Rural, Regional and Remote Medicare Access and Funding Inquiry

Senate Rural and Regional Affairs and

Transport References Committee

Friday, 27 March 2026

Medical Technology Association of Australia Ltd
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About the Medical Technology Association of Australia (MTAA)

MTAA is the peak association representing companies in the medical technology industry. MTAA aims to ensure the benefits of modern, innovative and reliable medical technology (MedTech) are delivered effectively to provide better health outcomes to the Australian community.

MTAA's membership spans Australian start-ups through to global MedTech leaders. Our members develop, manufacture and supply MedTech used in the diagnosis, prevention, treatment and management of disease and disability. The range of MedTech is diverse, with products ranging from high technology implantable devices such as pacemakers, defibrillators and orthopaedic implants to familiar items such as syringes and wound dressings. Products also include hospital and diagnostic imaging equipment such as ultrasounds and magnetic resonance imaging machines, as well as digital health technologies such as remote monitoring devices and digital therapeutics.

MTAA members distribute the majority of non-pharmaceutical products used in the diagnosis and treatment of disease and disability in Australia. Our member companies also play a vital role in providing healthcare professionals with essential education and training to ensure the safe and effective use of medical technology.

About MedTech in Australia

The MedTech industry is one of the most dynamic advanced manufacturing industries in Australia and provides substantial health improvements and high-level employment opportunities to Australians and grows Australia's technology exports. Through innovation, this industry will continue to expand and share its discoveries with the world.

Over 2.5 million patients per year are served with lifesaving and improving medical technologies.

MedTech not only saves lives but – as demonstrated in the treatment and management of type 1 diabetes by insulin pumps and continuous glucose monitoring – its use can also significantly improve patients' quality of life.

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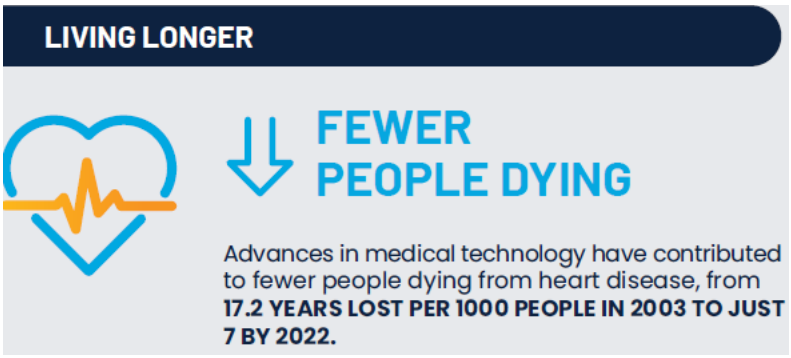

MedTech plays a crucial role in treating the five most burdensome disease groups which account for close to two-thirds of the Australia's disease burden.[i] This shows MedTech's significant contribution to not only making Australians healthier, but also to decreasing stress on the wider health system.

The MedTech industry contributes significantly to the broader Australian economy, adding $5.4 billion to Australia's GDP and supporting over 17,000 direct and 51,000 total jobs. Australian MedTech exports $1.95 billion overseas, contributes to over 4,000 manufacturing jobs, and has been experiencing revenue and employment growth, which is projected to continue.[ii]

Despite representing a relatively small market globally, Australia ranks as a prominent developer of MedTech worldwide. From the smallest sutures and neurosurgical coils to the largest linear accelerators, MedTech provides the platform from which healthcare is delivered.

Executive Summary and Recommendations

The Medical Technology Association of Australia (MTAA) welcomes the opportunity to contribute to the Senate inquiry into rural, regional and remote Medicare access and funding.

MTAA's submission centres around the underutilisation of digital therapeutics (DTx) and remote patient monitoring (RPM), the funding and access challenges for these technologies. MTAA provides 8 recommendations regarding how these technologies should be supported and funded for the benefit of regional, rural and remote communities.

MTAA Recommendations Summary

Reference Term(s)	Recommendation
A	1. **Expand Rural Medicare to Fund Digital Care** As part of wider implementation across the healthcare system, the Commonwealth should expand Medicare's rural digital care settings to include funded access to evidence-based digital therapeutics and remote patient monitoring, including

	healthcare professional support, where these are prescribed, recommended, or overseen by an appropriate clinician as part of a broader care plan.
B	2. **Adopt Patient-Centred Reimbursement Models** Patient-specific reimbursement for individual technologies and clinical support services and remote monitoring should be key funding mechanisms for to enable access to DTx and RPM, but augmented with block funding arrangements especially for very remote, low-volume settings.
	3. **Invest in Workforce and Digital Capability** Implementation support should include wider funding for workforce training and digital capability investments so local providers can use digital therapeutics as part of routine care.
C	4. **Establish a Clear Evidence-Based Assessment Pathway** A pathway should be created for assessing funding for digital therapeutics and remote patient monitoring in clinical areas where there is a credible evidence base for reducing deterioration, improving adherence, or lowering avoidable hospital demand.
D	5. **Integrate Digital Therapeutics into Team-Based Care** Funding should support digital therapeutics as part of mixed-team care models, integrated within clear clinical governance, referral pathways, shared data standards, and integration with existing telehealth and primary care settings.
E	6. **Design Rural-Safe Funding Pathways** The Government should design any DTx and RPM funding pathway with explicit considerations and safeguards for small rural providers, including recognising the impact of lower volumes and higher overheads, simple claiming rules, technology-neutral standards, and fit-for-purpose onboarding support.
F	7. **Apply a Rural Impact Assessment Framework** The Government could apply a formal rural impact assessment to any proposed funding pathway for DTx and RPM, including assessment across Modified Monash Model categories and consultation with rural providers, patients, and community stakeholders.
G	8. **Recognise Digital Therapeutics in Medicare Reform** The Commonwealth should recognise funded digital therapeutics as a legitimate and necessary component of equitable rural Medicare reform, particularly where they are

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	evidence-based, clinician-linked, and capable of improving access and continuity in underserviced communities.

Introduction

MTAA supports digital-health enabled, multidisciplinary clinician-led models of primary care to address critical patient needs and reduce hospitalisations. MTAA believes this must include the use of smart digital interventions especially in rural, regional and remote settings. In many thin-market settings such as these, digital therapeutics (DTx) and remote patient monitoring (RPM) can improve access, continuity, self-management, and earlier intervention when integrated properly with primary care, specialist care, and multidisciplinary services. These technologies also represent a significant opportunity to improve healthcare outcomes in regional and remote communities, including for Aboriginal and Torres Strait Islander peoples.

There are other digital technologies beyond DTx and RPM including tools to enable hospital-in-the-home which will not be the focus of this submission but will be important components of longer-term solutions in rural, regional and remote areas.

What are Digital Therapeutics (DTx) and Remote Patient Monitoring (RPM)?

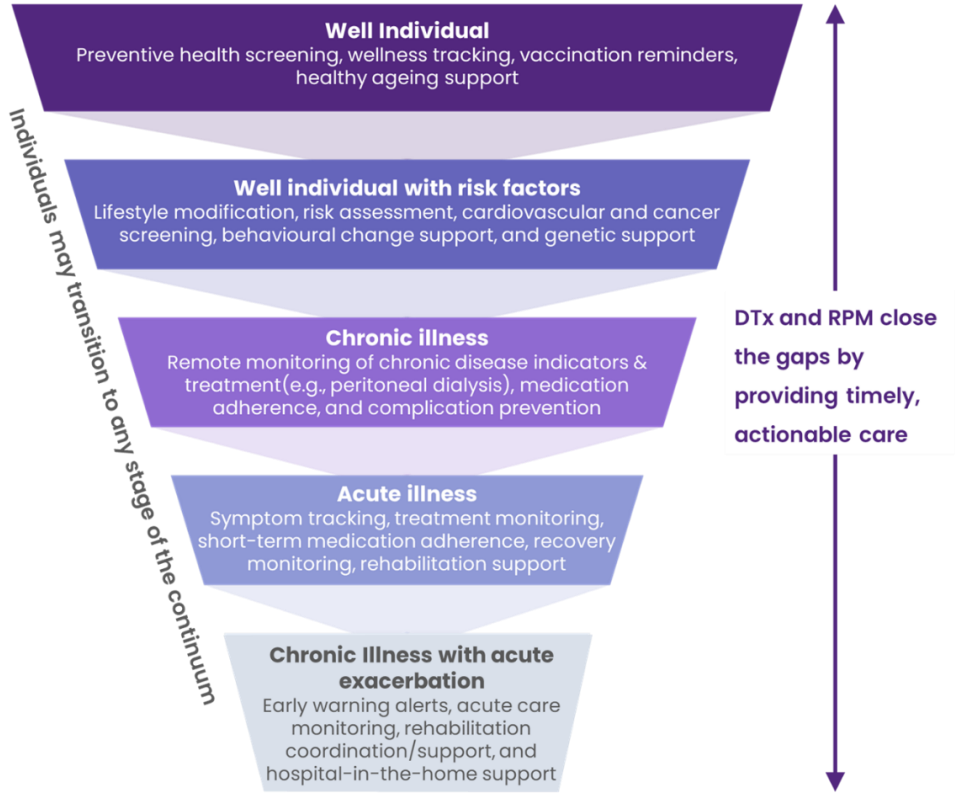
In this submission, digital therapeutics (DTx) refers to Therapeutic Goods Administration (TGA)-regulated software to help a patient self-manage or prevent a disease, disorder, condition or injury under the guidance of a clinician. Remote patient monitoring (RPM) refers to TGA-regulated technology-enabled monitoring and management of a patient by a healthcare practitioner. In both cases, the technology is often used outside the context of a live consultation between the patient and the healthcare professional. These interventions range from low to high touch clinical support depending on the status of the patient.

Examples of DTx and RPM Technologies

- Guided self-management cardiac rehabilitation with clinical supervision from multidisciplinary teams
- Hospital-quality dialysis monitoring in community settings
- Continuous monitoring using implanted cardiac devices
- Remote monitoring and management of cancer patients
- Personalised remote monitoring and support for musculoskeletal conditions
- Remote virtual reality mental health therapy
- Remote monitoring of falls risk

The Value of Digital Therapeutics (DTx) and Remote Patient Monitoring (RPM)

DTx delivers the treatment, RPM provides the monitoring: *together they enable clinician-guided care to shift from hospitals to the home or prevent hospitalisation in the first place.* They can also improve efficiency of healthcare delivery in the community. As outlined in MTAA's *Enabling Remote Care: Funding Pathways for Digital Therapeutics and Remote Patient Monitoring* 2025 report they can play a role at many stages of the care continuum:



These technologies will never replace direct care by a healthcare professional but can augment, enable and target this care more effectively.

Both DTx and RPM have been identified by the Productivity Commission as important levers to address healthcare challenges.

The Commission noted that:

> *Telehealth use has exploded since 2020, but uptake of remote patient monitoring and digital therapeutics has lagged behind.* (p.2)

Access and Funding Challenges for Digital Therapeutics (DTx) and Remote Patient Monitoring (RPM)

MTAA has set out proposals for funding of DTx and RPM in its *Enabling Remote Care* report. However, these require targeted healthcare professional and practice funding in combination with funding for the technology itself. These elements must be addressed, and rural, regional and remote settings offer an opportunity to implement funding changes that would be beneficial system wide. These would augment existing and future investments in telehealth, workforce, digital capability and chronic disease management.

MTAA recognises that there are likely to be unique challenges in very remote areas that make some volume-based funding for clinical services, particularly MBS codes, less suitable in isolation and a blended funding model is especially required in those regions. It is further understood that there are connectivity and digital literacy and comfort barriers that may mean DTx and RPM is not suitable on all occasions. However, further infrastructure investment and support for education by healthcare professionals can address many of these concerns over time. The many advantages and savings achieved through DTx and RPM can also allow greater support for those unable to be managed through these means.

Any consideration of future funding and resourcing of healthcare in rural, remote and regional areas must take into account the opportunities presented by technology developments and not discuss traditional models alone. While this is now well understood for telehealth, this has not translated into recognition of emerging DTx and RPM models.

Consequences of Not Having a Fit-For-Purpose Funding Pathway for DTx and RPM:

The consequences of not having a fit-for-purpose funding pathway for digital health technologies include:[iii]

- **Patients miss out on life-saving and life-changing care** – facing preventable deterioration, hospitalisations and out-of-pocket costs, with rural Australians, including indigenous communities facing the greatest inequity.

- **Higher health system costs** – through avoidable acute care and hospital admissions. Australian evidence shows these technologies deliver significant benefits, including reduced bed days, emergency presentations and readmissions, delivering net savings over time.[iv]

- **Productivity is lost –** for patients, the health system and workforce more broadly.

Response to Terms of Reference:

Term of Reference A:

The impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians:

MTAA Position

Recent Medicare changes have reinforced the importance of care continuity and telehealth, but they do not yet provide a sufficient framework for modern, digitally enabled care in regional and remote settings.

Evidence and reasoning

In many rural and remote communities, the core barriers to care are not limited to standard consultation fees. They include workforce shortages, long travel distances, time away from work, low service density, and limited access to follow-up care between appointments. For people managing chronic conditions and behavioural health conditions, in rehabilitation, or with ongoing monitoring needs, access to a consultation alone, even via telehealth, is often not enough. A practical care pathway also requires tools that support monitoring, behaviour change, treatment adherence, and early escalation between visits.

Evidence-based DTx and RPM can help fill that gap when used under clinical supervision. These tools can complement telehealth and in-person services by enabling structured, guideline-based interventions outside the consulting room, while preserving continuity with a patient's usual care team. For rural and remote patients, this can mean less time spent travelling for routine follow-up, earlier intervention before health issues worsen, and better support to manage care closer to home.

Currently there are no dedicated funding pathways to cover DTx and the technology component of RPM and this will need to change to take advantage of those technologies. However, there are also few or no MBS items that explicitly fund healthcare practitioners to:

- Help set up, educate or review a patient using DTx.
- Monitor a patient remotely including reviewing alerts.

Monitoring and support of this type is limited to renal physician support for home dialysis and remote monitoring of cardiac implantable electronic devices. However, even in both these cases, MBS items are restrictive and do not cover the full support required.

GP chronic condition management plan (GPCCMP) items do not cover either of the above healthcare practitioner activities as they do not reimburse technology support or asynchronous care such as remote monitoring of data being transmitted. Furthermore, there are still limitations on the type of

healthcare professionals who can receive funding of any kind through the MBS when nurses, Aboriginal health workers and other allied health could cost-effectively support technology-enabled remote care under GP or specialist direction.

Example 1: Elekta ONE Patient Companion Platform

The Elekta One Patient Companion Platform consists of a mobile app combined with machine learning symptom tracking and structured clinical team management for cancer patients. Patients undergoing cancer treatment often have follow up gaps and delayed identification of treatment toxicities necessitating ED presentations. In rural and regional areas, travel times make face to face consultations for symptom management particularly burdensome, and the impact of ED presentations are greater. The Elekta ONE Patient Companion The system enables remote patient monitoring between scheduled appointments, facilitating early detection of treatment-related toxicities and supporting personalised care delivery over a larger population. It also enables more efficient and accurate collection of data. Studies show high patient satisfaction and time saving in-clinic (for further details and references refer to MTAA's *Enabling Remote Care* report Appendix D).

Funding problem: There is no funding in the community setting for the technology itself. Clinicians are funded through MBS for direct patient interactions but not reviewing information. There is likewise no funding for nursing or allied health staff to perform this role. There are also no incentives to encourage the improved outcomes and efficiencies that remote monitoring provides.

The exclusive focus on synchronous consultations without remotely enabled care is particularly disadvantageous for rural, remote and regional populations who, in addition to their overall worse health status, are more affected by the need to travel for care. Furthermore, these technologies can compensate for thin workforces in these non-metro areas by enabling more efficient use of the available workforce or taking advantage of remotely located healthcare professionals.

The issues of the lack of funding for healthcare professional support of patient-use digital technology has also been highlighted in a recent government-funded report by the Australian Institute of Digital Health Funding Mechanisms for Preventative Health Apps in Primary Care.

Recommendation 1

As part of wider implementation across the healthcare system, the Commonwealth should expand Medicare's rural digital care settings to include funded access to evidence-based digital therapeutics and remote patient monitoring, including healthcare professional support, where these are prescribed, recommended, or overseen by an appropriate clinician as part of a broader care plan.

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Term of Reference B:

The financial sustainability of independently owned rural general practices under current Medicare funding and incentive structures.

MTAA Position

Medicare should support digital therapeutics in ways that are easily accessible by rural general practices regardless of volume and scale.

Evidence and Reasoning

Small rural clinics often operate under tight workforce and financial constraints. If digital care tools are funded only through individual grant or agreement arrangements, there is a risk they will benefit larger corporate providers with greater administrative capacity, rather than local services embedded in regional communities.

A better model is one in which digital therapeutics are accessible for all practices through funding of individual technologies and service funding is provided through a mix of suitable MBS items and block funding that all practices can access regardless of volume and other infrastructure investments. This would allow rural practices to extend their reach, improve follow-up, and support patients between appointments without having to absorb the full implementation and technology cost themselves.

However, individual funding streams will need to be augmented by broader investment in training and digital capabilities for rural clinics.

Recommendation 2

Patient-specific reimbursement for individual technologies and clinical support services and remote monitoring should be key funding mechanisms for to enable access to DTx and RPM, but augmented with block funding arrangements especially for very remote, low-volume settings.

Recommendation 3

Implementation support should include wider funding for workforce training and digital capability investments so local providers can use digital therapeutics as part of routine care.

Term of Reference C:

The extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas.

MTAA Position

Medicare should fund digital therapeutics and remote patient monitoring where they can demonstrably support early intervention, better self-management, and improved monitoring for chronic and complex conditions, especially in areas where delayed care can lead to hospital escalation.

Evidence and Reasoning

In regional and remote settings, preventable deterioration often reflects gaps in follow-up, long intervals between appointments, and difficulty accessing timely review. Where clinically appropriate, DTx and RPM can support ongoing treatment adherence, symptom monitoring, behavioural support, rehabilitation, and escalation triggers between visits.

This is particularly relevant to chronic disease management and post-discharge support, where small changes in access and continuity can have an outsized impact in thin markets. A funded DTx and RPM pathway would give local clinicians another practical tool to maintain contact, reinforce treatment plans, and identify problems earlier.

Example 2: Cardihab Cardiac Rehabilitation

Cardihab is a TGA-registered digital therapeutic for cardiac rehabilitation (CR) combining a mobile app, guideline aligned care programs and structured telehealth consultations. Monitoring and support is provided by nurses and allied health professionals in conjunction with usual clinical care providers. It is designed for patients discharged following a broad spectrum of cardiac events and procedures and can be applied to people with high risk of future cardiac events. Most CR is now offered in provided in person which is a particular challenge for many patients in rural, regional and remote locations despite them often having higher rates of cardiovascular disease. A recent data 5 year long statewide data linkage study showed that less than 10% of patients eligible for CR (metro or rural) did not complete it despite the demonstrated survival benefit and the high rate of cardiovascular events following a hospital admission. 12-month outcomes shows that Cardihab improved uptake and survival, was more cost effective in 87% of scenarios, and reduced re-admission bed days by 71%. (Further detail and references can be found at Appendix A of MTAA's Enabling Remote Care report)

Funding problem: There is no funding in the community setting for the technology itself. There is likewise no funding for nursing or allied health staff to deliver the program virtually.

It would be appropriate to evaluate DTx and RPM technologies and interventions through a form of health technology assessment (HTA) that is specifically tailored to these technologies. This includes allowing provisional listing to generate further data.

Recommendation 4

A pathway should be created for assessing funding for digital therapeutics and remote patient monitoring in clinical areas where there is a credible evidence base for reducing deterioration, improving adherence, or lowering avoidable hospital demand.

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Term of Reference D:

The adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities

MTAA Position

Digital therapeutics should be recognised as an enabling tool for mixed-team care that augments and empowers the role of clinicians.

Evidence and Reasoning

Rural care often depends on flexible teamwork across general practitioners, nurses, allied health professionals, specialists, pharmacists, and visiting services. In that setting, digital therapeutics can help augment and enhance care pathways, support patient engagement between visits, and allow clinicians to work at top of scope with better visibility over patient progress.

However, the value of digital therapeutics and remote patient depends on integration. If these tools are isolated from the care team, they risk creating fragmentation. If they are integrated into multidisciplinary care, they can improve coordination and support more consistent management across distance.

This makes funded DTx and RPM particularly relevant to mixed-team models in small communities, where access to specialist input may be intermittent and workforce time must be used efficiently. DTx and RPM are particularly amenable to involvement of nurses and allied health professionals who can provide necessary support under the guidance of the treating clinician. This needs to be recognised in MBS items as well as block funding arrangements for low volume service providers who may be able to commission external support especially for remote patient monitoring and follow up.

Example 3: Musculoskeletal Virtual Care

A product in development delivers a hybrid model of care that combines digital health technology with clinician oversight to support patients with musculoskeletal (MSK) conditions. This technology-enabled approach shows early evidence of improving access to care, particularly in regional and remote communities where consistent in-person services are often limited.

The model supports patients across the full continuum of care, from prevention and chronic disease management through to surgical rehabilitation through structured, personalised programs delivered via a digital platform. These programs include education, motion-tracked exercises, and progress monitoring, complemented by telehealth support from qualified clinicians. The program is delivered in partnership with clinicians by allied health professionals.

By enabling continuous care between traditional appointments, this model aims to improve patient engagement and clinical outcomes, while providing clinicians and health system partners with real-time visibility to intervene early and reduce the risk of deterioration and avoidable escalation of care.

Funding problems: There is no funding in the community setting for the technology itself. There is likewise no funding for nursing or allied health staff to deliver the program virtually or for remote patient monitoring and intervention.

Recommendation 5

Funding should support digital therapeutics as part of mixed-team care models, integrated within clear clinical governance, referral pathways, shared data standards, and integration with existing telehealth and primary care settings.

Term of Reference E:

The impacts of current Medicare rules and incentive arrangements on large corporate providers compared with small, community-embedded rural clinics

MTAA Position

Any future digital funding model must avoid creating a system that favours scale, corporate infrastructure, or metropolitan administrative capacity over local rural service need.

Evidence and Reasoning

New funding models can unintentionally advantage large providers if they require very high throughput, complex compliance processes, proprietary software integration, or centralised contracting arrangements that are difficult for smaller clinics to navigate.

For rural Australia, this matters because local, trusted services are often the backbone of continuity of care. A digital therapeutic funding pathway that works only for larger entities would risk widening, rather than narrowing, the rural access gap.

MTAA therefore supports a design principle that future digital funding should be simple, interoperable, clinically governed, and equally accessible to smaller rural providers. It should specifically support technology and program onboarding and patient education.

It is MTAA's view that funding technologies and clinical services individually for the patient, similar to the current PBS and utilising the MBS, should be the backbone of resourcing DTx and RPM. However, more remote settings will certainly require other forms of funding.

Recommendation 6

The Government should design any DTx and RPM funding pathway with explicit considerations and safeguards for small rural providers, including recognising the impact of lower volumes and higher overheads, simple claiming rules, technology-neutral standards, and fit-for-purpose onboarding support.

Term of Reference F:

Reforms needed to ensure Medicare is fair, workable and sustainably funded for rural, regional and remote Australians, including the requirement for rural stress-testing of future changes

MTAA Position

Funded digital therapeutics should form part of broader Medicare reform for rural Australia, and models could be initially trialled if there is uncertainty about their implementation effects with adjustments made accordingly.

Evidence and Reasoning

The strongest case for digital therapeutics is often in the places where service access is most constrained. Rural and remote communities face higher travel burdens, thinner workforce coverage, and fewer alternatives when in-person care is delayed or unavailable. These are exactly the settings where a digital adjunct to clinician-led care can offer the greatest value.

At the same time, rural communities also face greater barriers in connectivity, digital literacy, implementation support, and interoperability. To address this, prior to implementation of a nationwide scheme to fund DTx and RPM, specific models for rural, remote and regional Australian should be examined, particularly whether they:

- work for small clinics and multidisciplinary teams,
- reduce rather than increase administrative burden,
- support continuity with usual care,
- account for connectivity and implementation constraints, and
- improve equity in access and outcomes.

Recommendation 7

The Government could apply a formal rural impact assessment to any proposed funding pathway for DTx and RPM, including assessment across Modified Monash Model categories and consultation with rural providers, patients, and community stakeholders.

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Term of Reference G:

Any other related matters

MTAA Position

DTx and RPM should be treated as part of core health system reform, not as an optional technology overlay.

Evidence and Reasoning

DTx and RPM are increasingly relevant to the delivery of evidence-based care across chronic disease, rehabilitation, mental health, and other areas where ongoing support between consultations matters. In rural and remote settings, their value is often amplified because the alternative is not always timely face-to-face care, but delayed care, additional travel, or no care at all.

This inquiry provides an opportunity to recognise that modern Medicare settings must evolve to support clinically integrated digital models that are safe, evidence-based, and equitable. If funded appropriately, DTx and RPM can help extend the reach of local clinicians, reduce avoidable travel, and improve patient engagement in communities that continue to face structural access barriers.

Example 4: Biotronik Home Monitoring Platform

BIOTRONIK's Cardiac Device Home Monitoring provides continuous cardiac device monitoring for patients across Australia, enabling cardiologists to manage device patients remotely.

It is a TGA-registered, globally deployed remote monitoring platform for patients with implanted cardiac devices (including pacemakers, ICDs, CRT devices and cardiac monitors), automatically transmitting real-time data to clinicians without requiring patient interaction. This enables earlier detection of clinical and technical issues, overcoming key limitations of conventional care where up to 98% of time is unmonitored and most in-clinic visits are don't require action. Travel time to clinic is reported as a concern for many patients and this will impact rural, regional and remote patients more significantly.

The technology demonstrates significant improvements in outcomes, such as a 50% reduced mortality in heart failure patients, two-thirds reduction in hospitalisations, 34% reduction in length of hospital stays and higher patient adherence, while maintaining safety.

Funding problems: Public Local Health Networks often have budget constraints limiting remote monitoring capability to 60-70% coverage. The private sector has 90-95% remote monitoring coverage but this is partly enabled by Prescribed List coverage of industry technical service cost for the device typically provided to patients regardless of location and which requires private insurance. Importantly, there is MBS funding for annual clinician reviews of remote monitoring data and responding to alerts.

However, clinicians report this is not sufficient in many cases requiring out of pocket costs to be charged to patients.

Recommendation 8

The Commonwealth should recognise funded digital therapeutics as a legitimate and necessary component of equitable rural Medicare reform, particularly where they are evidence-based, clinician-linked, and capable of improving access and continuity in underserviced communities.

H: Additional Considerations

MTAA recognises that DTx and RPM are not appropriate in every circumstance and should not replace essential face-to-face care where that care is clinically required. The objective should be to improve access, treatment and continuity, not to shift unsupported risk onto patients or communities.

Accordingly, MTAA supports a funding model for digital therapeutics that is:

- evidence-based,
- clinician-linked,
- interoperable,
- technology-neutral,
- accessible for small rural providers, and
- evaluated transparently.

MTAA also notes that implementation will require attention to digital connectivity, software integration, privacy, patient support, and workforce readiness. These are not peripheral issues. They are central to whether digital funding succeeds in rural and remote settings.

Conclusion

Targeted reform to funding frameworks is needed to support modern, digitally enabled models of care that address the structural barriers faced in rural, regional and remote Australia.

MTAA stands ready to support government to design and implement practical, evidence-based funding reforms that enable modern models of care and improve equitable access for patients across Australia.

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Endnotes:

[i] Australian Burden of Disease Study 2022: https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2022/contents/about

[ii] The Value of MedTech Report 2023: https://www.mtaa.org.au/sites/default/files/uploaded-content/field_f_content_file/the_value_of_medtech_report.pdf pg. 68.

[iii] See '*Enabling Remote Care: Funding Pathways for Digital Therapeutics and Remote Patient Monitoring*'.

[iv] See '*Enabling Remote Care: Funding Pathways for Digital Therapeutics and Remote Patient Monitoring*', Table 1: Australian solutions delivering benefits, pages 12-13.

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