Expanding Medicare access for treating opioid dependence

Sarah Garry, Ryan D'Cunha, Hayden Green, Paul MacCartney, Dean Membrey, Hester Wilson, Thileepan Naren

OPIOID DEPENDENCE is a chronic health condition with substantial health, economic and social costs. A highly evidence-based life-saving treatment, opioid dependence treatment (ODT) uses the long-acting opioids methadone and buprenorphine to stabilise people with opioid dependence, and it is associated with reductions in health, economic and social harms for both individuals and society.[1] Most people in long-term ODT do extremely well, and their ongoing care can be managed in general community settings.

Nationally, 82–90% of ODT is delivered by private prescribers, likely to be mostly general practitioners (GPs) outside publicly funded facilities.[2] Access to ODT in rural Australia is often inequitable, with rural and remote Australians travelling 7–9 times farther than their metropolitan counterparts to access ODT.[2] These inequities are often further compounded by other social determinants of health that this patient group frequently experiences, including poverty, unstable housing, unemployment and stigma.[3] For many, the additional burden of travel, cost and systemic barriers to care makes engagement with treatment an insurmountable challenge.

Opioid dependence treatment and virtual care

Ideally, ODT should occur in a setting where wholistic care can address all of a patient's biopsychosocial needs. However, as access to ODT is inequitable, providing ODT through telehealth can be paradigm changing. Early evaluations of Australian telehealth ODT show the viability and effectiveness of remote ODT delivery, notably showing high retention and engagement.[4] NSW has been running virtual ODT clinics since 2019 with well-established guidelines and protocols.[5,6]

Australian and international research has shown improved appointment attendance and accessibility through telehealth addiction medicine services. Patients often report greater comfort engaging with telehealth because of reduced perceived stigma, especially in regional and rural contexts.[7] Further studies show that patients who receive ODT via telehealth are more likely to be retained in therapy than those treated in person.[8] In addition, outcomes regarding emergency department presentations and all-cause mortality are equal where care is delivered via telehealth versus face to face.[9]

More broadly, telehealth continues to be recognised in its utility in servicing the Australian community and relieving pressure on overburdened in-person services and accordingly is being recognised with increased funding commitments. The Victorian Virtual Emergency Department (VVED) is poised to receive a $437 million investment to expand and make permanent its service, including its dedicated urgent diabetes care line.[10]

Limitations with current Medicare Benefits Schedule telehealth items

The current Medicare Benefits Schedule (MBS) model of care for opioid dependence relies on face-to-face consultations at least every 12 months for GP and nurse practitioner (NP) prescribers. This requirement significantly limits access for people living in rural and remote areas where there are few registered ODT prescribers. Specialist medical practitioners' access to telehealth MBS items is not limited by the same rules. Such a model recognises that access to specialist services should be available to all, irrespective of factors such as mobility and geography.

MBS exemptions have allowed some health services to be delivered via telehealth without this initial face-to-face review, including for management of blood-borne viruses (BBVs) and pertaining to sexual and reproductive health (ie MBS items 92731–92742 for telephone consultations and 92715–92726 for video consultations). Given that remaining MBS items require face-to-face review within the previous 12 months, patients are limited to services they have accessed recently in person.

We suggest that the current existing telehealth MBS items for BBVs and sexually transmitted infections without face-to-face requirements for GPs and NPs could be expanded to incorporate the management of opioid dependence.

This exemption will help expand access to ODT to all Australians, irrespective of geography. This is a simple and accessible option that may reduce reliance on current overburdened ODT prescribers and public and private alcohol and other drug services.

Conclusion

Given the scale of the unmet treatment need for people with opioid dependence, and the effectiveness of ODT, expanding MBS access for GPs to provide care for this treatment via telehealth, unbounded by limitations of face-to-face consults, is a much-needed intervention. By funding and providing accessible care, we have an opportunity to improve health outcomes for this underserved population. This, in turn, can provide support for individuals, families and communities while delivering substantial social and economic returns to the Australian taxpayer.

Authors

Sarah Garry BSc (Hons), MBBS, FRACGP, Addiction Medicine registrar, cohealth, Melbourne, Vic

Ryan D'Cunha BSc, MBBS, FRACGP, Addiction Medicine registrar, cohealth, Melbourne, Vic; Monash Addiction Research Centre, Monash University, Melbourne, Vic

Hayden Green BBiomed, MD, FRACGP, Addiction Medicine registrar, cohealth, Melbourne Vic

Paul MacCartney MBBS, FRACGP, FAChAM, Addiction Medicine Specialist, cohealth, Melbourne, Vic; Chief Addiction Medicine Advisor for Victoria, Department of Health, Melbourne, Vic

Dean Membrey MBBS (Hons), DCH, FRACGP, FAChAM, Addiction Medicine Specialist, cohealth, Melbourne, Vic

Hester Wilson BMed (Hons), MMH, FRACGP, FAChAM, Chief Addiction Medicine Specialist, NSW Health; Clinical Director of Alcohol and Other Drugs, Murrumbidgee Local Health District, Wagga Wagga, NSW; Chair, Addiction Medicine Specific Interests group, The Royal Australian College of General Practitioners

Thileepan Naren MBBS, MHM, MPH, FACRRM, FRACGP, FAChAM, GAICD, Addiction Medicine Specialist, cohealth & Western Health, Melbourne, Vic; Adjunct Clinical Associate Professor, Monash Addiction Research Centre, Monash University, Melbourne, Vic

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Correspondence to:
sarah.garry@cohealth.org.au

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