



Australian Government

Medical Services Advisory Committee

## Public Summary Document

### ***Application No. 1360.1 – Specialist dermatology services delivered by asynchronous store and forward technology***

**Applicant:** Australian College of Dermatologists

**Date of MSAC consideration:** MSAC 69<sup>th</sup> Meeting, 6-7 April 2017

Context for decision: MSAC makes its advice in accordance with its Terms of Reference, [visit the MSAC website](#)

#### **1. Purpose of application**

A resubmission for two new Medicare Benefits Schedule (MBS) listings of specialist dermatology services delivered by asynchronous store and forward technology (ADT) for patients with inflammatory skin conditions was received from the Australasian College of Dermatologists by the Department of Health (the Department).

#### **2. MSAC's advice to the Minister**

After considering the evidence presented in relation to the safety, clinical effectiveness and cost-effectiveness MSAC did not support public funding of specialist dermatology services delivered by asynchronous store and forward technology. MSAC was still not convinced of the clinical place and effectiveness of this service compared to using the presently funded Telehealth MBS items for investigative services in dermatology. MSAC considered that there might be emerging unmet clinical need, especially if there is further reduction in use of these existing services, particularly in rural and remote areas. To enable a better comparison and determine the potential use of the proposed service, MSAC requested further effectiveness and utilisation data on the existing Telehealth services for investigative purposes in dermatology.

MSAC also requested there be further consultation with rural doctors and health centres regarding the reasons behind the changing patterns of Telehealth services, especially in the context of dermatological investigations, and thus the potential clinical place and utilisation of this service.

Any resubmission would need to be considered by ESC.

#### **3. Summary of consideration and rationale for MSAC's advice**

MSAC noted that the application requesting MBS listing of specialist dermatology services delivered offline by ADT had been considered in November 2014. For the proposed service, digital images and patient history are forwarded to a dermatologist. The dermatologist

provides a diagnosis and treatment recommendations to the GP, who is then responsible for patient management. MSAC recalled that it had not supported public funding of the service in November 2014 due to uncertain clinical effectiveness and cost effectiveness ([MSAC Public Summary Document \(PSD\) Application 1360](#), November 2014).

In considering this resubmission, MSAC acknowledged a potential unmet clinical need for access to specialist dermatologist services for patients in remote populations remained. MSAC noted the shortage of dermatologists and considerable waiting times for specialist consultation more broadly.

MSAC noted federal funding already exists for a similar service (TeleDerm), which also uses store and forward technology, hosted by the Australian College of Rural and Remote Medicine (ACCRM). MSAC considered that further evidence regarding the use of TeleDerm may be informative, particularly the number and type of patients using the service and any available evidence of its benefit in terms of patient outcomes. MSAC advised that ongoing funding of ADT via this arrangement may be more appropriate than an MBS listing.

MSAC noted that the eligible population in the resubmission includes only patients in country and regional locations who reside at least 15km for the nearest dermatology specialist. The proposed service is intended for patients with suspected skin cancer or inflammatory skin conditions who require referral to a specialist dermatologist. MSAC noted that patients who require dermoscopy for diagnosis of melanoma would be excluded. The resubmission includes face to face consultation as the gold standard and Telehealth videoconferencing (VC) or TeleDerm services where face to face consultations is not possible. The comparators included are as requested by MSAC for the resubmission.

MSAC noted that the proposed service is now considered as an investigation rather than a consultation due to the fact that the patient is not present during the provision of the service. MSAC questioned the appropriateness of this classification. MSAC noted that an investigation does not require a named referral, however, identifying clinical information is provided when rendering this service. MSAC was also concerned as to how this classification might apply to other dermatology services. MSAC noted that considering the proposed service as an investigation would have implications for the type of evidence MSAC requires to assess effectiveness, particularly regarding clinical utility, which has not been assessed in this application.

No new evidence on effectiveness or safety is provided in the resubmission. MSAC considered that, due to the poor quality of evidence available, uncertainty remains regarding both safety and effectiveness of ADT relative to face to face consultation. MSAC noted that ADT may have superior comparative safety to TeleDerm and VC due to higher quality imaging but that there was no confirming evidence available. MSAC noted that there was no evidence that ADT is more effective than VC or TeleDerm. MSAC noted that concordance with face to face consultations was inconsistent between studies, ranging between 0.46 and 0.91 in the 30 studies included in the meta-analysis. MSAC were concerned that concordance was low, even in some of the more recent studies.

MSAC noted that the base case evaluation suggests that ADT is more expensive and less effective if it replaces all VC and TeleDerm services. The economic evaluation suggests that ADT is more expensive and less effective in comparison to face to face dermatology consultations. MSAC were concerned that no downstream consequences from differences in concordance between ADT and face to face consultations, such as delayed diagnosis of skin cancer, were modelled in the economic evaluation. MSAC noted that the increased costs for

ADT are largely due to additional GP consultations. MSAC noted that the incremental cost effectiveness ratio (ICER) was highly sensitive to travel costs for patients.

MSAC noted that the fee requested appears high and requires further justification.

MSAC noted that estimates of utilisation are based on the implications to the MBS if the same proportion of the population who currently access specialist dermatology services in major Australian cities were to access them in the eligible areas for Telehealth. The estimated cost to the MBS for ADT services is \$14.7 million in year one, increasing to \$16.0 million in year five after listing. MSAC considered that the estimates of volume are uncertain and noted that the applicant disagreed with the approach taken to determine financial impact estimates. MSAC noted that if the population was limited to remote and very remote patients the eligible population and total costs for the service would be reduced by 90% to around \$1.47 million per year. To enable a better comparison and determine the potential use of the proposed service, MSAC requested further utilisation data on the existing Telehealth services for investigative purposes in dermatology.

MSAC questioned whether GPs would benefit from the availability of ADT or would be more likely to do a biopsy and rely on histopathology for diagnosis in many of these patients, negating the need for travel to a specialist dermatologist. MSAC suggested that the difference between rural areas and major cities in specialist referral rates may be due to differences in rural GPs' approach to patient care, rather than reflecting an unmet need, which would have implications for this application. MSAC advised that it would be informative to have substantive input from rural doctors and health centres regarding the reasons behind the apparent changing patterns of Telehealth services, especially in the context of dermatological investigations, and thus the potential clinical place and utilisation of this service.

After considering the evidence presented in relation to the safety, clinical effectiveness and cost-effectiveness MSAC did not support public funding of specialist dermatology services delivered by asynchronous store and forward technology due to uncertain effectiveness and cost-effectiveness. MSAC noted that any future applications for ADT would need to:

- address the requirements of a diagnostic test application, given that the service is considered an investigation;
- consider the reference standard as face to face consultation, with biopsy, VC and TeleDerm also included as comparators;
- include substantial consultation with rural doctors and health centres;
- provide evidence of usage patterns and outcomes for patients using the current TeleDerm service; and
- provide further justification of the requested fee.

#### **4. Background**

Application 1360 was considered at the November 2014 MSAC meeting. MSAC did not support public funding because of uncertain clinical effectiveness and cost-effectiveness due to:

- uncertainty that the appropriate comparator had been identified for comparative evaluation and costing;
- insufficient evidence regarding diagnostic performance equivalence between ADT and VC;
- uncertain cost-effectiveness of ADT against VC and with other existing services (e.g., Telederm);

- uncertainty that an interaction between the GP and dermatologist (only) meets the requirements of a consultation, which in all other cases includes direct interaction between the patient and the medical practitioner(s) billing for the item(s); and
- lack of clarity on the eligible population for those patients where it is proposed that eligibility be determined based on ‘disability’.

Amendments were made to the Protocol based on MSAC’s recommendations and were considered by PASC.

## **5. Prerequisites to implementation of any funding advice**

The specialist dermatologist may require training in the use of the ADT technology. The referrer may need training in the type of digital images (and how to obtain the clearest images) required by the dermatologist to prevent rejection of a consult or need for further images.

There is currently no Australian technical or medical guidance for photographic imaging for store-and-forward consultations. Technical guidance is available in the UK (Quality Standards for Teledermatology using store and forward images; British Association of Dermatologists, 2011) and the US (American Telemedicine Association Practice Guidelines for Teledermatology; American Telemedicine Association, 2007).

## **6. Proposal for public funding**

The application proposed changes to the MBS item descriptors to:

- address some of the privacy concerns
  - The patient will need to expressly consent to their clinical data being sent electronically; and
  - They are able to consent
- address some of the concerns about how often a specialist dermatologist can continue to ask for information
  - The person needs to be assessed as suitable for a ADT (it is hoped that guidelines developed by the college may outline what type of lesion or skin condition is most suitable for a referral for this type of consultation)
  - The referral must be to a form specified by the Australian College of Dermatologists (ACD). If image quality, lighting conditions and perspectives of the images based on their location is specified by the ACD this should minimise the need for a specialist to keep referring back to a GP.
- To address some of the concerns around when would a consultation be considered complete and could be billed; a specialist should only be able to bill when the referring GP has received the Management Plan from the specialist dermatologist. It should be the responsibility of the specialist or the ACD to minimise unnecessary requests to the GP for further information or images by clearly providing guidelines and training to GPs around their requirements.
- A subsequent consultation cannot be triggered by the specialist dermatologist but requires ongoing involvement of the GP
- Responsibility for the care of the patient’s skin condition resides with the specialist dermatologist who has accepted the consultation.

The revised proposed MBS item descriptors are shown in Table 1.

**Table 1 Revised Proposed MBS item Descriptor for ADT**

Category [category number] – [Category description]
<p>MBS [item number]  Dermatology-Asynchronous Initial Consultation for patients with inflammatory skin conditions or suspected skin cancer, who is not an admitted patient, and:</p> <ul style="list-style-type: none"> <li>a) resides in telehealth eligible areas, and, at the time of the attendance, at least 15 kms by road from the specialist; or</li> <li>b) is a care recipient at an eligible Residential Aged Care Facility; or</li> <li>c) is a patient of Aboriginal Medical Service; or</li> <li>d) is a patient of an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies</li> <li>e) <i>the person has been assessed as suitable for a ADT</i></li> <li>f) <i>the person has consented to their clinical data being sent electronically</i></li> <li>g) <i>the person has a referral from a GP to a standard prescribed by the ACD*</i></li> <li>h) <i>the treatment of the patient will be managed by a GP under guidance from the specialist dermatologist</i></li> <li>i) <i>after the service, the eligible dermatologist provides a Management Plan to the referring medical practitioner mentioned in paragraph (g)</i></li> </ul> <p>Fee: \$72.72  Referrer is required to complete dermatologist template and provide photos, both to a standard whereby the dermatologist can decide if asynchronous consultation is suitable</p>
<p>MBS [item number]  Dermatology-Asynchronous Follow-up Consultation for patients with inflammatory skin conditions or suspected skin cancer, who is not an admitted patient, and:</p> <ul style="list-style-type: none"> <li>a) resides in telehealth eligible areas, and, at the time of the attendance, at least 15 kms by road from the specialist; or</li> <li>b) is a care recipient at an eligible Residential Aged Care Facility; or</li> <li>c) is a patient of Aboriginal Medical Service; or</li> <li>d) is a patient of an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies</li> <li>e) <i>the person has previously been assessed as suitable for a ADT</i></li> <li>f) <i>the person has consented to their clinical data being sent electronically</i></li> <li>g) <i>the person has a referral from a GP to a standard prescribed by the ACD*</i></li> <li>h) <i>the treatment of the patient will be managed by a GP under guidance from the specialist dermatologist</i></li> <li>i) <i>The referring GP provides new information in the form of digital images or clinical information</i></li> <li>k) <i>The patient has already been seen under MBS item XXX (item above) and the referring GP has received a Management Plan from the dermatologist for this patient's skin condition</i></li> <li>j) <i>after the service, the eligible dermatologist provides a Management Plan to the referring medical practitioner mentioned in paragraph (g)</i></li> </ul> <p>Fee: \$36.36  *Referrer is required to complete dermatologist template and provide photos, both to a standard whereby the dermatologist can decide if asynchronous consultation is suitable</p>

The proposed descriptor has not specified an MBS category under which the item will be provided. In previous assessment MSAC 1360, the item descriptor was placed under Category 1 as the service was described as a professional consultation, and this is where the comparators are placed. Departmental advice was that the proposed service may not be appropriate for inclusion within the professional attendances section of the MBS. PASC advised that the issues regarding the classification of the service for MBS purposes, and its potential location within the schedule should be resolved in consultation with the Department.

The proposed fee is 85% of the Fees for MBS items 104 and 105. The rationale for the requested fee was that it is a balance between increased dermatology responsibility and skills, plus risk, reduced by the time taken and convenience of the proposed SAF technology.

## 7. Summary of Public Consultation Feedback/Consumer Issues

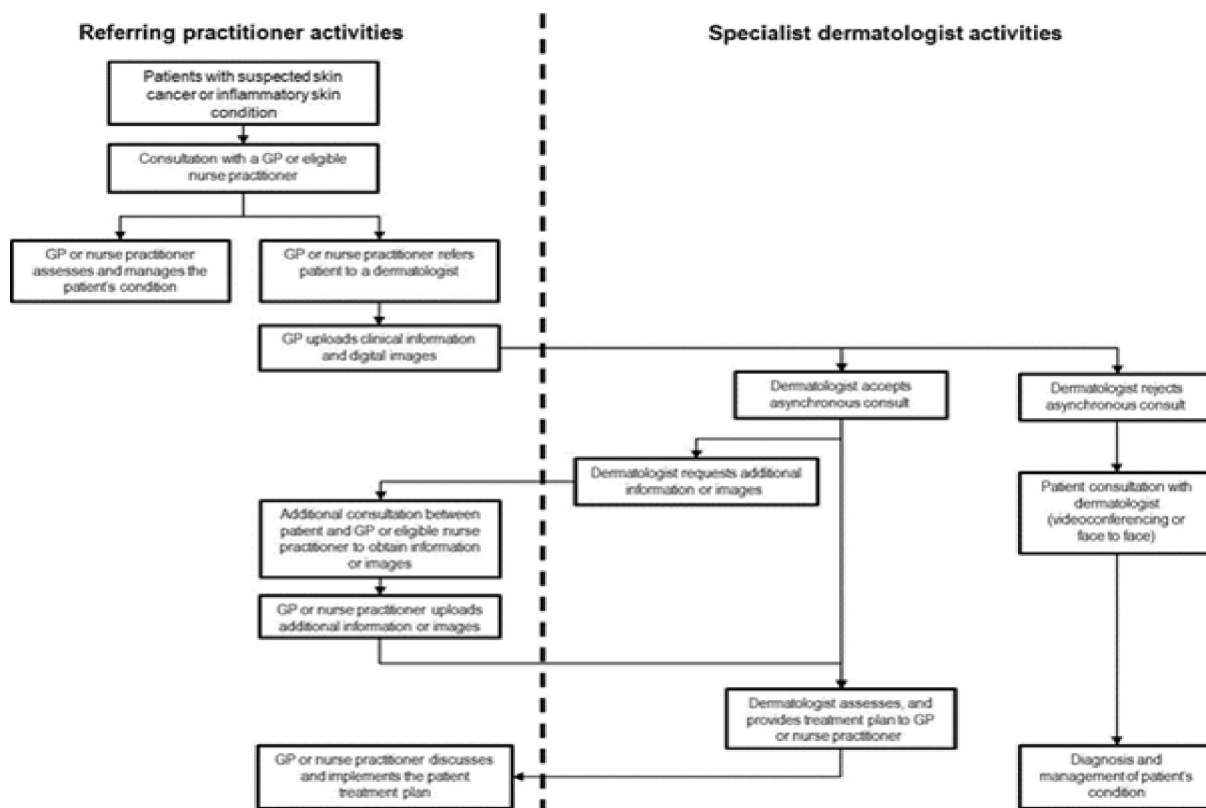
The Protocol Advisory Sub-Committee (PASC) public consultation received one response from an organisation which suggested that the population should be extended to the ‘whole population of Australia’. Also that image standards, software usage, General Practitioner

Also see [PSD for Application 1360](#) on the MSAC website.

## 8. Proposed intervention’s place in clinical management

Under the current situation where ADT is not available, a patient in an Eligible Area, with suspected skin cancer or skin inflammation, will be referred by a GP (or another specialist or participating nurse practitioner), to a specialist dermatologist using a written referral. The dermatologist has a face-to-face consult with the patient and provides them with a diagnosis, treatment and advice. Alternatively, this consultation may take the form of a videoconference, in which all parties are present at the same time, referrer, patient and consultant, to discuss the patient’s skin condition. In the event that a videoconference is insufficient to manage the patient’s condition, patients may have to travel for a face-to-face consultation with a specialist dermatologist.

Figure 1 Proposed pathway for managing patients with inflammatory skin conditions or skin lesions



The clinical pathway incorporating the proposed service is shown in Figure 1. Under the proposed clinical pathway where ADT is available, a patient with suspected skin cancer or skin inflammation, has the choice of being referred by their GP (or another specialist or participating nurse practitioner) for either a synchronous or asynchronous consultation to a specialist dermatologist using a written referral after receiving the patient’s consent. It is anticipated that this will increase access to dermatology services for patients in the Eligible Areas of Australia.

Synchronous referrals will remain the same, but in the case of an asynchronous referral, the referral will be in the form of digital images, and a completed template according to guidelines prepared by the dermatologist. The GP or referrer will access the dermatologist's template and provide the required clinical information and digital images to a secure portal or web. The dermatologist will then access the online information, and if the information and images are of sufficient quality, will provide an online report to the referrer with a diagnosis and treatment plan. If the information or images are inadequate the dermatologist will request additional information, after which they will provide the referrer with a diagnosis and treatment plan. If the dermatologist decides the patient is unsuitable for an asynchronous consultation they will advise the GP accordingly. Where the specialist dermatologist provides a diagnosis and treatment plan back to the referrer, the referrer then will provide feedback to the patient and implement the dermatologist's advice. Similar to the current situation, depending on the skin condition a follow-up appointment may be required but, instead of a face-to-face consult, this may also be an asynchronous consultation via telecommunications.

## **9. Comparator**

Face-to-face and video conferencing based consultations with specialist dermatologists are the nominated comparators for this intervention, as both types of synchronous consultations by specialist dermatologists have the potential to be replaced by an ADT.

The PICO confirmation nominated face-to-face consultations with specialist dermatologists as the reference standard for ADT.

## **10. Comparative safety**

As previously noted by MSAC for Application 1360, there are no inherent safety concerns with ADT compared to Face-to-Face (FTF) consultations. However, there were some conflicting data regarding the reliability of ADT for (i) diagnosis of pigmented lesions and (ii) exclusion of melanoma. Safety concerns will mainly be around the potential for an increase in the number of misdiagnosis of malignant lesions.

## **11. Comparative effectiveness**

The evidentiary basis to inform the comparative effectiveness of ADT compared to face-to-face consultations was 30 moderate quality prospective studies, which reported diagnostic concordance between teledermatology and FTF and a FTF consultation was the reference standard. Although the teledermatologist was blinded to the diagnosis of the face-to-face consultation the risk of bias could not be excluded from many of the studies as consecutive enrolment was not always stated.

The literature search did not identify any new studies that compared specialist dermatology consultation by videoconference with ADT.

Results of all 30 studies that compared the diagnostic concordance of FTF consultations and teledermatology for the primary diagnosis showed concordance as low as 0.46 and as high as 0.90. Out of the 30 studies, the kappa coefficients were either reported or able to be calculated from the text in 10. The reported kappa coefficient ranged from 0.32 indicating slight agreement (Warshaw 2015, non-biopsied non-pigmented lesions images by digital photography only), to 0.906 almost a perfect match (Nami 2015, in which pigmented lesions were excluded from the population).

The 30 studies were included in a meta-analysis of proportions random effects model using DerSimonian-Laird methodology. The pooled proportion was 0.70473 (95% CI = 0.661675 to 0.746031). The percentage of variation across studies that is due to heterogeneity rather than chance is significant ( $I^2 = 94.1%$  (95% CI = 92.9% to 95%).

The evaluation considered that significant heterogeneity was likely present due to the different populations included in the meta-analysis; some studies included all skin conditions including lesions, some lesions only and some skin conditions only. Two further meta-analyses were done, one for studies that only included lesions and one for studies that were predominantly skin conditions only.

### Clinical Claim

The clinical claim in the PICO Confirmation was that ADT will be non-inferior to specialist dermatology services by videoconferencing and ADT will be superior to FTF consultation on the basis of earlier diagnosis leading to improved outcomes.

## 12. Economic evaluation

The economic evaluation compared the cost-effectiveness of interventions in two settings:

- the current scenario where ADT is not available; and
- the proposed scenario where ADT is available.

The model structure was different from the previous one presented for Application 1360 which assessed the diagnostic performance of adding Store and Forward (SAF) to current clinical practice, using histopathology as the reference standard. The revised model structure presented the concordance of the primary diagnosis among the different modes of delivery of specialist dermatology consultations.

The base case results of the economic evaluation are summarised in Table 3. This analysis compares the current scenario where a proportion of patients are treated by their GP only, their GP with the assistance of TeleDerm, referred for a consultation via videoconferencing or referred for a FTF consultation with the proposed scenario where ADT is available to meet unmet demand for dermatology consultations or to substitute for some FTF or VC consultations.

**Table 3: Basecase results of economic evaluation**

Intervention	Total costs	Outcome (proportion of patients concordant diagnosis)	ICER
Current scenario	\$266.46	0.69	
Proposed scenario	\$346.57	0.57	
Increment	80.11	-0.11	Not calculable

The results of the basecase economic evaluation showed that the proposed scenario of asynchronous consultation alongside, FTF, Telederm and VC is dominated by the current scenario of no asynchronous specialist dermatology. That is asynchronous specialist dermatology is both more expensive and less effective in comparison to the current scenario where more patients receive specialist dermatology services FTF.

Varying a series of parameters in the sensitivity analyses generated quite consistent results compared with the basecase analysis. This is mainly due to setting the effectiveness of TeleDerm, ADT and VC equal for the same skin conditions. The modelled results were most sensitive to the inclusion of travel costs and reducing the proportion of patients managed by TeleDerm.



### 13. Financial/budgetary impacts

The financial implications to the MBS resulting from the proposed listing of ADT are summarised in Table 4 and Table 5.

**Table 4 Additional services required in Eligible Areas if ADT available to address unmet demand**

	2016-17	2016-17	2017-18	2017-18	2018-19	2018-19	2019-20	2019-20	2020-21	2020-21
<b>RA</b>	<b>104</b>	<b>105</b>	<b>104</b>	<b>105</b>	<b>104</b>	<b>105</b>	<b>104</b>	<b>105</b>	<b>104</b>	<b>105</b>
Inner regional	66,676	66882	67,924	67795	69,196	68718	70,492	69650	71,812	70592
Outer regional	38,735	46846	39,443	47942	40,164	49061	40,898	50203	41,646	51368
Remote	6,932	9771	7,347	10339	7,786	10939	8,252	11574	8,746	12246
Very remote	4,561	6542	4,481	6433	4,402	6327	4,325	6222	4,249	6118
<b>Total</b>	<b>116,904</b>	<b>130041</b>	<b>119,195</b>	<b>132509</b>	<b>121,549</b>	<b>135045</b>	<b>123,967</b>	<b>137649</b>	<b>126,452</b>	<b>140325</b>
<b>GP consult</b>	<b>116,904</b>		<b>119,195</b>		<b>121,549</b>		<b>123,967</b>		<b>126,452</b>	
<b>VC</b>	888.37	-	-	-	-	-	-	-	-	-
<b>TeleDerm</b>	462		462		462		462		462	
<b>Total services</b>	<b>115,092</b>	<b>128,691</b>	<b>118,271</b>	<b>132,047</b>	<b>120,625</b>	<b>134,583</b>	<b>123,043</b>	<b>137,187</b>	<b>125,528</b>	<b>139,863</b>

**Table 5 Total costs to the MBS associated with ADT**

	2016-17	2017-18	2018-19	2019-20	2020-21
Eligible Areas	\$13,048,688	13,401,931	13,665,249	13,935,784	14,213,789
After patient co-pay	\$11091384	11391641	11615461	11845417	12081721
Additional GP consult For management of patient	\$4,264,160	4,381,950	4,469,142	4,558,731	4,650,798
After patient co-pay	\$3,624,536	3,724,657	3,798,771	3,874,921	3,953,178
VC	\$40643				
After patient co-pay	\$34546	-	-	-	-
<b>Total</b>	<b>\$14,681,374</b>	<b>\$15,116,298</b>	<b>\$15,414,232</b>	<b>\$15,720,338</b>	<b>\$16,034,899</b>

The estimated total financial implications are \$14.7 million in Year 1 increasing to \$16 million in Year 5. The estimate of the costs do not include any costs or savings that may result from ADT substituting for FTF consultation in the Eligible Areas.

The applicant preMSAC response stated that the financial impact analysis overestimates the projected cost and the projected utilisation.

### 14. Key issues from ESC for MSAC

An application for asynchronous services delivered by telecommunications (ADT) was first considered by MSAC in November 2014, at which time public funding was not supported due to uncertainty of clinical effectiveness and cost effectiveness. ESC noted the following differences in the reapplication:

- The initial application considered the proposed service as a consultation, however as there is no direct interaction between the specialist and patient this application considers the proposed services as an investigation. ESC questioned the most appropriate place on the MBS for this proposed item.

- The application proposes that the service be available for patients in country and regional locations who reside at least 15km from the nearest dermatology specialist. In the reapplication people with disabilities (located in all areas) have been removed from the target population.
- In the initial application the comparator was telehealth videoconferencing. Following advice from MSAC a second comparator, face to face consultations, was added in this application.

ESC noted that current MBS items cover face to face (FTF) consultations with dermatologists (items 104 and 105) and telehealth items which provide for specialist dermatologist services via videoconferencing in real-time (item 99). Item 99 does not cover ADT. However ADT services (Telederm) are currently hosted by the Australian College of Rural and Remote Medicine, funded through the grants from the Department of Health and provided to rural/regional patients. ESC questioned the place of ADT in a fee for service model.

ESC also noted uncertainty around sharing of responsibility for the patient and the potential shifting of workload to general practitioners. ESC noted questions remain regarding how specialist dermatologists will determine suitability for referral to the service and the likely rate at which cases are determined to be unsuitable for ADT. ESC noted that Telederm excludes use for diagnosis of pigmented lesions and given the literature evidence, advised that this application should also exclude use in pigmented lesions. ESC noted that [Application 1356: Melanoma surveillance photography — total body photography and digital dermoscopy](#), which is currently being considered by PASC, may have relevance for this application.

ESC noted that no new evidence on effectiveness or safety were provided and uncertainty remains regarding both safety and effectiveness of ADT relative to FTF consultation due to the poor quality of evidence available. The comparison is based on diagnostic concordance with FTF consultation which has questionable clinical meaningfulness. ESC also noted heterogeneity across the trials, particularly across conditions.

ESC noted economic modelling suggested ADT is more expensive and less effective than the current scenario without ADT. ESC noted that the service is only cost effective when societal costs (travel time) are included. ESC questioned whether this is reasonable given that ADT should be substantially faster than the comparator. ESC questioned some of the cost inputs and assumptions in the economic model, specifically:

- the cost for 2.3 follow-up consultations, which ESC considered would occur with or without the requested service. ESC noted that follow-up with a specialist would be slightly more expensive than with a GP. ESC noted a lack of detail for costing of follow-up pathways;
- the extra cost for additional GP time, which ESC noted was a significant factor in the additional cost of ADT in the model. ESC considered that most of the information captured in the report for ADT would also be captured in a referral for a FTF consultation and that GP time for either process would be similar; and
- the model does not account for reduced waiting time which may lead to reduced biopsy rates and early diagnosis.

ESC advised that the applicant should provide justification for the requested fee, which is 85% of the MBS fees for item 104 and 105. ESC noted that ADT appears to be substantially faster than FTF or videoconferencing and this are inconsistent with the fee requested for ADT.

ESC noted that the uptake rates for the proposed item are uncertain and difficult to predict. The financial impact estimates assume a significant unmet need, leading to increased usage where there is a current lack of access. ESC noted existing problems of access to dermatology specialists in regional areas due to long waiting times. ESC also noted potential for escalation of costs where additional information is requested or repeat follow-up consultations are required.

ESC noted that initially this might appear to have consumer appeal because of potential to improve service access. ESC noted that the quality and efficiency of the proposed service is also important to consumers and that minimum standards for photographic imaging (eg British Association of Dermatologists) and GP referral would be supported. It was also noted that the arbitrary cut-off of 15km distance from services may introduce questions of equity.

## **15. Other significant factors**

The applicant's preMSAC response highlighted the following issues:

- Requirements identical to Telederm, necessity to allow access to patients non Telehealth areas
- The responsibility for patient management rests with the GP
- Process complete (billing) advice given to GP
- Numbers driven by referrer, not Dermatologist
- Evidence not available yet VC, Telederm funded
- Cost – sensitivity, include travel changes cost of \$80.11 to saving \$85.60
- Cost \$14,681,374 overestimate because:
  - Item 99 VC only 4,481/year
  - ACCRM funded Telederm \$190,000 and only 1,500 OOS/yr
- Request re-analysis of costs
- Defined Referral Template

## **16. Applicant's comments on MSAC's Public Summary Document**

Addressing inequalities in health service access in regional, rural and remote Australia is a key government priority. Harnessing innovative technology-based solutions to achieve this aligns with the guiding principles of the Commonwealth's National Digital Health Strategy (May 2017). ADT is one such established and innovative model for service delivery, supported by international evidence and guidelines. As technology advances, new models of care will continue to emerge to fill gaps in service delivery, not all of which may be in the best interest of the consumer. It is essential that models with demonstrated clinical effectiveness such as ADT be integrated and recognised as a service that delivers best practice clinical care and narrows the inequality gap. The Applicant is disappointed that no further progress has been made to embed ADT within the public health system, a move which complements existing Telehealth and TeleDerm services and would safeguard access to best practice care for those patients with dermatological conditions in underserved areas. The Applicant thanks MSAC for their considered feedback to strengthen this proposal and will continue to consult with rural health professionals and their representative organisations.

## **17. Further information on MSAC**

MSAC Terms of Reference and other information are available on the MSAC Website: [visit the MSAC website](#)