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Letter to the Editor

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A Call for Addressing Barriers to Telemedicine: Health Disparities during the COVID-19 Pandemic

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Dear Editor,

Wright and Caudill [1] impart the importance of distance-based treatment in responding to the 2019 coronavirus disease (COVID-19) pandemic. Not only are clinicians confronting barriers to implementation of telemedicine, but many individuals in need of mental health care are also facing barriers to accessing telemedicine, though the internet and mobile devices seem ubiquitous in this era. These barriers can widen health disparities and undermine the considerable efforts made to mitigate COVID-19 impact globally.

Telemedicine is crossing the chasm between use by visionaries and adoption by pragmatists as technological infrastructure has advanced rapidly over the years. More clinicians begin to deliver mental health services remotely during the COVID-19 pandemic to limit travel and exposure. Telemedicine shifts prevention, treatment, care, and support from clinics to homes and mobile devices, which permits uninterrupted care of clients. Hence, it is urgent to identify barriers to telemedicine to inform the development of treatment delivery in order to address health disparities and manage COVID-19 impact in this challenging time.

Notwithstanding that it appears promising to make the most of telemedicine (through videoconference, telephone, e-mail, text, or apps) in responding to disasters and public health emergencies such as the COVID-19 pandemic [2], there are challenges to deliver timely care to individuals having pressing mental health needs at a distance. First, many individuals encounter barriers to telemedicine due to low socioeconomic status (SES) and the limitation of infrastructure among the least developing countries [3]. Nearly 3.6 billion people (i.e., around half of the world population) still remain offline, while 97% of the world population lives within reach of a cellular signal [3]. For example, some low SES and homeless individuals face financial barriers to afford smartphones and the internet [4]. Low SES is also associated with less freedom of leveraging the technology when and where one wants [5], which encumbers timely help-seeking behaviors and treatment delivery. Further, internet access plays a key role in providing important health care and supportive resources [6]. When the world urban and rural households are considered together, 43% of households do not have internet access at home, and the majority of the offline population are mostly in Africa (71.8%) and Asia and Pacific (51.6%) [3]. It is less likely for them to gain resources or internet access from relatives, friends, and communities due to privacy and confidentiality issues, and protective measures (e.g., city lockdown, stay-

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at-home order, social distancing) during the pandemic. Thus, some individuals lack access to providers offering telemedicine; meanwhile, clinicians cannot reach out to these populations and deliver timely care at a distance [7].

Second, not every internet connection is stable and suitable for telemedicine through videoconference because internet bandwidth often varies depending on geographic locations and internet plans [3]. Recent research [8] shows that internet-based video consultation offers advantages in respect of cost-effectiveness and building rapport compared to telephone-based consultation; meanwhile, the rate of internet-based video consultation continues rising, yet the rate of telephone-based consultation is in decline [7]. The clinical experience through videoconference will be, however, optimized when the bandwidth meets videoconferencing software requirements, according to a consensus guideline from the American Psychiatric Association and the American Telemedicine Association. Some clinicians and their clients may experience disruptions of communication if the bandwidth is occupied by other internet users (e.g., family, co-worker).

Third, telemedicine may not be accessible to individuals with disabilities and older adults [9]. Hearing and vision impairment may affect treatment delivery via telehealth technology. Age is another crucial factor associated with the inequality around telemedicine [5, 7]. For instance, the odds of leveraging telemedicine via teleconference are less for people aged 65 or older compared to those aged 64 or younger [7]. Given that mental health problems are prevalent in older adults [9], telemental health services are urgently needed during the pandemic. Still, older adults have limited access to internet-based services due to low SES, internet skills, and acceptance of technology [5]. Consequently, the inequality around telemedicine could exacerbate mental health problems, widening global health disparities.

Fourth, lacking telemedicine training for clinicians before the pandemic outbreak may delay the dispatch of telemedicine and affect the clinical experience. Telemedicine training can prepare clinicians to build rapport via telehealth technology and to address technological difficulties, which provides opportunities to enhance their clinical competencies and confidence [10]. With adequate training, they will be well-positioned to approach clients in this challenging time.

Fifth, regulatory and reimbursement barriers refrain individuals in need of mental health services from the use of telemedicine. Before the Centers for Medicare and Medicaid Services (CMS) waived restrictions on care venues for telemedicine in response to the COVID-19 pandemic in the US, Medicare reimbursement had strict restrictions on geographic location, type of care providers, and delivery method (e.g., telephone call) for telemedicine. Although CMS is waiving limitations, some barriers remain. For example, licensed professional mental health counselors, accounting for one third of the mental health care workforce, are still excluded from the provider list of CMS. Many states have not lifted restrictions to allow clinicians to practice across state lines. Further, not every telephone-based consultation is eligible for reimbursement, which in turn keeps individuals only with telephone access from the use of telemedicine. Therefore, further action by policymakers and legislators is urgently needed to support the provision of telemedicine throughout the public health emergency and beyond.

Although telemedicine is integrated into daily practice in responding to the public health emergency, these barriers to telemedicine and issues surrounding health disparities should not be neglected. Given that the need for mental health care continues surging, it is vital to build awareness of these barriers to telemedicine to inform about the development of the provision of telemedicine during this crisis. First, removing financial barriers to using telemedicine may be effective for low SES and homeless populations. Implementing waivers to purchase essential devices and internet access, waiving copayments for telemedicine, and offering education programs could aid underserved populations in seeking help via telemedicine. Second, it is crucial to fund telemedicine infrastructure and provide technical assistance to support telemedicine implementation in underserved regions (e.g., rural areas, developing countries) [7]. Developing an interactive map and database can help the public and internet service providers to identify the broadband challenges in underserved regions, which also assists providers in bidding on projects to expand internet services. Third, telemedicine technologies should be compatible and easy to use for individuals with disabilities and older adults. Designing and developing online technologies and offering training programs (through telephone and mail) can bridge the internet knowledge and skill gaps among older adults, which helps to address digital inequality and health disparities [5]. Outreach programs also serve a vital role in improving and extending the reach of telemedicine because individuals with limited internet access may be unaware of helping resources. Fourth, online telemedicine training should assist clinicians in not merely addressing technology issues but also enhancing distance-based clinical competencies. Last but not least, it is imperative to move legislation and regulation forward in order to facili-

tate the delivery of timely mental health care. States should suspend certain licensing provisions to support clinicians to practice and help clients across state lines. The American Counseling Association needs to continue lobbying for policy reforms to close the provider gap in responding to the national provider shortage during the pandemic and beyond. With the united endeavors, mental health professionals will better support individuals in need of treatment and care to traverse the rough terrain.

Conflict of Interest Statement

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