clinician, or if it should refer to effective clinical handover after episodes of care with another clinician.

The MRAC considered that an important purpose of the principle is to discourage opportunistic and aggressively commercial service models and those that offer telehealth-only consultations focused on a single disease or medicine. However, the MRAC also acknowledged the need for coordination where there are episodes of care (such as medical termination care) with a different clinician. The MRAC decided to largely retain the original wording, adding the concept of ‘coordinated’ care. Given that different clinicians are covered by different codes of conduct, the MRAC decided against referencing any specific code governing clinical handover. The MRAC noted that in relation to general practice, the introduction of MyMedicare has the potential to further improve continuity of care, and to replace and improve upon current arrangements through broader links to telehealth services.

Principle 4

Original	Revision
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Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.

[Retain without amendment]

The MRAC considered revising Principle 4 to designate telehealth as ‘complementary’ rather than as a ‘substitute’ for face-to-face consultations, and to identify face-to-face consultation as the preferred modality because it allows for comprehensive physical assessment. However, the MRAC noted that when comprehensive physical assessment is unnecessary, telehealth can be an effective substitute. The MRAC considered that more prescriptive wording risked devaluing and undermining telehealth.

The MRAC agreed to retain the original wording, noting that the intent of Principle 4 is to ensure that patients continue to have access to face-to-face care.

Principle 5

Original	Revision
Should prefer video over phone, as video offers richer information transfer, with fewer limited exceptions being allowed over time.	Options of telephone, video and face-to-face consultations must be offered to patients, though the type of 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 intent of Principle 5 is to give guidance on which telehealth modality (video or telephone) is preferred. Principle 5 builds on Principles 1 and 2, which set out when telehealth is an acceptable alternative to face-to-face consultation.

The MRAC discussed whether practices using telehealth items (as well as face-to-face consultations) should be encouraged or even required to offer both telephone and video modalities to patients to discourage lack of investment in video capability. However, it was noted that such a requirement could have unintended consequences for practices that operate almost entirely face-to-face, complemented with occasional telephone consultations.

The MRAC acknowledged that video more closely approximates face-to-face consultation, giving the clinician access to both verbal and non-verbal information. However, the MRAC considered that the research evidence about any difference in clinical effectiveness was not strong enough to justify a blanket preference for video. The MRAC noted strong feedback from stakeholders that in many cases, there is no discernible difference in outcome between video or telephone consultations. Additionally, non-clinical issues (such as the patient’s access to and ability to use the technology) can mean telephone offers a better experience for the patient and/or provider in some circumstances. Therefore, the MRAC considered that clinicians should weigh factors and choose the most clinically appropriate modality for each consultation.

Principle 6

Original	Revision
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Support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation.

Should support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation, if appropriate, enabling rebates for support by both the treating clinician and patient-end clinician.

The MRAC noted that the intent of Principle 6 was to expand and better recognise the engagement of clinicians that support the patient face-to-face during a telehealth consultation with another (remote) clinician. The MRAC considered that Principle 6 should be retained, with additional explanatory detail.

In Principle 6 (and others), the term ‘clinician’ includes allied health professionals and pharmacists.

Principle 7

Original	Revision
Should be implemented and modified through time-limited transition arrangements.	Amendments to MBS telehealth should follow sufficient advance notice of changes to MBS items for clinicians and patients to adjust.

Principle 7 signals the department’s intention to give notice of changes to telehealth items. The principle was introduced in response to stakeholder feedback that during the MBS Review, practices had not been given enough time to adjust to item changes.

The MRAC noted stakeholder feedback that the wording of Principle 7 was confusing. The MRAC considered that the intent of the principle should be retained, but rewritten in plain language.

Principles 8, 9 and 10

Original	Revision
Supports different funding models consistent with patients’ need, clinical specialty and purpose.	[Remove]
Should take into account contemporary evidenced-based relevant guidelines and principles.	[Remove]
Require ongoing data collection, research and evaluation into outcomes and utility.	[Remove]

The MRAC noted that unlike the first 7 Principles, Principles 8, 9 and 10 apply to Medicare as a whole, rather than being specific to telehealth. The MRAC also noted that the overarching MBS rules apply equally to telehealth. While strongly supporting best practice and ongoing research, the MRAC therefore recommended the removal of Principles 8, 9 and 10.

Recommendation 1: Adopt the revised MBS Telehealth Principles.

Telehealth services review

Optimal telehealth care, and phone and video services

The MRAC recalled the evidence for comparing telehealth modalities (see [Telehealth vs face-to-face consultations](#), [Telehealth as a substitute for in-person care](#) and [Video vs telephone consultations](#)).

The MRAC considered that changes to telehealth services over time resulted in an increase of telehealth consultations by video, but it had potentially resulted in inequitable access to telehealth for some populations.

Some research has been published on video-based telehealth, but evidence from direct comparison of outcomes from video and telephone services remains scarce. Expert opinion and anecdotal evidence suggested that video would be preferable to telephone and result in better care, especially when:

- diagnosing a condition with visual signs or if measurements need to be validated
- consulting about a condition where it is important to observe the patient (for example, a patient experiencing a psychotic episode or a patient who has an eating disorder)
- paediatric patients are involved.

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). For example, if a patient requested a phone consultation but the clinician felt it was not clinically inappropriate, then the clinician would reserve the right to refuse to provide that type of service. These decisions should be clearly communicated to the patient. On the other hand, patients should be able to access telehealth if it is clinically appropriate.

The MRAC identified the following telehealth services to be in scope for reintroduction:

- GP Chronic Disease Management plans and reviews
- subsequent consultations for consultant physicians as part of ongoing care (see Table 2)

Table 2. Subsequent consultations

Service	Face-to-face item	Video item	Telephone items
Consultant physician. Subsequent attendance	116	91825	New Item
Consultant physician, Subsequent assessment	133	92423	New Item
Neurosurgeon, subsequent attendance	6011	92612	New Item
Neurosurgeon, subsequent attendance	6013	92613	New Item
Neurosurgeon, subsequent attendance	6015	92614	New Item
Geriatrician, review a management plan,	143	92624	New Item
Consultant psychiatrist, review management plan	293	92436	New Item
Consultant psychiatrist, review management plan	293	92436	New Item
Paediatrician, to review an eating disorder plan	90267	92173	New Item

The MRAC also pointed to MyMedicare as a potential eligibility criterion that could be applied to GP items involving complex care and planning, to ensure the existence of an ongoing clinical relationship between a patient and their GP and practice.

Also see [non-GP specialist attendances](#) for additional information and recommendations regarding telehealth items for this group of clinicians.

Recommendation 2: Reintroduce a) GP telephone services with a known clinician; and b) subsequent consultant clinician telephone services as options for patients receiving continuing care.

Reimbursing asynchronous care

The MRAC noted that, currently, the MBS only supports the synchronous delivery of telehealth services that are analogous to in-person consultations. These are synchronous (real-time) services for which the patient must be present for the clinician to bill Medicare. For many common items, it is the amount of time with the patient that determines the appropriate item to claim.

The MBS Review Taskforce and the Medical Services Advisory Committee (MSAC) have previously received submissions advocating for MBS items for asynchronous care, such as for time taken for correspondence, writing referrals, filling in forms, taking notes or reviewing reports. Rather than items for consultations, these types of activities may be more closely aligned with items for services that are outside the legal definition of professional attendance – for example, pathology and other specific diagnostic services, and case conferences or contributions to patients’ care plans.

The MRAC specifically noted MSAC’s decision in 2017 to not support an application for [specialist dermatology services delivered by asynchronous store and forward technology](#), due to no benefits in safety, effectiveness or cost-effectiveness. The MRAC also considered that, to an extent, administrative tasks should be considered as part of the high-value care that clinicians are already providing to a patient as part of the initial service – for example, surgical fees that include the surgery and follow-up consultations.

The MRAC determined it was difficult to make generalised recommendations on asynchronous services, as the scope of services provided by different specialities are so broad. In addition, remuneration for asynchronous services does not fit with the MBS framework of payment for services provided to a patient. There was a perceived incompatibility with the intent of such items to be for payment of providers, while the MBS is foremost for the payment of rebates to patients. In the context of bulk billed services, such an approach had potential to introduce new risks of fraud to the MBS program, and generally it may be difficult to ensure claims were appropriate and represented value to patients and funders.

Overall, the MRAC considered it inappropriate for additional MBS items to be created to compensate for the administrative workload many clinicians are facing. The MRAC determined that it may be more appropriate to instead review the remuneration for some MBS items so that it better reflects current administration requirements for a complete service.

However, the MRAC acknowledged that for many clinicians this administrative workload is increasing. The MRAC considered that longer time-tiered MBS items may be appropriate for patients who require substantial extra work. It was also noted some untimed but annual frequency-limited items such as chronic disease and mental health planning were already associated with higher fees for GPs to assume additional administrative tasks (compared to a regular time-tiered consultation).

The MRAC also recommended exploring other funding pathways that could remunerate clinicians for this type of work. The MRAC noted the opportunities MyMedicare may provide for recognising additional time that can be associated with managing some patients in primary care. The following MBS services and incentives will be available to practices that are registered in MyMedicare:

- MBS-funded telephone calls and access to a triple bulk-billing incentive for longer MBS telehealth consultations for eligible patients
- blended funding payments for general practices to support people with conditions that require them to frequently use hospital services
- [General Practice in in Aged Care Incentive](#)
- chronic disease management items non-exclusively linked to a patient's registration.

MyMedicare offers the potential to remunerate the general practice or the clinician, or both. However, the MRAC acknowledged that MyMedicare framework limits the types of clinicians that can be remunerated. In acknowledgement of the risks identified, solutions which could apply for non-GP specialists and other providers unlikely to align with a MyMedicare practice warranted consideration. It was also noted that there was emerging potential for increased automation of administrative tasks and reduced individual burden of this work would restore or permit more time with patients.

Recommendation 3: Consider how MyMedicare and other non-MBS funding options could better remunerate clinicians directly for the asynchronous and non-contact work that is often associated with managing patients.

Telehealth eligibility requirements and exemptions

As of March 2024, GPs and other clinicians working in general practice can only provide MBS-rebated telehealth services if they have an existing and continuous relationship with a patient. This means that patients must have seen their GP or another clinician within the same practice face-to-face at least once in the previous 12 months (known as the 12-month rule or the 1 in 12 rule). The rationale for these eligibility requirements is to prevent fragmentation of care and foster continuity of care which is associated with the best clinical outcomes.

These requirements were introduced in July 2020 in response to expert advice, along with exemptions intended to support access for vulnerable patients and scenarios when patients have an acute need for health assessment or advice and their regular GP is unavailable.

Exemptions to the established clinical relationship have changed over time as part of the response to the COVID-19 pandemic. This included temporary MBS items for GP consultations for nicotine cessation, BBVSR, pregnancy counselling and mental health, introduced in 2021. The intention was to ensure access to these services when face-to-face consultations were not possible due to quarantine or social distancing restrictions.

The MRAC noted the lack of general support for condition-specific MBS telehealth items from the Royal Australian College of General Practitioners and the Australian Medical Association. However, the MRAC considered that condition-specific telehealth items may improve access for some populations where access is a barrier to obtaining high-quality health care.

The MRAC also considered that patients eligibility for GP telehealth services could be supported by the MyMedicare model. MyMedicare formally recognises a patient's relationship with their

registered general practice, and qualification also has face-to-face requirements. The MRAC noted that this was already an eligibility pathway for GP Level C (longer than 20 minutes) and Level D (longer than 40 minutes) consultations, and linkage to GP items for chronic disease management was forthcoming, from November 2024. The MRAC considered that the similarities of MyMedicare registration and the existing clinical relationship requirements meant that MyMedicare registration could provide an alternative pathway to recognise patients' eligibility for MBS GP telehealth services generally.

The MRAC referred to previous general conclusions (see [Populations and services where access can be optimised with telehealth](#)) to inform the following recommendations for ongoing eligibility requirements and exemptions.

Nicotine cessation temporary MBS items

Note: The MRAC considered these MBS items in 2023, and the MRAC interim recommendation to cease such items was actioned by the Department of Health and Aged Care from 1 January 2024.

The MRAC noted that condition-specific MBS telehealth items exempt from usual eligibility requirements could result in some more commercially oriented service models. There is some evidence of this in MBS data, with providers that appear to focus solely on telehealth nicotine cessation services.

However, a typical 'episode of care' with the use of these MBS items was one consultation between a patient and provider, and this did not align with expectations of clinical management of nicotine dependence. The MRAC also noted that PBS data did not reveal any change in dispensing of PBS nicotine cessation therapies after the introduction of the specific GP telehealth items. This is interpreted to indicate that the nicotine cessation temporary MBS items did not interact with or change practitioners' and patients' behaviour in relation to PBS nicotine cessation therapies. However, there are limitations to this analysis, as factors such as medicine availability may impact PBS statistics.

Acknowledging recently renewed commitments to prevention and reduction of nicotine dependence by all Australian states and territories, the MRAC noted that GPs were well trained in providing nicotine cessation services. The MRAC considered that these services would be available and more effective from patients' usual GPs using generic MBS items for consultations. In this context and with no evidence temporary GP nicotine cessation items improved access to evidence-based therapies, there was no need for these MBS items to continue beyond their scheduled expiry of 31 December 2023.

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

Temporary MBS BBVSR items

A small number of approved prescribers for some medications and privacy concerns have been cited as reasons people may seek alternative providers to their regular GP for some sexual-health related consultations. The GP BBVSR telehealth services can be used to provide time-critical treatment, including but not limited to medical termination and pre-exposure prophylaxis for human immunodeficiency virus.

The MRAC considered that access to BBVSR services served a more obviously unmet clinical need and services to a more vulnerable population, in contrast to telehealth nicotine cessation services. Overall, there was an ongoing role for specific BBVSR items and their exemption to existing clinical relationship requirements, and that these items were likely to improve access without being a high risk for misuse.

The MRAC noted stakeholder feedback suggesting that patient privacy could still be compromised when booking BBVSR telehealth services, but that this risk was the same for any telehealth booking, not just for BBVSR.

The MRAC also noted stakeholder feedback suggesting that removing the requirement for a GP referral for non-GP specialist BBVSR services, which began in 2021, would increase access to such specialised services. However, the general principle of GP referral remains important for avoiding fragmentation of care where possible, and that even in the case of episodes requiring specialist referral, joint care with a GP that may provide more frequent consultations with the patient was desirable.

The MRAC noted that these temporary items and exemptions expire on 30 June 2024.

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

Continuation of exemption for non-directive pregnancy counselling MBS items

The MRAC noted from 2022-23 MBS data, that non-directive pregnancy counselling MBS items were claimed a total of 35,000 times and approximately 6000 of these were by telehealth. The MRAC noted that some co-claiming occurs (about 35% of the time), with the most common combination being a face-to-face pregnancy counselling item followed by MBS items [23](#) or [36](#). The MRAC considered it unnecessary to continue the exemption for pregnancy counselling items, noting that many services may be superseded by making GP BBVSR items permanent, or may be provided as part of other GP telehealth services, including in relation to mental health where consideration may be given to perinatal depression. However, current BBVSR items may need to be updated to ensure they allow for all services currently provided under non-directive pregnancy counselling.

The long-term relevance of GP non-directive pregnancy items may also need to be considered in the context of concurrent or future reviews of mental health and GP MBS items.

The MRAC noted that the exemption for non-directive pregnancy counselling MBS items expires on 30 June 2024.

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

Continuation of exemption for GP mental health MBS items

The MRAC considered that removing the exemption on mental health telehealth services may decrease access for some vulnerable populations that may not have an ongoing relationship with a regular GP or general practice. Examples include young people, university students who have moved away from home, people in rural or remote areas, and those in domestic violence situations. In

addition, the MRAC considered that many people with mental health conditions are disengaged from a regular practice. The MRAC noted the mental health and suicide statistics in Australia and determined that ensuring access to MBS mental health services was of paramount importance.

The MRAC noted that a GP referral is required to access psychological specialist services, and considered that timely referral and/or confident management by a GP specialising in mental health therapy was important. However, the MRAC was conscious of the unintended consequences of exemptions to access telehealth MBS items, such as encouraging online-only services that focus on quantity over quality, which may result in low-value, fragmented care. The MRAC was also concerned that mental health planning items delivered by online services would result in the patient not appropriately being followed up and their progress would not be reviewed. The MRAC was careful to acknowledge that not all online-only services result in low-value care, and some business models may be suitable. The MRAC queried whether there were opportunities to introduce rebates and incentives (and disincentives) to avoid undermining face-to-face services.

The MRAC considered different thresholds for patients' eligibility for MBS GP mental health services, and noted that [MyMedicare](#), as it is proposed for MBS chronic disease items would be a suitable model for GP mental health planning and reviews of plans. This would introduce contemporary GP telehealth eligibility requirements which encourage continuity of care, and while no explicit requirement applies to GPs who provide mental health treatment plans to be the primary GP for the recipient of the plan, it was noted that planning was intended to be holistic and inclusive of biological, psychological and social factors (see [MBS Note AN.0.56](#)).

While MyMedicare could apply to planning and review items, it was essential that treatment services, including the GP mental health consultations longer than 20 minutes (for example, MBS items 92115 and 92127) and GP Focused Psychological Strategies continued to be exempt from telehealth eligibility requirements. This approach ensured that GP mental health treatment services by phone and video were as accessible as mental health treatment from allied mental health professionals and consultant psychiatrists.

The MRAC emphasised video as the preferred telehealth modality for mental health services, as it is often important to be able to observe the patient. For non-GP providers the majority of telehealth services being provided by video is already the case. The MRAC referred to Principles 1 and 2; that patient preference must be considered and that clinicians must deliver a service that they determine to be safe and effective.

The MRAC noted that any mental health telehealth services should comply with the [National Safety and Quality Digital Mental Health Standards](#), acknowledging that these are voluntary.

Recommendation 7:

- a) Retain eligibility exemptions for telehealth GP mental health MBS treatment items.**
- b) Make telehealth GP mental health MBS planning and review items non-exclusively linked to MyMedicare.**

Continuity of care and consistency of eligibility requirements

The MRAC discussed the eligibility requirements and how these exist to support the concept of continuity of care. The MRAC did not think these were applied consistently, and that some telehealth items for certain clinician groups did not currently have any eligibility requirements – such as nurse practitioners and allied health. The MRAC considered it appropriate to apply the existing

relationship rule to nurse practitioner telehealth items as it applies to similar consultations provided by GPs, as underpinned by Principles 1, 2 and 3.

In recognising the importance of balancing continuity of care with urgent scenarios, MRAC also considered relevant exemptions for patients seeking sexual and reproductive healthcare and specific mental health services from Nurse Practitioners. This would mean better recognising scope of practice, potentially with specific MBS items, similarly to what is available for GP telehealth services.

Not all telehealth services that should have an established clinical relationship require it to be defined the same way. While an existing clinical relationship requirement based on an in-person assessment for MBS midwifery telehealth services would also emphasise continuity of care, antenatal and postnatal telehealth services may be better defined by episodes of pregnancy.

The MRAC did not consider it necessary to apply eligibility requirements to allied health telehealth services. Allied health services in relation to chronic disease management and mental health treatment are already expected to require planning, referral and coordination by a GP responsible for most of a patient's care. Furthermore, in combination with annual caps on subsidised services the MRAC considered it unlikely that services are misused.

Recommendation 8: Introduce eligibility requirements and exemptions to nurse practitioner MBS items and midwifery MBS telehealth items, including selected services which have no established clinical relationship requirement.

Non-GP specialist attendances

The MRAC agreed that continuity of care and consistency in policy was important to implement across the broad range of MBS telehealth items. The MRAC noted that, currently, initial non-GP specialist consultations could be claimed via face-to-face or video consultation. This means care may commence and continue by telehealth without an obligation for any in-person assessment, even for new patients.

The MRAC discussed the appropriateness of re-instating a telephone equivalent of [MBS item 116](#), and how the recent removal of this has negatively impacted some specialist services. The MRAC noted that many specialists are instead claiming MBS item 119 in place of item 116, as this item is available for telephone consultations, and some specialists are not billing for a follow-up telephone consultation at all. The MRAC considered that there are instances where clinicians could provide safe and effective care via telephone – for example, after a face-to-face consultation, where patients may have travelled long distances for that initial consultation.

The MRAC acknowledged that there are circumstances where patient care would not be negatively affected by a telehealth service with a non-GP specialist for an initial consultation. For some patients, it may be advantageous to have a telehealth consult before a face to face – for example, to provide the opportunity to plan the course of treatment before a patient attends a face-to-face consultation.

The MRAC also acknowledged stakeholder feedback that application of a 12-month rule that applies to GP telehealth, or similar, across all non-GP specialist groups may disadvantage many patients. This would most likely impact those who need to travel long distances to see a non-GP specialist, and those that are housebound due to physical or mental health conditions. The MRAC considered

that [home visits and patient-end support services](#) may help in these circumstances, with the additional benefit of supporting team-based care (see Recommendation 10)

Overall, the MRAC believed it important that the telehealth service provided be of high quality, and that it may be more appropriate to consider a standard or process of work within clinical governance groups to optimise telehealth for initial consultations, rather than limit patient access to initial consultations by telehealth.

Recommendation 9: Maintain current telehealth policies for MBS video telehealth items that are for initial consultations with non-GP specialists.

Home visits and patient-end support services

The MRAC discussed the GP home visits as a service with declining annual volumes and which may be being superseded by telehealth in many circumstances. There are, however, patient populations at risk of perverse and unintended reductions in access to comprehensive consultations, if telehealth were their only option.

Acknowledging great diversity in practice models, including scenarios where home visits are routine, the MRAC heard that, for many GPs, these services are less commercially viable compared to services provided in consultation rooms or telehealth. The MRAC acknowledged that face-to-face services remained important for some housebound patients, and discussed whether home visits should be better incentivised. While an amendment to relevant rebates is an option, the MRAC recommended an alternative approach harnessing patient-end support for telehealth consultation with the patient's GP. This would involve nurses or allied health providers under GP stewardship beside the patient to facilitate the service. The MRAC noted that this was more consistent with earlier advice from the MBS Review Taskforce in relation to GP services (MBS Taskforce 2020b).

The MRAC also noted stakeholder feedback that changes in 2022 to MBS items for GP/other clinician patient-end support for telehealth with private non-GP specialists and consultant physicians created inequity of access, particularly for some people living in rural and regional areas and for older patients. While such services continue to be available with nurses and Aboriginal Health Workers assisting the patient, increases in services by these providers have not overcome the reduction resulting from removal of the GP items. It was recommended that GP patient-end support items be reinstated, and the MRAC referred to Principles 1, 2 and 6 to support this recommendation.

Previous GP patient-end support items were based on consultations between GPs and private non-GP specialists, and the creation of new patient-end support services represents an opportunity to consider how consultations with non-GP specialists working in public hospital settings may also be included. It was noted by the MRAC that patient-end support for consultations with private practitioners only was a shortcoming, particularly in relation to First Nations health and patients who cannot afford private non-GP specialist care.

The MRAC acknowledged that residents and staff of aged care facilities rely on telehealth consultation with GPs. Often this relates to care for residents who have cognitive or other impairments that make them unable to participate in their own care, and there needs to be a way to enable communication between carers and GPs. For many residents, the consultation is between a staff member or nurse and the GP without patient involvement.

There are MBS GP contributions to chronic disease and multidisciplinary care plans for patients in residential aged care (e.g. MBS Item 232 and 731) which may be appropriate in these scenarios; however, these items are frequency-limited to once every 3 months. Similarly, while multidisciplinary case conferencing (e.g. refer MBS items 735 – 758) is an option, it was not always possible to satisfy the minimum participant requirements when the demands for health advice are unplanned or urgent. The MRAC noted that, without flexible patient-end support options for these residents, there is increased likelihood of waiting for locum GPs. This would risk delaying care or compromising continuity of care; or sending residents to emergency care and increasing the load on hospitals unnecessarily.

In considering its recommendation for patient-end support, the MRAC highlighted the value of these services with potential for a broad range of patients to benefit, not just patients who experience profound challenges with attendance to a clinic or in aged care. The participation of an additional provider who can contribute expertise efficiently may mean better testing, diagnoses and team care, with the potential to improve the skills of practitioners responsible for most of a patient's services. The MRAC suggested that facilitated GP telehealth consultations with a nurse practitioner or allied provider at the patient's side could qualify patients for ongoing access to GP telehealth, as a service which satisfies the requirement for a face-to-face service within the previous 12-months.

Recommendation 10: Expand patient-end support by:

a) Reintroducing GP patient end support for telehealth with a non-GP specialist and extend it to include nurse practitioners.

b) Extend patient end support to include nurse practitioners, allied health, and Aboriginal and Torres Strait Islander Health Practitioner patient-end support for telehealth with a GP.

c) Introduce a support type service for GP telehealth in a residential aged care setting, when GPs advise patients' carers or registered nurse in lieu of the patient (in circumstances where the patient lacks capacity).

If the MBS is not a suitable funding pathway for patient-end support services, explore other funding possibilities (such as MyMedicare, practice incentives, Primary Health Networks, or a new funding initiative).

Consultation and feedback review process

Consultation with relevant and interested organisations, peak bodies and consumers is considered essential in the formulation of advice to government on recommended changes to MBS items. The MRAC and its working groups seek feedback on their understanding of the existing model of care and issues of consideration, with particular emphasis on any (yet) unidentified consequences that may result from proposed changes.

All feedback provided through consultation processes is considered.

Telehealth Principles

A targeted stakeholder survey was conducted in May–July 2023 about the 10 MBS Review Taskforce Telehealth Principles, seeking ratings of agreement with each principle (in its current form) from 1 to 5 stars. The survey also included opportunity for written feedback.

Feedback received from this process was considered by the MRAC and used to inform proposed revisions to these Principles.

Consultation on the draft report and recommendations

On 25 September 2023, the MRAC Telehealth Post-Implementation Review Draft Report was published on the Department's Consultation Hub. Stakeholders were invited to submit feedback on the draft report over a six-week public consultation period, which closed on 6 November 2023.

Throughout this period, more than 450 responses were received from a variety of stakeholders, including clinicians, health organisations, peak bodies, consumers and other interested parties. The MRAC has carefully considered the diverse perspectives, experience and knowledge of these stakeholders' feedback when finalising its recommendations.

In general, stakeholders were largely supportive of recommendations 1–7 and 10.

Recommendations 8 had mixed feedback. Workforce concerns were raised for both maintaining current settings (with the expansion of online only business models seen as detrimental to quality care) and introducing eligibility and exemptions to nurse practitioner telehealth items (with the changes seen as having detrimental impacts on nurse practitioner business and scope of practice). The MRAC also determined that, overall, the intent of the recommendation was unclear to stakeholders, which appeared to drive some of the feedback, and therefore sought to improve clarity in its final recommendation 8.

Stakeholders were markedly unsupportive of recommendation 9. Some stakeholders appeared to (incorrectly) interpret that recommendation 9, if it were implemented, would remove telehealth completely for all non-GP specialist MBS telehealth items, which was not the MRAC's intention. However, the MRAC also acknowledged stakeholder concerns that making mandatory face-to-face initial consultations with non-GP specialists would negatively impact equity and access for many people, leading to poor health outcomes, and reversed its draft recommendation with updated wording to reflect this decision.

Finally, although recommendations 2 and 3, were broadly supported, the MRAC recognised that clarity was needed and thus amended the wording, but not intent, of the final recommendations 2 and 3.

Consumer Health Forum workshops

Two Consumer Health Forum workshops were held on 8–9 February 2024 on behalf of the department to better understand consumer experience and perception of telehealth, and to explore policy options. Each workshop had 10–15 participants, who explored the same topics.

MRAC noted that overall participants were in strong support of telehealth. They acknowledged that telehealth can remove barriers in terms of rural and remote location, time, and enhance access to specialist care, scripts and referrals. They also acknowledged limitations such as when a patient or provider has poor digital literacy, issues with technology, or when a physical examination is required.

MRAC acknowledged there were mixed views in terms of appropriate use of telehealth. Some participants thought telehealth is most beneficial in the context of a continuous relationship between a provider and the patient, yet others thought that telehealth could be effectively delivered to a new patient for a new condition. The provision of telehealth services for specialist consultations (including an initial consultation) was supported with the view that a referral from a GP to a Specialist should be sufficient to receive telehealth.

MRAC also acknowledged that there were mixed views from participants in terms of eligibility. Participants strongly supported the flexible delivery of telehealth and their right to choose. While majority recognised the benefits of an existing relationship, many participants did not support eligibility criteria being applied and argued against the 1 in 12 rule (stating it was complicated, undermined the concept of equivalence, impacted access, and did not make sense for a 'well' person).

In addition, patients had differing views about MyMedicare. Some considered it to be a good measure of eligibility, whereas others identified limitations as not every GP is participating and it may create a barrier to care.

Appendix A MBS Continuous Review and committee

Medicare Benefits Schedule Continuous Review

The Medicare Benefits Schedule (MBS) is a list of health professional services (items) subsidised by the Australian Government for health consumers. MBS items provide patient benefits for a wide range of health services including consultations, diagnostic tests, therapies and operations.

The MBS Continuous Review builds on the work of the MBS Review Taskforce (the Taskforce). From 2015 to 2020, the Taskforce provided the first extensive, line-by-line review of the MBS since its inception in 1984.

In October 2020, the Australian Government committed to establishing a continuous review framework for the MBS, consistent with recommendations from the Taskforce Final Report.

Established in 2021, the MBS Continuous Review allows for ongoing rigorous and comprehensive reviews of Medicare items and services by experts, on a continuous basis, to ensure that the MBS works for patients and supports health professionals to provide high-quality care.

Information on the Medicare Benefits Schedule (MBS) Continuous Review is available on the Australian Government Department of Health and Aged Care's website.

Medicare Benefits Schedule Review Advisory Committee

The MRAC is an independent, clinician and consumer-led, non-statutory committee, established to advise government on publicly funded services listed on the MBS.

The MRAC aims to improve patient access to high-value care through consideration of the appropriateness of existing MBS services, in addition to wider health reform solutions which may include alternate funding models or means of service provision and the addition of new services where a health technology assessment (HTA) is not appropriate.

Through review processes, the MRAC examines how the MBS is used in practice and recommends improvements based on contemporary clinical evidence. It also allows for continuous monitoring of previously implemented changes and assists with identification of priority areas where targeted research, investment or support is required, through the assessment of cross-speciality items, to maximise system benefits.

The MRAC:

- undertakes thematic assessments across the MBS to examine issues including, but not limited to, consistency between items, methods of service delivery and multidisciplinary models of care
- considers changes in service delivery that may inform both MBS and non-MBS approaches (such as alternative funding models) to improving patient health outcomes and deliver high-value care to the community
- considers applications from the sector for MBS changes where the informed considerations of the MRAC do not require a new stand-alone HTA assessment
- identifies key areas for review as informed by patterns and trends in MBS data and other identified evidence and data sources

- undertakes a progressive schedule of work that builds upon the work of the MBS Review Taskforce and aligns with government and Department of Health and Aged Care priorities
- provides clinical and service delivery advice on policy issues identified by the department, relevant to the scope of the committee.

The MRAC comprises practising clinicians, academics, health system experts and consumer representatives. The current MRAC membership is available on the Department of Health and Aged Care's [MRAC webpage](#).

MBS Continuous Review Guiding Principles

The following principles guide the deliberations and recommendations of the MBS Continuous Review:

a) The MBS:

- is structured to support coordinated care through the health system by
 - recognising the central role of general practice in coordinating care
 - facilitating communication through general practice to enable holistic coordinated care
- is designed to provide sustainable, high-value, evidence-based and appropriate care to the Australian community
 - item descriptors and explanatory notes are designed to ensure clarity, consistency and appropriate use by health professionals
- promotes equity according to patient need
- ensures accountability to the patient and to the Australian community (taxpayer)
- is continuously evaluated and revised to provide high-value health care to the Australian community.

b) Service providers of the MBS:

- understand the purpose and requirements of the MBS
- utilise the MBS for evidence-based care
- ensure patients are informed of the benefits, risks and harms of services, and are engaged through shared decision making
- utilise decision support tools, Patient Reported Outcome and Experience Measures where available and appropriate.

c) Consumers of the MBS:

- are encouraged to become partners in their own care to the extent they choose
- are encouraged to participate in MBS reviews so patient health care needs can be prioritised in design and implementation of MBS items.

The MRAC and its working groups recognise that general practice general practitioners are specialists in their own right. Use of the term 'general practice', both within this report and in the MBS itself, does not imply that general practitioners are not specialists.

The MRAC notes that the MBS is one of several available approaches to funding health services. The MRAC and its working groups apply a whole-of-health-care-system approach to its reviews.

Government consideration

If the Australian Government agrees to the implementation of recommendations, it will be communicated through government announcement.

Information will also be made available on the Department of Health and Aged Care website.

References

ABS (Australian Bureau of Statistics) (2023) [Patient experiences in Australia: summary of findings](#), ABS website, accessed 5 April 2024. ANAO (Australian National Audit Office) (2023) [Expansion of telehealth services](#), ANAO, Canberra.

Butler DC, Joshy G, Douglas KA, Bin Sayeed MS, Welsh, Douglas A, Korda RJ and the ANU Telehealth in Primary Care Study team (2023) '[Changes in general practice use and costs with COVID-19 and telehealth initiatives: analysis of Australian whole-population linked data](#)', *British Journal of General Practice* 73(730):e364–e373.

Caffery L, De Camargo Catapan S, Taylor M, Kelly J, Haydon H, Smith A and Snoswell C (2024) 'Telephone versus video consultations: A systematic review of comparative [effectiveness studies and guidance for choosing the most appropriate modality](#)', *Journal of Telemedicine and Telecare*.

Hardie R, Sezgin G, Imai C, Gault E, McGuire P, Kashif Sheikh M, Pearce C, Badrick T and Georgiou A (2022) 'Telehealth-based diagnostic testing in general practice during the COVID-19 pandemic: an observational study', *British Journal of General Practice* 6 (1).

Health Design Lab (unpublished) *Understanding the use of video telehealth in general practice*, Australian Government Department of Health and Aged Care, Canberra.

MBS Taskforce (Medicare Benefits Schedule Review Taskforce) (2020a) [Telehealth recommendations 2020](#), prepared for the Australian Government Department of Health, Canberra.

MBS Taskforce (Medicare Benefits Schedule Review Taskforce) (2020b). [Taskforce findings – General Practice and Primary Care Clinical Committee report](#), prepared for the Australian Government Department of Health, Canberra.

Scott AM, Krzyaniak N, Cardona M, Greenwood H, Clark J, Peiris R and Glasziou P (2021) *Final report: telehealth in primary care*, prepared for the Commonwealth Department of Health, Canberra.

Scott AM, Atkins T, Bakhit M, Greenwood H, Clark J, Byambasuren O and Glasziou P (2023a) *Interim report: telehealth work package A*, prepared for the Commonwealth Department of Health and Aged Care, Canberra.

Scott AM, Atkins T, Bakhit M, Greenwood H, Clark J, Byambasuren O and Glasziou P (2023b) *Interim report: telehealth work package B*, prepared for the Commonwealth Department of Health and Aged Care, Canberra.

Scott AM and Glasziou P (2023) *Telehealth reviews – work package C: update*, prepared for the Commonwealth Department of Health and Aged Care, Canberra.

Wabe, N, Thomas J, Sezgin G, Kashif Sheikh M, Gault E, Georgiou A (2022) '[Medication prescribing in face-to-face versus telehealth consultations during the COVID-19 pandemic in Australian general practice: a retrospective observational study](#)', *British Journal of General Practice* 6 (1).