Consumers Health Forum of Australia

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1. INTRODUCTION

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interest of Australian healthcare consumers and those with an interest in healthcare consumer affairs. CHF works to achieve safe, quality, and timely health care for all Australians, supported by accessible health information systems.

Consumer views and experiences are not only an important barometer of the health system, but their involvement, insights and behaviours can also be the change makers in health policy and practice. On 13 March 2020 the Federal Government introduced a range of new telehealth items directly related to addressing the growing Covid 19 pandemic. On 20 April 2020 additional telehealth items were introduced for non-GP specialists and allied health providers. In just 6 weeks 274 new MBS items were created. The stated objectives were to provide an alternative to face-to-face consultations in an effort to reduce the increasingly rapid spread of the virus, protect patients and health providers and to save lives. In response to a national and international health emergency, normal processes related to the introduction of new MBS items were substantially streamlined. Consequently, since their initial introduction, these telehealth MBS items have been continuously and frequently subjected to change.

2. CHF TELEHEALTH RESEARCH CONTRIBUTION TO POLICY DEVELOPMENT

Telehealth policy recommendations arising from extensive research, in which CHF has been involved, focus on embedding telehealth into the MBS. Importantly CHF holds to a commitment to patient choice in terms of how they access their health care – in this context choice also relates to the "means" in terms of video, telephone or face-to-face. This gives rise to a need for improvements in varied mediums to provide consumer choice.

CHF has been an active participant and adviser in digital health initiatives, including the development of the original National Digital Health Strategy, the roll-out of the opt-out strategy for My Health Record and more recently the implementation of e-prescriptions and telehealth. CHF has participated in and led extensive research and consultations with consumers as COVID has driven the introduction of digital health innovations. We have also advocated for strategies to ensure equality of access to digital health care modalities, such as 'digital navigators' and our support for the digital health literacy and education work of organisations such as The Good Things Foundation.

Overall, consumers see the opportunities digital health can deliver, particularly following the expansion of telehealth items during Covid. There is now a real desire among consumers to see improvements in how digital health is delivered and indeed extended. This is particularly the case for rural, remote, and regional consumers but importantly for all consumers throughout the country with disabilities and/or chronic illness that currently reduce their access to healthcare.

In 2021 CHF participated in a collaborative research project with the Digital Health Collaborative Research Centre, Curtin University and Deloitte (Australia) which focused on consumer experiences and attitudes to telehealth. The research was supported by the

Federal Department of Health. (DOH)[1] A final report was submitted to DOH in late 2021 and followed by an information session with Departmental representatives to present the research results.

In 2021 CHF also undertook research for the Australian Digital Health Agency (ADHA) on consumer experiences with digital health and in particular telehealth which represented a significant contribution to development of the ADHA's draft of a revised National Digital Health Strategy. We are advised by ADHA that the final CHF report was shared with DOH.

Neither the research reports provided to DOH or ADHA are publicly available. Research papers on data from the collaborative research project undertaken by CHF and Curtin University are currently under review for publication in Australian and international journals.

3. CONSUMER ATTITUDES AND EXPERIENCES ON THE INTRODUCTION OF TELEHEALTH

Telehealth has demonstrated that it can provide a means of increased access to and engagement in healthcare for consumers who are marginalised, including those living in rural and remote areas, and disadvantaged and minority groups. CHF research indicated, however, that processes need to be improved to provide equity in access (e.g., interpreter services, improved digital literacy). Accessing care via telehealth can also, for some consumers, remove some of the stigma and discomfort they may experience attending face-to-face appointments, particularly among vulnerable groups, and encourage engagement with services that may otherwise not have been considered. Overall, telehealth may increase equity in access for those that find attending a face-to-face appointment physically, psychologically, logistically, or culturally challenging.

Research delivered a consistent view that consumers do not see telehealth as a replacement for face-to-face consultations but a valuable additional option, particularly for straightforward issues such as prescription renewals and ongoing care management. International research indicates that digital health can help improve access and outcomes for some and has considerable benefits when integrated alongside face-to-face care.

A strong view expressed throughout the research was support for use of telehealth where an existing relationship exists either between the GP or practice. This contributed to confidence in the quality of the consultation and health advice provided to consumers in that the provider would have direct knowledge of or access to their health information.

Consumers' perception of the "value for money" of telehealth is that they view it as less value than face-to-face, largely because of shorter consultation times, the inability to be assessed comprehensively, and the impersonal nature of a virtual consultations. Work needs to be done to explore willingness to pay aspects and how these relate to rural and remoteness, gender,

[1] The Federal Government Department of Health, Health Economics and Research Division commissioned the Digital Health CRC, Consumers Health Forum of Australia, and Curtin University to undertake research that captured the consumer preferences and experiences of telehealth across Australian general practice.

and age. Consumers living in rural and remote settings tended to value telehealth higher than those in urban areas, which relates to the increased access to services afforded by telehealth.

In late 2020 a final report from CHF's Consumer Commission was published for consideration by the broader consumer community, as well as ministers, governments, health care professionals and industry representatives. The Commission report noted that there is a growing evidence base showing the effectiveness of telehealth consultations for a range of services and that funding models (both public and private) need to recognise telehealth as an ongoing part of healthcare.

4. GOVERNMENT PLANNING AND CONSULTATION

Given CHF's contribution to specific research on telehealth for ADHA (shared with DOH) and DOH and provision of policy recommendations based on research outcomes, there was a reasonable expectation that CHF would contribute or participate in DOH consultations on proposed changes to telehealth MBS items. While CHF had the opportunity to participate in an information session with DOH on the collaborative research and policy recommendations no further follow up or consultation occurred.

While there was an expectation that the temporary telehealth MBS items, introduced as an "emergency", measure would change after a review by DOH there is significant disappointment that CHF has not been part of this process in terms of consultation. This is of particular concern given the facts that consumers have welcomed and embraced telehealth and that the numerous changes to MBS item numbers significantly impact on a range of high need and marginalised consumers.

The recent elimination of around 70 telehealth items and changes to time limits for GP telehealth consultations items are of particular concern in terms of impact on consumers who are already marginalised in access to health care – and particularly as Australia faces a further COVID wave this winter. While face-to-face and visual consultations may be preferred and the 'gold standard', telephone telehealth protects both patients and health professionals from exposure and potential infection. A case could be made to further extend temporarily for 3-6 months. A case could also have been made for exempting specific groups of consumers, rural, remote, and those with chronic health and or disability issues that impact on mobility, from restricting GP telehealth time limits to Level B consultations.

Further, there is concern for those with mental health issues which have increased significantly with Covid and continue. CHF shares concerns expressed by Lived Experience (Australia) at the decision to remove the option of utilising the telephone for telehealth services from health professionals providing essential mental health care. However, this new limitation of video only for long consultations has been applied to a significant range of MBS items. This restriction to video only for longer consultations severely limits access to those with little or low digital literacy and as the 2021 Telstra Digital Inclusion Index clearly shows it is these consumers that are most highly digitally excluded. Digital exclusion data is linked to low socio-economic status and lower education levels. Thus, CHF would argue that based on the data and research this change alone actively discriminates against these consumers who also represent cohorts with higher health needs and who are already marginalised. It also

impacts on rural, remote, and regional consumers who experience ongoing and, in some cases, a severe lack of and/or instability of connectivity and, again, are among the most marginalised in terms of access to healthcare.

There is no data that CHF is aware of that indicates consumer preference for video over telephone consultations or the impact on perceptions of the quality of the consultation. Neither in the extensive research undertaken by CHF and Curtin University, and that undertaken by CHF for ADHA, was preference for video over telephone raised by consumers in terms of the quality of the consultation. Rather consumers focused on the difference between a telehealth consultation, whether video or phone, and face to face consultations. CHF thus questions the rationale for the decision to limit longer consultations to video. Video consultations were and are predominantly used by non-GP specialist and some allied health providers. However, this in fact gave rise to complaints from some consumers who had several different health providers about the numerous and different platforms that were used by providers and the complexity and frustration it caused even for the digitally literate consumer. CHF the underpinning rationale for introducing such a limitation which impacts so adversely on consumers, particularly those most in need, with multiple providers and with varying degrees of literacy and/or connectivity. CHF would argue that a better, and more consumer centred approach, could potentially have been one that aimed to drive consistency, through a standards-based approach, in the use of video platforms for telehealth consultations.

5. TELEHEALTH "RULES" CONFUSION

With the initial introduction of telehealth items during the pandemic there was some confusion that arose given the absence of clear advice to consumers. CHF was not consulted prior to their introduction but simply informed.

The numerous and frequent changes to "rules" around the provision and delivery of telehealth services has not only created confusion for providers but also consumers. One minute GP consultations are bulk billed and the next they are not, for example. While these ongoing amendments to the rules can be excused to some extent given their rushed implementation at the height of the Covid pandemic, the ongoing nature and frequency of the changes and poor communication about the changes cannot. Further there was little or no information on changes that CHF could provide to consumers as they were altered frequently without consultation, or advice including the rationale behind such changes. The different "rules" for non-GP specialists that did not require consultations to be bulkbilled also created confusion particularly reflected in complaints of sometimes very high charges for an extremely short consultation.

The Royal Australian College of General Practitioners' submission to this consultation starkly demonstrated the continuous and overwhelming number of changes from the initial introduction of telehealth. Clearly changes that specifically impacted on consumers, in terms of costs and requirements for "use" by GPs represent a source of much confusion for both providers and consumers.

6. MANAGING CONSUMER EXPECTATIONS

With the initial introduction of telehealth items CHF is of the view that it should have been clear there was a need to manage consumer expectations and understanding of how telehealth was to be delivered. CHF would have liked to have seen guidance/information to consumers from DOH that we could have disseminated widely.

CHF heard numerous consumers complain that after a telehealth consultation the GP said the issue needed to be addressed in a face-to-face consultation. Complainants often saw this as GPs "rorting the system". CHF explained to consumers that providers base this decision on their obligation to ensuring quality and safety and in this context their provider had every right to require the patient to attend face to face in the interests of the safety and quality of their care. Certainly, in some instances this situation could have been avoided by the provision of guidelines for practice booking staff outlining some basic clinical health issues that were likely to be unsuitable for telehealth consultations, skin issues for example.

While CHF welcomes the incorporation of a range of telehealth items permanently into the MBS, we are concerned at a somewhat rash approach in decision making around the design of what items stay, those telehealth items now abandoned, and design decisions. It reflects an approach that has not taken into consideration the important benefits that telehealth has delivered to the most marginalised Australians who experience barriers to access of health care. It neglects extensive Australian research of the past 2 years or more that indicate a way forward to incorporate a significant step in integrating a basic digital technology into the Australian health system. Given the importance of this move in digital health it is very disappointing that consultations on consumer impact issues were seemingly overlooked. This is particularly the case because in collaboration with government CHF has and continues to actively work to drive consumer adoption of digital health.

Telehealth represented a first step for many consumers into the digital health world and they welcomed and embraced it. As such it set the groundwork for increased acceptance, trust, and use of developing digital health technology as part of the health system. There is no doubt that consumers who now miss out on the benefits of telehealth as a truly integrated and consumer focussed element of our progress in changing the health system, are left with a real sense that a measure that so improved their lives and access to health has been taken from them. This will no doubt impact on consumer adoption of digital health innovation and are likely to create a level distrust the "life span" and consistency of delivery of other digital innovations.

7. CONCLUSION

While health care services are designed to offer consistent access and delivery for everyone, the system's design frequently fails to acknowledge the various socio-economic, regional, and cultural barriers that hinder equitable access to care. This inconsistency is illustrated by the significant disparities in health outcomes and overall health of across the population.

The overriding impression is that telehealth was designed as a measure aimed at ensuring access to healthcare for all consumers. Recent changes, however, seem to treat Australians

as a homogenous population - which it is not, particularly in terms of equity in access to healthcare. The recent changes and elimination of a raft of telehealth MBS items appear to reflect an abandonment of the initial driving principle that represented a focus on, and concern for the health of all Australians.