Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College Submission
July 2022

Australian National Audit Office (ANAO) Audit: Expansion of Telehealth Services during and post the COVID-19 pandemic

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care***. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM has more than 5000 rural doctor members with1000 doctors in training, who live and work in rural, remote, and indigenous communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

The College welcomes the opportunity to provide feedback to inform the audit of the Department of Health's[1] management of the expansion of telehealth services during and post the COVID-19 pandemic.

The more rural and remote you live in Australia, the more difficult it becomes to access medical and healthcare services and this is reflected in the sharp decline in per capita MBS billings that occurs with remoteness.[2] Even before the pandemic, access to service was a critical issue. Those living outside

[1] Now the Department of Health and Aged Care

[2] AIHW. (2021). *Medicare-subsidised GP, allied health, and specialist health care across local areas: 2019–20 to 2020–21.* Retrieved from https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21

metropolitan areas experience poorer health outcomes, often having shorter lives and higher incidence of disease. This puts people living in rural and remote areas at greater risk of health complications arising from COVID-19.

While telehealth consultations can improve access to healthcare, they can never replace high quality, in-person care arrangements. Both patients and providers have shown strong preference to have both these options available to them, and to be able to make use their local, continuous, in person, face to face healthcare services as well as any telehealth opportunities.

Telehealth consultations, when backed by appropriate staff, resources, systems, and training, can substantively improve the quality of medical care that our doctors provide to rural and remote communities, however, government policy needs to take cognisance of some key issues:

- That telehealth use in rural and remote areas is largely telephone-based and many of the most vulnerable patients such as the aged, and the economically disadvantaged and people in very remote situations are often the people least likely to have access or capacity to use video-conferencing options.

- That given the disproportionate reliance on telehealth by people in rural and remote communities, feedback from members strongly indicates that the removal of MBS items for longer telephone consults will undoubtedly serve to widen the existing health disadvantage experienced by people in rural and remote areas, including older Australians and people in remote Aboriginal and Torres Strait Islander communities. This is particularly relevant during the winter period where there is heightened need for a response to COVID-19 and influenza outbreaks. Longer telephone conversations with rural GPs in proximate rural areas are vital for service access in rural and remote communities. Members of the College's rural and remote Community Reference Group have raised similar concerns.

- That removing the support for general practitioners to take part in patient telehealth consultations with a consultant specialist has been a retrograde step in addressing the fragmentation of care that impacts on the quality of care that people in rural and remote areas are able to receive.

Response to Consultation Questions

1. Was the expansion informed by robust planning and policy advice?

The response to the COVID-19 pandemic highlighted the confusion created by the differing responsibilities and legislative scope of the Commonwealth, States and Territories. In the initial stages of the pandemic, this disjoint resulted in a time lag between decision making, communication and implementation, further adding to confusion. However, communication did improve as the situation progressed and systems and processes were refined.

With reference to the temporary introduction of MBS rebates for primary care telehealth consultations in the early stages of the pandemic, in this and other policy areas, the College was able to have a very strong and regular line of communication to the Minister and the Department at a senior level. ACRRM was able to inform them on key issues as they arose in rural and remote communities including any unintended consequences and to make recommendations for adjustments.

Rural and Remote Access

MBS funded telehealth consultant specialist services have been available to some parts of the Australian health service since 2011, when a limited number of Medicare rebates and incentives were made available for video consultations with consultant specialists. This funding was introduced to address some of the barriers to accessing medical services, particularly non-GP specialist services,

for Australians in remote, regional, and outer metropolitan areas. In many cases, these telehealth consultations provide patients in eligible areas with access to consultant specialists sooner than would otherwise be the case and without the time and expense involved in travelling to major cities.

The College has consulted extensively since this time with the Australian Government about the merits of further expanding Medicare funding for telehealth services to include:

- GP to Patient telehealth consultations
- GP Consultations where the patient is not present, such as
    - GP to Specialist
    - GP to Remote Area Nurse
    - GP to Aboriginal Health Worker
    - GP to RACF Nurse
- Store and Forward telehealth services – such as Tele-Derm[3].

Removal of Loading for Rural Services

As part of the 2011 funding arrangements the College strongly supported the loading that was applied to each telehealth MBS item billed in recognition of the setup, delivery and extra work required during each telehealth consultation to maintain both quality and safety, which is not required during an in-person consultation e.g. additional identity checks, complexities of talking a patient through a physical examination; and dealing with technology issues. In June 2019 the MBS Taskforce consulted about changes to Consultant Specialist Item Numbers which included those for telehealth consultations.

The College made it clear in its Submission to the MBS Taskforce in 2019[4] that the removal of the 'loading' or 'incentive' to these item numbers would impact rural patients access to care:

> ***"Telehealth Recommendations:*** *The College has particular concerns about the proposed changes in Recommendation 7 – A new framework for telehealth and the potential for these changes to create barriers for patients living in rural and remote locations in accessing healthcare. ACRRM regards telehealth as a significant enabler for rural and remote patients in accessing specialist services without the associated costs and burden of travel and time away from home or work.*
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> *In particular, the College questions the rationale that the incentives for uptake of telehealth are no longer required because they have not resulted in a significant increase in usage. The telehealth MBS item numbers were introduced in 2012 and included the item numbers and an on-boarding incentive. The on-boarding incentive ceased in 2014 and the item numbers remain. It is important to distinguish between the incentives scheme that is now retired and the additional item number loading, which is not an incentive for use.*
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> *Even though there has been a reduced level of uptake, ACRRM believes that the incentives have made a significant contribution to maintaining the level of telehealth consultations and that many specialists who provide telehealth services rely on these incentives to cover the increased administration and infrastructure costs associated with telehealth consultations. Telehealth consultations require technology and administrative support to enable efficient delivery. These*

[3] https://mycollege.acrrm.org.au/search/find-online-learning/details?id=13725
[4] https://www.acrrm.org.au/docs/default-source/all-files/s190628-mbs-consultant-and-specialist-physician-clinical-committee.pdf?sfvrsn=1d566dec_12

include telehealth equipment, scheduling software and mechanisms to collate and email patient records and investigation results - all of which add to the cost of the consultation.

Feedback from consultant specialists and telehealth coordinators indicates that organising a telehealth consultation is more complex and time consuming than a face to face consultation because it requires real-time coordination of two doctors in two different locations and the patient. Given the cost structures involved, there is a significant risk that the proposed changes to reduce the fee available to the specialist for a telehealth consultation will result in the specialist either being forced to pass on the gap payment to the patient (something rural and remote families can ill afford) or withdrawing from providing telehealth services. It will be rural and remote patients who will suffer most from these consequences, although there would also be a detrimental impact on rural and remote GPs who rely on specialist support provided through telehealth consultations.

The report recommends that any savings made through changes to the fee for the telehealth item number be made available for training and education to increase uptake of telehealth. ACRRM has invested significantly in this area, developing standards, guidelines, and education opportunities for its members. The College consults widely through a diverse range of stakeholders and is regarded as a national leader in the field. ACRRM does not agree with the proposal to use any savings to fund Primary Health Networks (PHNs) to undertake education and engagement activities. In the College's experience, the performance of the PHNs is variable, especially in terms of their engagement with, and support for, medical practices. Education and training are not commonly reported as barriers to the uptake of telehealth.

The College identifies key barriers in coordination and scheduling and the current funding models which do not support services such as store-and-forward consultations (which are particularly useful in areas such as dermatology) and case conferencing between a consultant specialist and the local treating GP. The willingness of consultant specialists to offer telehealth access is a significant barrier and there is no real evidence that suggests that 'education' is the answer, rather that other factors are required to change behaviour. Rather than increasing expenditure on education and communication, it would be preferable to develop a robust and realistic funding model for MBS rebates for consultant specialist telehealth consultations, and fund this accordingly."[5]

Despite these comments, the changes were introduced in January 2022 and rural loading was removed. The changes also included the removing the funding for a GP to attend the patient telehealth consultation with a Consultant Specialist in support of the patient and the Consultant Specialist.

It was particularly unfortunate that this change came at a time when healthcare providers were still managing the outcomes from COVID-19 pandemic and seeking to see patients using telehealth rather than in person.

The College considers the decision to not fund the in-situ GP who provides continuity of care to be part of the consultation was a critical error on the part of policy makers which has almost certainly exacerbated the fragmentation of patient care. This is detrimental to healthcare everywhere but especially injurious for people living in remote and rural communities. In these areas, the in-situ doctor is required to appropriately deliver all follow up care and expected to address whatever emergency situations may arise. People living in these areas receive far fewer MBS billed services of any form from non-GP specialists and rely far more on the continuing care of their local doctors and health professionals. People in remote areas for example, received 59% fewer MBS billed services from non-GP specialists than people in major cities in 2020-21.[6] Of note, patient surveys have found that the

[5] https://www.acrrm.org.au/docs/default-source/all-files/s190628-mbs-consultant-and-specialist-physician-clinical-committee.pdf?sfvrsn=1d566dec_12, pages 2-3

[6] AIHW. (2021). *Medicare-subsidised GP, allied health, and specialist health care across local areas: 2019–20 to 2020–21.* Retrieved from https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21

likelihood of a general practitioner not having been informed of their patients' care received by specialist increased significantly with remoteness.[7]

Feedback from Members

The College has received feedback related to the changes to the telehealth schedule from our members who are Rural Generalist doctors working across rural and remote Australia.

The advice we received from our members highlighted that they anticipated that this would lead to their no longer participating in their patient's telehealth consultations and that this would increase out of pocket costs to the visiting consultant specialists as well as to their patients.

Example

"We are seeing the impact of the poorly publicised change to the telehealth schedule. We are now receiving emails from Specialists withdrawing services from our patients. The fanfare last week *has hidden a significant "gotcha" that has not been publicised.*

The immediate impacts of this change will be:

- *Increased out of pocket costs for our visiting plastic surgeon service as we can no longer use the nurse item for telehealth enabled dressings and wound reviews by the specialist.*
- *Increased out of pocket costs for our patients seeing Psychiatrists (we have a very limited visiting service and almost universal telehealth psychiatry)*
- *Cessation of Patient end supported Telehealth, we host at a minimum 4 - 5 telehealth specialist consultations almost every day. This involves a dedicated room and administration assistance. Patients are assisted in many ways to meet the needs of the specialist inclusive of taking observations, providing prescriptions etc…"*

FACRRM, Emerald, Queensland

2. Was the expansion supported by sound implementation arrangements?

Due to our extensive involvement in telehealth education and support since 2011 the College and its Members were well positioned to increase their delivery of telehealth services during the COVID-19 pandemic, albeit that access to equipment such as web cameras was difficult to obtain due to a shortage of supply in Australia.

The expansion and fee arrangements were decided upon and implemented quickly, without appropriate planning or messaging to ensure the profession was equipped, prepared, and felt comfortable with the new arrangements. Despite these shortcomings, as many of the College's members were already experienced in providing telehealth consultations to service their rural communities (the College Curriculum[8] has included telehealth and eHealth skills and competencies since its introduction in 1997), our members were well positioned to commence the service expansion. The College's knowledge, expertise and resources were in high demand in the early stages of the pandemic and we welcomed the support we could offer the Commonwealth Government in delivering

[7] AIHW (2016) *Survey* of Health Care: selected findings for rural and *remote* Australians. Cat. no. PHE 220. Canberra.
[8] https://www.acrrm.org.au/resources/training/curriculum

telehealth education and support which included reviewing several new resources created by the Government such as the COVID-10 Telehealth Items Guide.[9]

Accessing information about MBS Telehealth Items

The past two years has seen a high volume of changes to Medicare funding of telehealth services, often taking place over short periods of time. The information provided on websites quickly became out of date and College staff required to constantly make checks to update their knowledge and expertise, and to ensure that they were across which web pages were current, and to validate where up to date information could be sourced. For example:

- The web page https://www.health.gov.au/health-alerts/covid-19/coronavirus-covid-19-advice-for-the-health-and-disability-sector/providing-health-care-remotely-during-the-covid-19-pandemic provides some information on telehealth but does not link to supporting resources such as the factsheets and the guide.
- This page on www.mbsonline.gov.au was last updated in November 2021 http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB
- A further page on the MBS Online website does contain the latest factsheets http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Arrangements-Jan22

This complexity of multiple web pages across both the Department of Health and Aged Care (www.health.gov.au) and Medicare (www.mbsonline.gov.au) websites, and a lack of maintenance of the pages impacted the College's ability to maintain the currency of its own information when linking to these web pages and resources. This would have been problematic for our members who commonly rely on the College to provide this information, and it can be assumed that for those who tried to source it independently, these constant changes would have presented even greater challenges.

The provision of telehealth factsheets[10] in 2020 was a new service offered by the Government. The factsheets were written for each health professional group and provided detailed information and answered many of our Members questions. We have found these factsheets very helpful and commend the Government in the time spent to produce and maintain these as an ongoing information resource.

Unfortunately, we didn't have the same experience with the production of the COVID-19 Telehealth Items Guide[11]. The Guide took a long time to produce and be made available. The College was consulted to review the content and provide feedback on the content within the Guide. The Guide has not been updated since December 2021 and hence is no longer a resource we can use to support Members in their understanding of Medicare billing for telehealth consultations.

The College would like to recognise the support it received from Roland Balodis, (Director – GP Section Medical Benefits Division of the Australian Government Department of Health) and his team. Having direct contact to key personnel to answer questions and provide advice and guidance to College staff and it's 'Rural and Remote Digital Innovation Group' was immensely helpful in the period of significant change with the telehealth Medicare item numbers.

[9] https://www.health.gov.au/sites/default/files/documents/2020/12/coronavirus-covid-19-telehealth-items-guide.pdf

[10] http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Arrangements-Jan22

[11] https://www.health.gov.au/sites/default/files/documents/2020/12/coronavirus-covid-19-telehealth-items-guide.pdf

3. Has monitoring and evaluation of the expansion led to improvements?

ACRRM, with the Rural Doctors Association of Australia undertook the advocacy that led to the initial establishment of MBS rebates for primary care telehealth consultations. At that stage, these were limited to communities experiencing extreme hardship due to the drought. The College was therefore pleased to welcome the widening of this policy and the eventual introduction of permanent MBS rebates for primary care telehealth consultations announced in December 2021.

The College believes that telehealth services form an essential component of effective rural and remote practice where they are used to complement, but not replace, face-to-face services. However, the subsequent removal of MBS Items for telephone consults at the end of June 2022 is of grave concern, particularly when many telehealth sessions across rural and remote areas take place by telephone, and not by video conference.

As argued in our initial discussions around the establishment of the original telehealth primary health care policy numbers arrangements, the College is pleased to support and incentivise telehealth through video conferencing, but this should not prevent people that are not able to use this technology living in remote parts of the country from receiving vital services. It is noted that videoconferencing capacity is far from guaranteed throughout rural and remote Australia and furthermore, this technology itself presents an access barrier for many patients who are uncomfortable or unable to work with it. It is likely that many such patients have particularly high healthcare needs, such as the elderly, and people with low socio-economic status.

Removal of MBS Item Numbers for Telephone Consults of 20 Minutes or more

Members have pointed to concerns about the Government's decision not to continue with Medicare telehealth item numbers for phone consultations lasting 20 minutes or more. Our Community Reference Group has raised similar concerns. These item numbers ceased on the 30 June 2022 and have not been extended in line with the announcement at National Cabinet on 17 June 2022 that current COVID-19 health funding arrangements would be extended until the end of the year.

At the time of writing, the relevant Medicare webpage has not been updated to reflect the cessation of these item numbers on 30 June. It is therefore unclear whether they will continue.

Example

"I find them (20 min MBS funded phone consultations) very useful as I have a large number of house-bound elderly patients who appreciate being able to get phone support. This is particularly important in Rural areas and very recant these days with increasing isolation and need for mental health support.
Many older patients cannot cope with the technology of video consultations ("telehealth") and the telephone is adequate usually for patients well known to the practice. I would hate to lose access to this important means of support and availability for mutual benefit to GPs and patients."

"I have to agree that the long phone consults are excellent for my elderly patients. A substantial proportion of my patient base are over 80, and a lot only have a home phone."

FACRRM, Rural NSW

Given the disproportionate reliance on telehealth by people in rural and remote communities, the removal of MBS items for longer telephone consults will undoubtedly serve to widen the existing health disadvantage experienced by people in rural and remote areas including people in remote Aboriginal and Torres Strait Islander communities. Telehealth services delivered by telephone by a proximate rural GP can facilitate access to healthcare services in rural and remote communities.

COVID-19 Situation July 2022

ACRRM and the Rural Doctors Association of Australia (RDAA) have contacted the Minister to request the return to long telephone consultations for a period of three months, as an emergency plan measure. With case numbers at current levels, it is important that for COVID-19 positive patients, or patients with symptoms, that our GPs return to an increased use of telehealth. Re-introduction of this item will help to protect health care professionals so they can continue to provide care to their communities, as well as to provide the maximum access to GP appointments.

Furthermore, the College has not seen solid evidence of the government undertaking monitoring and evaluation. The evaluation should include both patient and health professional feedback. There needs to be further investment in research and evidence on the impacts of patient accessing health services when using telehealth services.

4. Additional Comments

General practice telehealth which is clearly linked to a continuous care relationship has played an extremely important role in enabling triage, assessment and follow up of patients in rural and remote communities and it is important that it be supported to continue into the future. Other models such as those involving the patients primary care doctors and their specialist consultant or the patient, their general practitioner and their remote care nurse have clear capacity to improve remote peoples' care. These should be supported by appropriate funding mechanisms.

New technologies have the potential to greatly enhance care but should also support rather than replace human-driven, continuous care relationships. There is a risk of information technologies driving a trend toward low value, high convenience primary care. There is also risk that the interpersonal human relationships that are at the centre of effective primary care may be lost to the efficiencies of easy-to-access care. The pandemic lockdowns, highlighted for many of our members, how vital rural and remote GPs were to the support and well-being of their vulnerable, elderly patients, for whom their telehealth consultations with their GP became a vital opportunity for human contact. It is important that this most critical element of primary care is not lost going forward, particularly now that many telehealth services will continue under a restricted model which largely excludes long telephone consults.

Going forward, ACRRM views it as critical that further reforms take a role in steering emerging trends to assert the primacy of the importance of continuity of care and human relationships in the delivery of primary care. The College sees value in the reform process contributing to further exploration of options for appropriately financing other potentially valuable telehealth/digital health models of care that can enhance primary care especially in the remote setting.

There are still areas of Australia where limited access to adequate internet bandwidth and mobile phone coverage are significant impairments to the delivery of telehealth services. These deficiencies should be addressed urgently as part of the broader digital health policy agenda. Significant and ongoing investment is required in programs such as the mobile blackspot and regional connectivity programs, to enable expansion of the mobile network and guarantee access to affordable voice and data services which meet minimum standards of reliability. This is particularly important given the telehealth funding levers which support the use of video consultations.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future