

Telehealth—Improving access for rural, regional and remote communities

Over the past few years, the Alliance has been advocating for improvements to digital health capability and greater access to telehealth services for rural, regional and remote communities. The Alliance has been supportive of My Health Record, e-prescribing, secure messaging and home monitoring, for their potential to enhance health care integration and bolster coordinated care for improved health outcomes of rural, regional and remote communities.¹

However, it has been the fractured implementation of these initiatives that have caused some angst amongst health professionals and consumers alike. For example, effective implementation requires a whole-of-government approach that has the Australian Digital Health Agency working collaboratively with the Department of Infrastructure, Transport, Regional Development and Communications. This would ensure that the necessary infrastructure is in place to facilitate full functionality of digital health initiatives. Yet we know that not all parts of the country have the telecommunications infrastructure with sufficient bandwidth and connectivity. It is imperative that all Australians, regardless of location and treatment environment, are able to benefit from the availability of personal health information at the point of care. If not addressed, the system has the potential to increase health inequities that people in rural and remote Australia already experience.

Further, the Australian Government has rightly prioritised training for GPs and pharmacists to enable them to understand the benefits, features and functionalities of My Health Record. The Government has also provided eHealth practice incentive payments to GPs to allow them to keep abreast of changes to digital health and improve their data management and secure messaging systems. However, to achieve a truly integrated digital health system that improves care coordination, allied health professionals, nurse practitioners and Aboriginal health practitioners also need to be linked to the system and offered similar incentives. Much work still needs to be done to enable the entire health care system to use secure messaging that guarantees both patient privacy and more efficient data exchanges.

While the broader digital health transformation of health care may be moving relatively slowly, COVID-19 has been the catalyst to rapidly change the Australian Government's policy position on telehealth services. This has been very welcome

amongst rural health providers and consumers. The rolling out of the temporary Medical Benefits Schedule (MBS) telehealth items since March to GPs, medical practitioners, nurse practitioners, midwives and allied health providers has been vital to help reduce the risk of community transmission of COVID-19 and provide protection for patients and health professionals alike.

Now is the time to capitalise on the Government's common-sense approach to averting a health care crisis and embrace the use of digital technologies and telehealth options for a whole range of purposes, settings and demographics. The uptake of telehealth services in general practice between 1 April and 30 June 2020, during the height of the pandemic, was at 30.7% and even higher for mental health services offered by allied health providers and specialists, at 43.4% and 38.0%, respectively. For allied health and specialist providers of care other than mental health, the use of telehealth was lower at 3.8% and 23.7%, respectively. Notably, allied health and specialist providers of health services made greater use of videoconferencing telehealth than GPs, who only used this modality for 3.5% of services.²

There appears to be enthusiasm for the continuation of telehealth MBS items amongst the health care sector and consumers. A recent survey conducted by the Royal Australasian College of Physicians during the COVID-19 pandemic reported that 87% of respondents supported retaining the new telehealth items beyond the current crisis. The survey also found that almost 70% of the sample of members stated that their patients were more likely to keep their telehealth appointments than their face-to-face appointments, which suggests that the convenience of not having to travel to appointments is highly attractive to consumers, regardless of place of residence.³

Previous research published in this journal has already demonstrated that using telehealth-based models of care can have benefits for those residing in rural and remote communities, the health care provider and the system.^{4,5} One study showed that telehealth can be successfully applied to the management of patients with a spinal fracture, which allowed the patient to be cared for in their local rural hospital and offered opportunities for allied health professionals to upskill and work to their full scope of practice, while also providing cost efficiencies for the health service.⁵ Another innovative

application of telehealth was an integrated approach to oral health in rural aged care facilities with an oral health therapist screening residents using an intraoral camera probe that transmitted a live feed to a dentist in another health care facility.⁴ With so few dentists living in rural and remote Australia, there is real opportunity to scale up this sort of application of telehealth for other population groups such as Aboriginal and Torres Strait Islander people living in remote communities. In rural and remote education settings, speech pathology teletherapy services have been able to overcome limited connectivity issues by successfully using low-bandwidth videoconferencing facilities.⁶ These examples demonstrate that telehealth can offer rural and remote communities a more flexible and convenient mode of access to health care, while also upskilling rural health generalists, parents and educators by linking them and their patients or clients to urban-based specialists.

An issue that still needs to be addressed more fully is the quality of telehealth services, particularly when considering the use of telephone versus videoconferencing consultations. Certainly from the perspective of specialist physicians, videoconferencing is considered preferable for patient assessment and establishing patient rapport. It is better for communicating with geriatric patients and those with impaired hearing and those from a non-English-speaking background.³ However, the same survey found that many elderly patients found it difficult dealing with the technology required to use videoconferencing platforms and poor connectivity was also flagged as a problem for those living rurally. One of the recommendations from the report was that Government should consider additional funding for videoconferencing and other digital health technology for selected households.³ The Alliance would certainly support such measures, but there must also be resources put towards improving digital health literacy for both consumers and health care providers so that all Australians can be enabled to make optimal use of digital and telehealth services.

One final consideration in the move to greater access to telehealth services must be about ensuring that rural health private providers are offered protection from telehealth providers that offer no local services. The Australian Government's recent decision to reform the Medicare-subsidised telehealth

services is helpful. Under stage 7 of the telehealth reforms, the GP telehealth provider will be required to have an ongoing relationship with the patient receiving the care to enable continuous, high quality care. Specifically, the patient will have to have seen the same GP or practice in the last 12 months to be eligible to receive the Medicare rebate. Ultimately, without some safeguards, primary care practices, particularly those in rural and remote communities, may not remain viable, which short-changes rural communities in the long term.⁷

Gabrielle O'Kane PhD, Associate Professor, Chief Executive Officer

National Rural Health Alliance, Canberra, ACT, Australia

Email: gabrielle@ruralhealth.org.au

REFERENCES

1. National Rural Health Alliance. *Inquiry into the My Health Record System: Senate Committee on Community Affairs*. Canberra, ACT: National Rural Health Alliance; 2018:9.
2. Shakespeare P. *Telehealth During COVID-19*. Canberra, ACT: Australian Government; 2020.
3. Royal Australasian College of Physicians. *Results of RACP Members' Survey of New MBS Telehealth Attendance Items Introduced for COVID-19*. Sydney: RACP; 2020.
4. Tynan A, Deeth L, McKenzie D, et al. Integrated approach to oral health in aged care facilities using oral health practitioners and teledentistry in rural Queensland. *Aust J Rural Health*. 2018;26:290-294.
5. Gallagher R, Giles M, Morison J, Henderson J. Telehealth-based model of care redesign to facilitate local fitting and management of patients with a spinal fracture requiring a thoracic lumbar sacral orthosis in rural hospitals in New South Wales. *Aust J Rural Health*. 2018;26:181-187.
6. Fairweather G, Lincoln M, Ramsden R. Speech-language pathology teletherapy in rural and remote educational settings: decreasing service inequities. *Int J Speech Lang Pathol*. 2016;18:592-602.
7. Continuous care with telehealth stage seven [Minister for Health press release]. Canberra, ACT: Australian Government; [10 July 2020] <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/continuous-care-with-telehealth-stage-seven>, accessed 3 August 2020.