Principles for the Management of Tuberculosis in New South Wales

Summary This Policy Directive outlines key principles of the management of tuberculosis (TB) in NSW, including treatment of TB, public health management, preventive services and the provision of TB services free of charge to the patient.

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Secretary, NSW Health

PRINCIPLES FOR THE MANAGEMENT OF TUBERCULOSIS IN NEW SOUTH WALES

POLICY STATEMENT

All services related to diagnosis and treatment of presumptive or confirmed tuberculosis (TB) (active or latent) and complications arising from the TB disease process must be provided at no charge to patients within the NSW public health system. This includes the provision of services for TB related investigations, care and treatment, and management of any disease- or treatment-related complications.

SUMMARY OF POLICY REQUIREMENTS

TB is a notifiable condition under the NSW *Public Health Act 2010*, with doctors required to notify all persons they reasonably suspect to have TB to their local public health unit, and laboratories required to notify all positive results of TB tests.

District and network chief executives are responsible for ensuring appropriately skilled medical and nursing staff are available to manage patients with active or latent TB and provide TB prevention activities to minimise the public health impact of TB.

Districts and networks must appoint a TB coordinator to oversee for the provision of TB services within the district or network.

All cases of possible and confirmed TB are to be managed in conjunction with a TB service. All isolates of *M. tuberculosis* complex identified must be referred to the Mycobacterium Reference Laboratory for confirmation and drug susceptibility testing. Treating authorised prescribers must always treat TB disease with multiple anti-tuberculosis agents following the most recent evidence-based practice.

All patients diagnosed with TB in NSW are to be tested for human immunodeficiency virus (HIV). All rifampicin resistant and multidrug resistant TB cases in NSW are to be reviewed by an expert panel.

Patient management must be individualised and seek active input from patients to allow for the least restrictive management that enables them to achieve treatment success. Wherever possible, clinical care is to be delivered in a manner that allows patients to maintain normal employment and/or education activities once non-infectious.

Districts and networks must provide mechanisms to monitor adherence with treatment in a manner that is minimally restrictive to patients, while ensuring treatment success. A mechanism must be available to supervise all prescribed doses for patients identified as being at significant increased risk of treatment non-adherence if required.

All healthcare workers are required to comply with the NSW Health infection control guidance to minimise the risk of TB transmission in healthcare settings.

District and network TB services must quickly identify patients that are putting other people at risk, or are at-risk of such behaviours, and encourage, facilitate, and if required enforce compliance to TB treatment.

TB services are required to undertake contact investigation and screening of contacts.

Districts and networks are required to provide testing for latent TB infection to individuals at risk of acquiring TB infection or those vulnerable to disease progression, including review and follow-up health care workers and students that test positive for latent TB infection.

TB services are to triage, investigate, and provide follow-up care to people referred from the Department of Home Affairs that live within the district or network boundaries, and to provide the required feedback.

Districts and networks are required to provide a BCG vaccination service to residents living within the district or network boundaries.

REVISION HISTORY

Version	Approved by	Amendment notes
March-2022 (PD2022_007)	Deputy Secretary, Population and Public Health	Inclusion of public health management and preventative services and updated treatment adherence requirements.
December-2014 (PD2014_050)	Deputy Secretary, Population and Public Health	Updated and combined policy. Replaces PD2008_019, PD2008_018, PD2009_028 and PD2005_159
April- 2008 (PD2008_019)	Director-General	Replaces PD2005_141 – updated
December-2008 (PD2008_018)	Director-General	Replaces PD2005_579 – updated
May-2008 (PD2008_028)	Director-General	Replaces PD2005_076 – updated
January-2005 (PD2005_159)	Director-General	Replaces Circular 99/75 – updated

ATTACHMENTS

1. Principle for the Management of Tuberculosis in New South Wales: Procedures.

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1 BACKGROUND

1.1 About this document

Tuberculosis (TB) services in NSW are delivered through a network of metropolitan and regional local health districts (districts) and specialty health networks (networks), in a range of environments. These include large metropolitan chest clinics and community health centres in regional and rural areas.

Patients with possible or confirmed TB must be referred to their local TB service. TB services are to review the case, develop a management plan with the treating authorised provider, and initiate appropriate public health actions.

TB services, in collaboration with their associated public health units, are responsible for the public health management of people who have been in contact with an infectious TB case.

The NSW Health TB Program, Health Protection NSW, oversees policy, governance, and coordination of TB care in NSW, in conjunction with the NSW Tuberculosis Advisory Committee (TBAC).

1.2 Key definitions

Active tuberculosis disease

Illness caused by *Mycobacterium tuberculosis* complex *(M. tuberculosis or M.TB)*.

Admitted patient services

Services provided to patients admitted as an inpatient to hospital, or in the person's home under hospital in the home.

Health Assessment Portal (HAPlite)

The Health Assessment Portal (HAP) database used by the Department of Home Affairs to manage immigration health referrals - HAPLite is the limited view for clinician use.

Immigration Medical Examination (IME)

A medical assessment undertaken during visa application. This assessment could be undertaken offshore, in the country of origin of the visa applicant or onshore, in Australia during the visa.

Interferon gamma release assay (IGRA)

An in-vitro tuberculosis screening technique that uses whole blood to identify people likely to be infected with *M. tuberculosis*.

Latent Tuberculosis Infection (LTBI)

Tuberculosis infection without evidence of active tuberculosis disease.

Medical Officer of the Commonwealth (MOC)

A medical officer who undertakes visa medical assessments for, or on behalf of, the Department of Home Affairs.

Multi-drug resistant tuberculosis (MDR-TB)

Tuberculosis disease caused by *M. tuberculosis* bacilli that are resistant to isoniazid and rifampicin, with or without resistance to other anti-tuberculosis agents.

Non-admitted patient services

Services provided to patients who are not admitted to an inpatient bed. This includes outpatient clinics, community-based clinics, or community-based outreach services.

NSW Tuberculosis Program

The unit in Health Protection NSW responsible for tuberculosis management, policy, and guidelines for NSW.

Onshore deferral

The process whereby a person's visa application in Australia is delayed (or deferred) due to evidence or suspicion of tuberculosis requiring further investigation by tuberculosis services.

Preventive therapy

A course of tuberculosis medications to treat latent tuberculosis infection, thereby preventing progression from tuberculosis infection to active TB disease. Preventative therapy is also known as LTBI treatment of chemoprophylaxis.

Rifampicin resistant tuberculosis (RR-TB)

TB disease caused by *M. tuberculosis* bacilli that are resistant to rifampicin, with or without resistance to other anti-tuberculosis agents.

Tuberculosis (TB)

Disease or illness caused by *M. tuberculosis* complex, also referred to as active tuberculosis disease.

Tuberculosis clinical review

Assessment by an experienced clinician to diagnose or exclude active tuberculosis disease in a person who has confirmed tuberculosis infection, and/or abnormal chest radiograph (CXR) and/or symptoms suggestive of tuberculosis disease.

Tuberculosis coordinator

The NSW Health nursing staff member who is responsible for overseeing the implementation of NSW TB Program policies, guidelines and procedures, and ensure program outcomes are achieved within their district or network.

Tuberculosis health undertaking (TBU)

An agreement between a migrant and the Australian Government to meet the health requirement for visa approval prior to arrival in Australia, which requires migrants to attend a tuberculosis service for investigations/ongoing monitoring after arriving in Australia.

Tuberculosis infection

M. tuberculosis complex infection without disease/illness; also referred to as latent tuberculosis infection (LTBI).

Tuberculosis screening

Clinical assessment and testing by an experienced clinician to exclude tuberculosis disease and tuberculosis infection.

Tuberculin skin test (TST)

A test to identify people likely to be infected with *M. tuberculosis* complex. It measures cell mediated immune responsiveness to tuberculin purified protein derivative injected under the skin (in vivo). Tuberculin skin test is also known as a Mantoux test.

1.3 Legal and legislative framework

TB is a notifiable condition under the NSW *Public Health Act 2010*, with doctors required to notify all persons they reasonably suspect to have TB to their local public health unit, and laboratories required to notify all positive TB test results.

TB is a Category 4 medical condition under Schedule 1 of the NSW *Public Health Act 2010*. Under section 61 of the *Public Health Act*, the Secretary can, if there is a concern that a person may have a Category 4 condition and may be a risk to public health, direct a person to undergo a medical examination to determine if the person has the condition.

In addition, under Section 62, the Chief Health Officer or authorised medical practitioner can issue a public health order in respect of a person with a Category 4 condition who is behaving in a way that is, or may be, a risk to public health.

A public health order can direct the person to undergo treatment or counselling and/or to be detained. Note that the issuing of a public health order is generally an intervention of last resort when other methods have failed to control the public health risk and are to be considered only in consultation with the NSW TB program.

2 ROLES OF DISTRICT AND NETWORK TUBERCULOSIS SERVICES AND STAFF

Districts and networks must provide integrated, patient-centred diagnostic and treatment services for people with latent or active TB, public health management (including surveillance, assessment of immigration referrals), contact investigation and screening, and TB prevention services.

TB prevention includes:

- Ensuring appropriate standards of infection control for preventing transmission of TB within healthcare settings are maintained
- Conducting TB contact investigation and screening
- Provision of effective diagnostic and treatment services for latent TB infection
- Provision of the Bacille Calmette Guérin (BCG) vaccination.

District and network chief executives are responsible for ensuring appropriately skilled medical and nursing staff are available to manage patients with active and latent TB, and TB prevention activities to minimise the public health impact of TB.

Districts and networks must appoint a TB coordinator to oversee the provision of TB services within the district or network, ensuring policy directives and guidelines are followed and program outcomes are achieved (Role of Tuberculosis Coordinators in NSW). The TB coordinator is to be the primary contact point for the NSW TB program. The TB coordinator is also responsible to ensure surveillance data for all cases are entered into NSW notifiable conditions surveillance system (e.g. NCIMS).

District and network TB services are to contribute to the development and review of policies, and support research activities consistent with the aim of reducing the incidence of TB in NSW.

Education and training are to be provided by TB services as required to healthcare workers, the community, and other stakeholders on all aspects of the prevention and management of TB.

3 TREATMENT OF TUBERCULOSIS

All cases of possible and confirmed TB are to be managed in conjunction with a TB service in the district or network. TB services are responsible for providing timely access to assessment, treatment, and follow-up of people being evaluated for TB.

All isolates of *M. tuberculosis* identified must be referred to the Mycobacterium Reference Laboratory for confirmation, drug susceptibility testing and genome sequencing.

Treating authorised prescribers must always treat TB disease with multiple anti-tuberculosis agents following the most recent evidence-based practice. The recommendations for treatment of drug susceptible disease can be found in the most recent Australian Therapeutic Guidelines on Antibiotics (eTG Antibiotic). Treatment of drug resistant TB are to follow the most recent World Health Organization consolidated guidelines on tuberculosis and the recommendations of the NSW TB expert panel (see section 3.3).

Appropriate treatment is required to minimise the risk of drug resistance, treatment failure and/or relapse. Adverse reactions to anti-TB drugs must be promptly identified and managed by clinicians.

3.1 Screening for Human Immunodeficiency Virus (HIV)

All patients diagnosed with TB in NSW are to be tested for human immunodeficiency virus (HIV). HIV testing is to be undertaken as soon as practicable after TB diagnosis as

the early commencement of anti-retroviral therapy improves outcomes for people co-infected with HIV and TB.

3.2 Expert panel review

3.2.1 Expert panel review for rifampicin or multidrug resistant TB cases

All rifampicin resistant and multidrug resistant TB cases in NSW are to be reviewed by an expert panel. Expert panels will be convened by health protection NSW in collaboration with the treating authorised provider and the mycobacterium reference laboratory. The panel will provide advice on the clinical and public health management of the patient in line with current evidence-based practice and recent clinical experience.

3.2.2 Expert advice for other complex cases

Expert panel review can be requested to provide advice on other complex cases.

Treating authorised prescribers are encouraged to refer cases where the following issues are present:

- other resistance patterns where management is unclear
- complex drug intolerance
- complex co-morbidities
- significant paradoxical reactions
- where evidence is lacking to guide clinical practice
- minimal or no clinical improvement, or
- failure of sputum smear and/or culture conversion, or culture reversion, following more than two months of treatment.

3.3 Treatment adherence

Districts and networks, through their TB services, are responsible for supporting the patient to the successful completion of treatment to achieve cure for the patient and decrease the risk of disease recurrence, minimise the risk of developing antimicrobial resistance and the risk of infection to others.

The importance of developing a therapeutic relationship with patients at the beginning of treatment to ensure optimal treatment outcomes is acknowledged. This relationship provides the basis for ongoing clinician-patient rapport, effective case management, and the timely identification and management of adverse drug reactions.

Treatment adherence monitoring is particularly important for Aboriginal patients who experience higher rates of TB than non-Aboriginal people and have specific cultural and community obligations which may at times hinder treatment compliance (see section 4.2 for further information).

3.3.1 Assessment

A thorough assessment of patient needs, and barriers that may interfere with treatment adherence, is to be undertaken at the initiation of treatment. Barriers may include mental health or social issues, lack of access to appropriate services in rural/remote settings and work hours.

The initial assessment must be continuously re-evaluated considering clinical response, psychosocial issues, adverse drug reactions and any other challenges identified.

3.3.2 Monitoring

Treatment adherence is to be monitored using several alternate approaches, including by observation (in-person or videoconference), regular pill counting with blister packs, and use of other emerging patient-centred technologies.

Districts and networks must provide mechanisms to monitor adherence with treatment in a manner that is minimally restrictive to patients, while ensuring treatment success. A mechanism must be available to supervise all prescribed doses (up to seven days per week) for patients identified as being at significant increased risk of treatment non-adherence if required.

At a minimum, districts and networks must have the capacity to perform directly observed (in-person) therapy (DOT). Mechanisms for in-person directly observed therapy could include hospital or community centre clinic visits, and home visits by TB services, hospital in the home or community health providers. Video technology to support real-time and asynchronous video observed therapy (VDOT, eDOT or VOT) is also recommended.

Patients taking TB treatment require close monitoring regardless of whether their treatment is directly supervised or not.

3.3.3 Adherence monitoring recommendations

Patients prescribed thrice weekly intermittent therapy during either the intensive or continuation phase of treatment must be monitored closely. Methods for this may include direct or video observation of all doses due to potentially significant adverse consequences of missed doses.

Treatment adherence monitoring of at least five days per week is recommended for patients:

- diagnosed with rifampicin resistant-TB and multi-drug resistant-TB
- diagnosed with recurrent disease
- diagnosed with highly infectious TB, such as sputum smear positive patients and those with cavitary disease until they are non-infectious
- experiencing significant adverse drug reactions requiring the cessation and gradual re-introduction of medication until stabilised on an effective treatment regimen
- residing in institutional settings such as hospitals, aged care or residential care facilities, adult correctional centres, and youth justice centres

- with unstable psychological conditions or unstable social situations
- where expected clinical improvements are not observed such as extended time to smear and/or culture conversion, or radiological deterioration
- where there is evidence or suspicion that prescribed treatment is not being adhered to.

Treatment adherence is the key to reducing infection risk to others, reducing the risk of developing antimicrobial resistance and improving the outcome for the individual patient.

4 PATIENT CENTRED CARE

Patient management must be individualised and seek active input from patients to allow for the least restrictive management that enables them to achieve treatment success.

Wherever possible, clinical care is to be delivered in a manner that allows patients to maintain normal employment and/or education activities once non-infectious.

Key strategies to engage patients in treatment include assessment of health literacy, health education on TB disease, treatment, and medication side effects and an assessment of physical, psychological, social, and economic factors that may impact treatment outcomes. These may include mental health, appropriate housing, nutrition, and transport.

Cultural context is essential to patient centred care with consideration needing to be given to language, social context, and connection to country.

4.1 Culturally and linguistically diverse people

Individual approaches may be required to support culturally and linguistically diverse people diagnosed with TB in NSW. Aspects to be considered include identifying appropriate cultural brokers, including working with health workers from the relevant cultural background. District multicultural health units may be able to assist.

An accredited or certified interpreter must be engaged whenever language could potentially pose a barrier to effective care, including ensuring patient understanding of the disease, treatment, and importance of treatment adherence. Refer to the NSW Health *Standard Procedures for Working with Health Care Interpreters* Policy Directive (PD2017_044).

4.2 Aboriginal people

TB services must work in partnership with Aboriginal people to achieve the highest level of health possible for individuals, families, and communities. TB services must be tailored to meet the unique and local needs of Aboriginal individuals, families, and communities based on the principles outlined in the NSW Health Policy Directive *NSW Aboriginal Health Plan 2013-2023* (PD2012_066). This includes building trust through partnerships, including local Aboriginal community-controlled health services (ACCHSs), and ensuring integrated planning and service delivery with Aboriginal people.

Aboriginal health workers, Aboriginal health practitioners and Aboriginal liaison officers within the districts and networks can assist TB services in determining culturally appropriate approaches to care.

TB services must ensure that staff and the services provided are culturally competent and designed to deliver respectful, responsive, and culturally sensitive services with Aboriginal people.

All TB services staff must complete the online and face to face training as per the NSW Health Policy Directive *Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health* (PD2011_069).

5 PUBLIC HEALTH MANAGEMENT

5.1 Infection control

Infection control advice on managing patients with confirmed or suspected TB is available to minimise the risk of TB transmission to staff and other patients in healthcare settings. This includes the appropriate use of airborne precautions, negative pressure rooms and personal protective equipment.

All healthcare workers are required to comply with NSW Health Policy Directive *Infection Prevention and Control Policy* (PD2017_013) and the relevant sections of the NSW Infection Prevention and Control Practice Handbook to minimise the risk of TB transmission in healthcare settings.

For non-admitted patients that remain infectious and are being managed in the community, home isolation and exclusion from public places such as schools and workplaces are to be implemented to minimise the risk of transmission.

5.2 Management of people knowingly placing others at risk of infection

A person who has been diagnosed with TB is required to take reasonable precautions against spreading the condition. As a Category 4 Scheduled medical condition, the *Public Health Act 2010* contains mechanisms to restrict the behaviour of a person who has TB in certain circumstances, using a Public Health and/or Detention Order, where all other mechanisms of engaging a patient in care have failed.

District and network TB services must quickly identify patients that are putting other people at risk, or are at-risk of such behaviours and use the NSW Health Policy Directive *Tuberculosis Management of People Knowingly Placing Others at Risk of Infection* (PD2015_012) to encourage, facilitate, and if required enforce compliance to TB treatment.

5.3 Contact investigation and screening

District and network TB services are required to undertake contact investigation and screening of contacts in line with the NSW Health Guideline *Tuberculosis Contact Investigations* (GL2019_003).

5.4 Immigration referrals

TB services are to triage, investigate, and provide follow-up care to people referred from the Department of Home Affairs or the immigration service provider (currently Bupa Visa Medical Services) that live within the district or network boundaries. Nursing triage and medical review (minimum CXR and file review) are to occur within the following time frames:

5.4.1 Nursing and medical review times for immigration referrals

Referral type	Nursing triage	Medical review
Urgent referrals*	1 working day	3 working days
Onshore deferral	2 weeks	2 months
TB health undertaking	2 months	4 months

* Referrals received from a Medical Officer of the Commonwealth, usually by telephone

TB services are required to update appointment details and management plan on the relevant Department of Home Affairs database (e.g. HAPLite) for patients referred on a TB health undertaking. Clinic attendance reports must be provided for patients referred on an onshore deferral by uploading to the relevant Department of Home Affairs database or providing by email or fax to the Immigration service provider when TB disease has been excluded or treated.

TB services must notify in a timely manner non-attendance of people referred by the Department of Home Affairs or the immigration service provider via the HAPLite database or by email or fax to the immigration service provider.

Immigration clients are to be seen by TB services prior to discharge to physically check for signs and symptoms of active TB and risk factors for disease re-activation. The most recent radiology reports are to be reviewed alongside the images prior to discharge from TB services.

6 PREVENTATIVE SERVICES

6.1 Latent TB infection testing and preventive therapy

Districts and networks are required to provide testing for latent TB infection to individuals at risk of acquiring TB infection or those vulnerable to disease progression. This includes, but is not limited to, close contacts of a known infectious TB case, health care workers with known exposure, refugees, recent immigrants from countries with high TB incidence, and persons with conditions associated with increased risk of TB disease progression.

Districts and networks must review and follow-up health care workers and students that test positive for latent TB infection, in line with the NSW Health Policy Directive *Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases* (PD2020_017).

Where appropriate, preventive therapy is to be offered to those diagnosed with latent TB infection and to those who are at risk of rapid progression to active TB following recent TB exposure (e.g. children less than five years of age).

6.2 Bacille Calmette Guérin (BCG) vaccination

Districts and networks are required to provide a BCG vaccination service to residents living within the district or network boundaries. Districts and networks may negotiate with other districts and networks to offer BCG vaccination services on their behalf. The recommendations for BCG vaccination are as per the NSW Health Policy Directive *BCG (Bacille Calmette Guérin) Vaccination* (PD2013_032).

7 CHARGING FOR TUBERCULOSIS RELATED SERVICES

TB prevention and care requires effective and timely diagnosis of cases, and assessment and screening of people at increased risk of infection. To minimise the public health impacts of TB, it is important that there are no barriers to participation in screening and treatment, including costs.

7.1 Provision of TB services free of charge to the patient

All services related to diagnosis and treatment of presumptive or confirmed TB (active or latent) and complications arising from the TB disease process must be provided at no charge to patients within the NSW public health system. This includes the provision of services for TB related investigations, care and treatment, and management of any disease- or treatment-related complications.

This policy applies to, but is not limited to, the following:

- All Australian residents, including persons in adult correctional facilities and youth justice centres
- Migrants and refugees referred by the Commonwealth and/or State Health Departments or their nominated delegates
- Persons who are ineligible for Medicare benefits
- Temporary residents or overseas visitors
- Asylum seekers
- Persons without legal status in Australia.

NSW Health Policy Directive *The Medicare Ineligible and Reciprocal Health Agreement – Classification and Charging* (PD2016_055) mandates the provision of TB services free of charge for infection control and public health containment purposes.

This Policy applies regardless of whether the person attends with or without a referral from another health care provider.

7.2 Investigation

All clinical, laboratory, radiological and other investigations for cases, or possible cases, of TB (active or latent) carried out through admitted patient and non-admitted patient services (including ambulatory care services) in NSW public hospitals and health facilities must be provided free of charge to the patient.

7.3 Treatment and medication

All medications related to the treatment of active or latent TB provided through admitted patient and non-admitted patient services in NSW public hospitals and health facilities must be provided free of charge to the patient.

This includes any medications or treatments for complications or to ensure that TB treatment can be tolerated and completed without side effects.

Investigations required for patient monitoring prior to and during treatment, such as, but not limited to, blood chemistry, audiometry, and visual acuity, carried out through admitted patient and non-admitted patient services in NSW public hospitals and health facilities must be provided free of charge to the patient.

7.4 TB prevention

The provision of TB prevention services through admitted patient and non-admitted patient services in NSW public hospitals and health facilities must be provided free of charge to the community and patients. These services include contact tracing assessments (TB skin test or blood test, chest radiography, and TB clinical review), preventative therapy for latent TB, and professional and community education.

7.5 Charging for specified tuberculosis services

Districts and networks may apply a fee for services in the following specific situations (7.5.1-7.5.5), however, issues surrounding financial remuneration must not delay investigations, care, or treatment for persons with TB.

7.5.1 Occupational screening for students and new healthcare workers

Students and new health service employees who require a screening test for latent TB infection in accordance with the NSW Health Policy Directive *Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases* (PD2020_017) may be charged.

Any investigations following a positive test for latent TB infection must be provided free of charge.

7.5.2 Occupational screening for existing healthcare workers

Districts and networks are responsible for meeting the cost of occupational screening programs related to TB, including TB skin test, blood test or chest radiography for existing healthcare workers.

TB services may charge the relevant NSW Health department on a cost recovery basis only.

7.5.3 Occupational screening (other than healthcare workers)

TB services may charge any worker or group of workers requiring occupational screening for TB on a cost recovery basis only, unless this is related to contact screening, in which case it must be provided free of charge.

7.5.4 Immigration detention

Where TB services are provided to a person held in Commonwealth immigration detention or in community detention, the district or network may charge the Commonwealth Department of Home Affairs through its contractor at the appropriate ineligible patient rate.

7.5.5 BCG vaccination

TB services may elect to charge patients a service fee for BCG vaccination.

7.6 Referral to private providers

Where a public health organisation initiates TB investigation (on behalf of a patient) with a private practitioner or service, the public health organisation is responsible for meeting the cost of the service or investigations. This includes, but is not limited to, costs associated with offsite chest radiographs conducted by a private radiology service, and private pathology services. The patient is not responsible for meeting these costs.

Districts and networks must have mechanisms in place for the reimbursement of private practitioners or services.

7.7 Medicare benefits

Medicare benefits cannot be paid for professional services related to the care and treatment of TB provided for public patients in public health facilities funded by either the State or Commonwealth Health Department unless the Federal Minister for Health has directed that Medicare benefits are to be paid, for example where exemptions from section 19(2) of the *Commonwealth Health Insurance Act 1973* are allowed.