



Public consultation
Draft revised guidelines: Telehealth
consultations with patients

Medical Board of Australia
AHPRA

Bupa submission

Contact:



About Bupa

We're a healthcare leader in Australia with a purpose that sets us apart from the rest: we're committed to helping people live longer, healthier, happier lives and making a better world.

As one of Australia's largest health insurers, Bupa supports more than 4.7 million customers in their health and wellbeing. Health insurers are the most significant funders of health services in Australia, apart from governments.

We are also one of Australia's largest private providers of aged care, supporting over 5,000 residents across 59 care homes. Our health services offering includes responsibility for the health care delivered to Australia's Defence Force personnel on behalf of the Australian government.

The Bupa Health Foundation is one of Australia's leading corporate foundations dedicated to health, most recently with a focus on research into mental health. Over the past 10 years, the Foundation has invested over \$35 million in over 130 projects and partnerships focused on translating Australian research into real health and care improvements.

Our Members First network of over ten thousand registered healthcare providers, and the wealth of knowledge in Bupa Health Link, helps keep our customers healthier and happier. We help people pay less for things like dental check-ups, new glasses, or physio and support them with innovative health and wellbeing tools like the Stroke Foundation's EnableMe. We guide people to what they need most to help make their experience as seamless as possible.

We also recognise the health of people is directly linked to the health of our planet, so we invest in renewable energy and waste reduction strategies to reduce our impact on our environment.

Bupa Australia is part of the Bupa Group, an international healthcare company created in 1947 with the founding purpose – 'to prevent, relieve and cure sickness and ill-health of every kind' – enshrined in our original constitution. With no shareholders, our profits are reinvested into providing more and better healthcare for the benefit of current and future customers around the world.

Introduction

At Bupa, we want healthcare to be accessible, relevant and simple. We moved quickly at the start of the pandemic to cover consultations and treatments delivered digitally. Our customers and healthcare providers embraced the change, and we were proud to be the first Australian health insurer to announce permanent funding for many telehealth services.

Our digital health platform provides Australian consumers with a simple way to find, book and attend appointments with healthcare professionals. In other jurisdictions, the platform is evolving to act as a 'digital hospital' that can remotely monitor pregnancy, COVID-19 patients, and patients suffering from asthma and heart disease.

Bupa makes this submission in relation to the Medical Board's draft revised *Guidelines: Telehealth consultations with patients*, published on 14 December 2022.

Revising the guidelines is timely given the significant growth in the use of telehealth consultations in Australia since the beginning of the COVID-19 pandemic, and the role telehealth will need to play in the design and delivery of future focused, person-centred health care.¹

¹ Strengthening Medicare Taskforce Report, Australian Government, 2023

Telehealth has grown to be relied on by large numbers of Australians for access to regular medical consultations without the need for physical visits, for instance for follow up on prior health conditions, ongoing care for long term illnesses, requests for prescriptions, and increasing access to medical care for those who need it after hours or in remote locations. There is no indication of any widespread abuse of telehealth access, or of significantly increased utilisation of care.

As recognised in the recently released *Strengthening Medicare Taskforce Report*, we must maintain the momentum, continue to embrace change and innovate for the benefit of both patients and practitioners.

The revised *Guidelines: telehealth consultations with patients* are an opportunity to:

- empower medical practitioners with the evidence on telehealth safety and effectiveness, which has strengthened considerably since the guidelines were published in 2012; and
- build confidence in the use of multiple telehealth modalities, and in the selection of those most appropriate to meeting patient needs and optimising health system resources.

In this submission we suggest that the draft guidelines could be improved with:

1. amendments to the 'Background' section on page 8, including statements about the circumstances in which telehealth is an appropriate substitute for a clinical relationship involving face-to-face consultations;
2. including advice on differentiation between telehealth modalities and the capacity of each to meet the same standards of care as a face-to-face consultation; and
3. clarification of ambiguous language on page 11 regarding care which is not provided in real time.

Additionally, access to telehealth could also be improved in a complementary way by removing the Medicare Benefits Schedule (MBS) rule requiring that MBS-funded telehealth consultations must only be accessed in the context of an "established clinical relationship", meaning that a face-to-face consultation has occurred within the preceding 12 months.

1. Telehealth in comparison to face-to-face consultations

Bupa agrees with the Board that *"The standard of care provided in a telehealth consultation must be safe and as far as possible meet the same standards of care provided in a face-to-face consultation."* (page 8)

We also support the general view expressed that *"The Board considers telehealth is generally most appropriate in the context of a continuing clinical relationship with a patient that also involves face-to-face consultations. A mix of face-to-face and telehealth consultations can provide good medical care."* (page 8)

However, we would urge the Medical Board to consider replacing the opening paragraph with the following:

Telehealth provides great opportunities for access to, and delivery of healthcare. It can be used effectively to address the specific needs of patients and clinical conditions and as a valuable enabler of alternate models of care. However, not all telehealth modalities are appropriate for all medical consultations and should not be considered as a substitute for face-to-face consultations in all circumstances.

We suggest that it would also be appropriate to include a positive statement about the capacity for telehealth consultations to provide good medical care for patients with some conditions, even in a clinical relationship where there is an absence of face-to-face consultations. For example:

Telehealth may be a satisfactory substitute for face-to-face care for conditions where telehealth has demonstrated equivalent or superior clinical outcomes as face-to-face consultations and in circumstances where accessibility is limited such as after-hours care and in rural or remote areas.

The evidence supporting the use of telehealth as a substitute for face-to-face care that provides safe, good quality medical care to a patient, including as part of a telehealth-only clinical relationship, is discussed in the following sections.

Telehealth quality and safety

Research into telehealth benefits has long been recognised,² along with a demonstration of patient and clinician telehealth satisfaction.³ A recent systematic review of high rigour meta-analyses specifically on clinical effectiveness found that telehealth is equivalent to conventional care in most situations. In most speciality disciplines, telehealth interventions used to substitute in-person consultations demonstrated equivalent or superior clinical outcomes for patients.⁴

Another recent systematic review drawing together all the level 1A evidence⁵ on telehealth safety from the past decade found that across five medical disciplines represented (cardiovascular, neurology, pulmonary, obstetrics and intensive care) telehealth did not increase mortality rates, and in some studies, the rates of mortality reduced for patients who were managed by telehealth.⁶

While telehealth is not intended to completely replace in-person care in all circumstances, COVID-19 created a natural experiment that revealed circumstances where patients do not necessarily require a physical consultation.⁷

For example, a 2021 systematic review and meta analyses found that “for effectively treating anxiety and related conditions, interventions delivered by telehealth appear to be as effective as the same therapy delivered in-person” and that “outcomes related to anxiety, depression symptom severity, obsessive-compulsive disorder, function, working alliance, and satisfaction were comparable between the two modes of delivery.”⁸ This indicates that for mental health conditions, telehealth may be an appropriate substitute for in-person consultations.

² Moffatt JJ, Eley DS. The reported benefits of telehealth for rural Australians. *Aust Health Rev* 2010; 34: 276–281, and Snoswell CL, Smith AC, Page M, et al. Patient preferences for specialist outpatient video consultations: a discrete choice experiment. *J Telemed Telecare* 2021: 1357633X211022898.

³ Orlando JF, Beard M, Kumar S. Systematic review of patient and caregivers’ satisfaction with telehealth videoconferencing as a mode of service delivery in managing patients’ health. *PLoS One* 2019; 14(8): 1–20.

⁴ Snoswell CL, Chelberg G, De Guzman KR, et al. The clinical effectiveness of telehealth: a systematic review of meta-analyses from 2010 to 2019. *J Telemed Telecare* 2021: 1357633X211022907.

⁵ National Health and Medical Research Council (NHMRC). Levels of evidence and recommendation grading 2009. Available from: <https://www.nhmrc.gov.au/sites/default/files/images/appendix-f-levels-of-evidence.pdf>

⁶ Snoswell CL, Stringer H, Taylor ML, et al. An overview of the effect of telehealth on mortality: a systematic review of meta-analyses. *J Telemed Telecare* 2021: 1357633X211023700.

⁷ De Guzman KR, Caffery LJ, Smith AC, Snoswell CL. Specialist consultation activity and costs in Australia: Before and after the introduction of COVID-19 telehealth funding. *Journal of Telemedicine and Telecare*. 2021;27(10):609-614. doi:10.1177/1357633X211042433

⁸ Krzyżaniak, N., Greenwood, H., Scott, A., Peiris, R., Cardona, M., Clark, J., & Glasziou, P. P. (2021). The effectiveness of telehealth versus face-to face interventions for anxiety disorders: A systematic review and meta-analysis. *Journal of Telemedicine and Telecare*, 1-12. doi.org/10.1177/1357633X211053738 accessed at <https://research.bond.edu.au/en/publications/the-effectiveness-of-telehealth-versus-face-to-face-interventions>

As the mental health impacts of the pandemic continue to unfold, we need to make it as easy as possible for people to seek help. Mental health services delivered via telehealth will continue to play an important role in improving equity and access to care.

Expanding access to care

Telehealth has quickly become an established part of Australia's health care system, making better use of practitioners' and patients' time. If telehealth is not duplicative of in-person visits for a care specialty, it can be an effective tool to help expand access to care."⁹

An analysis of 35 million telehealth consultations found that most patients utilising telehealth do not require a follow-up consultation within 90 days. In nearly every specialty studied, most patients who had a telehealth visit did not require an in-person follow-up appointment in that specialty in the next three months. Mental health and psychiatry were two areas with the highest rates of telehealth utilisation, and among the lowest rates of follow-up required.¹⁰

This indicates that "telehealth visits are typically an efficient use of resources and are unlikely to require in-person follow-up care. For specialties where follow-up was required, the study found the additional visits were likely related to needing additional care, not duplicative care (for example, obstetrics, geriatrics)."¹¹

Another study analysing specialist consultation activity and costs in Australia before and after the introduction of COVID-19 telehealth funding found that telehealth consultations substituted in-person specialist care during COVID-19 and fewer consultations had an associated patient-end claim. This resulted in increased cost efficiency to the MBS when telehealth was used, as a higher number of specialist consultations were delivered for the same cost.¹²

Similarly, a US study suggests telehealth availability is not resulting in additional primary care visits, as there was little change in utilization as telehealth became widely available during the pandemic.¹³

Out of hours care and Emergency Department attendance

The utilisation of Emergency Department (ED) services has also been increasing rapidly, with Australian data showing that around 35% of ED attendances are for less urgent problems.¹⁴ In rural communities, ED service attendance for less urgent problems is up to 70%.¹⁵

⁹ Gerhart, J., Piff, A., Bartelt, K., Barkley, E. (2022), Telehealth Visits Unlikely to Require In-Person Follow-Up Within 90 Days, Accessed at <https://epicresearch.org/articles/telehealth-visits-unlikely-to-require-in-person-follow-up-within-90-days>

¹⁰ Ibid.

¹¹ Ibid.

¹² De Guzman KR, Caffery LJ, Smith AC, Snoswell CL. Specialist consultation activity and costs in Australia: Before and after the introduction of COVID-19 telehealth funding. *Journal of Telemedicine and Telecare*. 2021;27(10):609-614. doi:10.1177/1357633X211042433

¹³ Dixit RA, Ratwani RM, Bishop JA, Schulman K, Sharp C, Palakanis K, Booker E. The impact of expanded telehealth availability on primary care utilization. *NPJ Digit Med*. 2022 Sep 9;5(1):141. doi: 10.1038/s41746-022-00685-8. PMID: 36085158; PMCID: PMC9462602.

¹⁴ Australian Institute of Health and Welfare. (2020). Use of emergency departments for lower urgency care: 2015–16 to 2018–19. Available: <https://www.aihw.gov.au/getmedia/2ca4fefe-7666-41c0-ac32-0daca90dd5c7/Use-of-13emergency-departments-for-lower-urgency-care-2015-16-to-2018-19.pdf.aspx?inline=true>

¹⁵ Allen P, Cheek C, Foster S, Ruigrok M, Wilson D, Shires L. Low acuity and general practice-type presentations to emergency departments: a rural perspective. *Emerg Med Australas*, 2015; 27(2): 113-118. doi:10.1111/1742-6723.12366

In an environment with lower inpatient bed availability, rising ED presentations and emergency patients requiring admission causes access block, leading to diminished ED performance and over-crowding.¹⁶ This also results in ED blockage, ambulance ‘ramping’ or diversion and diminished capacity to respond to other calls, increased waiting times, an increased burden in caring for patients awaiting admission, and patients leaving without being seen.¹⁷

This poses a threat to patient safety,¹⁸ with evidence of associated adverse events and estimates of an annual 20-30% excess ED mortality rate directly attributable to overcrowding and access block.¹⁹ Prolonged length of stay in the ED has also been associated with subsequent increased inpatient length of stay and protracted patient flow throughout the wider hospital system.²⁰

Numerous studies have shown ED utilisation is influenced by the availability and accessibility of primary care services.²¹ When appropriate General Practitioner (GP) services are not available or too costly, patients choose EDs to meet their immediate health care needs.²² People with chronic and complex health conditions often become high users of hospital care in the absence of well-coordinated, comprehensive community-based primary health care services.²³ The resulting fragmentation of care incurs higher cost, affects quality of life, consumes ED resources, and often does not address important underlying issues.²⁴

¹⁶ Forero R, Hillman KM, McCarthy S, et al. Access block and ED overcrowding. *EmergMed Australas* 2010;22:119e35; Victorian Auditor-General. Access to Public Hospitals: Measuring Performance, 2009. Government Report. http://download.audit.vic.gov.au/files/hospital_indicators_full_report.pdf and Derlet RW. Overcrowding in emergency departments: increased demand and decreased capacity. *Ann Emerg Med* 2002;39:430e2.

¹⁷ Derlet RW, Richards JR. Overcrowding in the Nation’s Emergency Departments: Complex Causes and Disturbing Effects. *Ann Emerg Med* 2000;35:63e8.

¹⁸ Lowthian JA, Curtis AJ, Cameron PA, et al Systematic review of trends in emergency department attendances: an Australian perspective, *Emergency Medicine Journal* 2011;28:373-377.

¹⁹ Lowthian JA, Curtis AJ, Cameron PA, et al Systematic review of trends in emergency department attendances: an Australian perspective, *Emergency Medicine Journal* 2011;28:373-377; and Robinson, N ‘Death risk rises for emergency public patients’ *The Australian*.30 January 2023; Australian Medical Association. Australian public hospitals in logjam. January 2023. Available at: <https://www.ama.com.au/articles/australian-public-hospitals-logjam>

²⁰ Richardson DB. The access-block effect: relationship between delay to reaching an inpatient bed and inpatient length of stay. *MJA* 2002;177:492e5; and Liew D, Liew D, Kennedy M. Emergency department length of stay independently predicts excess inpatient length of stay. *MJA* 2003;179:524e6.

²¹ Afilalo J, Marinovich A, Afilalo M, Colacone A, Leger R, Unger B, Giguere C. Nonurgent emergency department patient characteristics and barriers to primary care. *Acad Emerg Med*, 2004; 11(12), 1302-1310 in Fatima, Yaqoot, Hays, Richard, Knight, Sabina, Neilson, Anne, Fleming, Rhonda, Panaretto, Kathryn, Jatrana, Santosh, and Skinner, Isabelle (2021) Drivers of general practice–type presentations to the emergency department in a remote outback community. *Australian Journal of Rural Health*, 29 (3). pp. 391-398; Lowthian JA, Curtis AJ, Cameron PA, et al Systematic review of trends in emergency department attendances: an Australian perspective *Emergency Medicine Journal* 2011;28:373-377; and Payne, K., Dutton, T., Weal, K. et al. An after hours GP clinic in regional Australia: appropriateness of presentations and impact on local emergency department presentations. *BMC Fam Pract* 18, 86 (2017).

²² Masso M, Bezzina AJ, Siminski, P, Middleton R, Eagar K. Why patients attend emergency departments for conditions potentially appropriate for primary care: reasons given by patients and clinicians differ. *Emerg Med Australas*, 2007; 9(4): 333-340. doi:10.1111/j.1742-6723.2007.00968.x

²³ Flarup L, Moth G, Christensen MB, Vestergaard M, Olesen F, Vedsted P. Chronic disease patients and their use of out-of-hours primary health care: a cross-sectional study. *BMC Fam Pract*, 2014; 15, 114. doi:10.1186/1471-2296-15-114; and Kraaijvanger N, van Leeuwen H, Rijpsma D, Edwards M. Motives for self-referral to the emergency department: a systematic review of the literature. *BMC Health Serv Res*, 2016; 16(1): 685. doi:10.1186/s12913-016-1935-z.

²⁴ Morgan, SR, Chang AM, Alqatari M, Pines JM. Non–Emergency Department (ED) Interventions to Reduce ED Utilization: A Systematic Review. *Acad Emerg Med*, 2013; 20(10); 969-985: doi:10.1111/acem.12219

In Australia, this may likely be a consequence of reduced availability of and access to GPs, arising from medical workforce shortages and changes in healthcare practice, including a decline in the rate of home and nursing home visits.²⁵

Evidence suggests that social and health support mechanisms for older people are becoming increasingly fragmented, with changes in family structures, alongside reduced access to primary care, whether patients are living independently or in a nursing home.²⁶

Telehealth can be used effectively to address these drivers of ED presentations by increasing access to after-hours care, enhancing the long-term management of chronic conditions,²⁷ and facilitating social or peer support.²⁸

However, the draft guidelines may be a disincentive to using telehealth as a way of addressing the lack of access to after-hours care, given the likelihood of no face-to-face clinical relationship existing prior to an out-of-hours telehealth consultation. We suggest that the guidelines be clarified to allow for this.

Telehealth's benefits for continuity of care and chronic disease

Continuity of care, or the degree to which a patient experiences their care as “coherent, connected and consistent with [their] medical needs and personal context”, is a subjective, multidimensional experience of patients and well recognised as a feature of high-quality medical care.²⁹

Telehealth has been shown to increase patient perceptions of continuity of care.³⁰ This has many benefits with data associating continuity with increased patient³¹ and provider³² satisfaction, decreased cost of care³³ and even decreased mortality.³⁴

Digital health can also increase engagement by the patient, which has been linked to shared responsibility and decision making, and trust in care between the health professional and patient.³⁵ In addition, patients have increased flexibility to access these services at a suitable time and location, helping to address perceived patient burdens, healthcare inequity and healthcare resource efficiencies. These are all important factors for improving the management of chronic conditions.

²⁵ Joyce C, Piterman L. Trends in GP home visits. *AFP* 2008;37:1039e42; Australian Medical Association. Out-of-hours primary medical care. In: *AMA, ed. 2004. Report*. <http://ama.com.au/node/1757>; and Wofford JL, Schwartz E, Byrum JE. The role of emergency services in health care for the elderly: a review. *J Emerg Med* 1993;11:317e26.

²⁶ Lowthian JA, Curtis AJ, Cameron PA, et al Systematic review of trends in emergency department attendances: an Australian perspective, *Emergency Medicine Journal* 2011;28:373-377.

²⁷ Vegesna A, Tran M, Angelaccio M, et al. Remote patient monitoring via non-invasive digital technologies: A systematic review. *Telemed e-Health* 2017; 23: 3–17, and Banbury A, Nancarrow S, Dart J, et al. Adding value to remote monitoring: Co-design of a health literacy intervention for older people with chronic disease delivered by telehealth – The telehealth literacy project. *Patient Educ Couns* 2020; 103: 597–606.

²⁸ Banbury A, Parkinson L, Gordon S, et al. Implementing a peer-support programme by group videoconferencing for isolated carers of people with dementia. *J Telemed Telecare* 2019; 25: 572–577.

²⁹ Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: A multidisciplinary review. *BMJ* 2003;327(7425):1219–21. doi: 10.1136/bmj.327.7425.1219.

³⁰ RACGP, accessed at <https://www1.racgp.org.au/getattachment/4e71dd20-d54d-4e33-b4ad-1e94645c9abb/Continuity-in-technology-enabled-care.aspx>

³¹ Saultz JW, Albedaiwi W. Interpersonal continuity of care and patient satisfaction: A critical review. *Ann Fam Med*;2(5):445–51. doi: 10.1370/afm.91.

³² Blankfield RP, Kelly RB, Alemagno SA, King CM. Continuity of care in a family practice residency program. Impact on physician satisfaction. *J Fam Pract* 1990;31(1):69–73.

³³ De Maeseneer JM, De Prins L, Gosset C, Heyerick J. Provider continuity in family medicine: Does it make a difference for total health care costs? *Ann Fam Med* 2003;1(3):144–48. doi: 10.1370/afm.75.

³⁴ Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open* 2018;8(6):e021161. doi: 10.1136/bmjopen-2017-021161.

³⁵ Qudah B, Luetsch K. The influence of mobile health applications on patient - healthcare provider relationships: a systematic, narrative review. *Patient Educ Couns*. 2019; 102(6): 1080– 9.

A recently published systematic review and meta-analysis of the effectiveness of digital dietary interventions found mobile and electronic health interventions produced small to moderate positive changes in diet quality score, fruit and vegetable intake, sodium, body weight, waist circumference and HbA1c (haemoglobin A1C, a test of average blood glucose over time).³⁶

The random effects meta-analysis showed a significant reduction in weight and waist circumference with digital health intervention, similar to the findings of other digital health reviews on weight³⁷ and waist circumference.³⁸

Telehealth's benefits for regional Australians and First Nations

The National Rural Health Alliance has found a persistent, ongoing maldistribution of health professionals in Australia resulting in substantially poorer access to health care for the 28% of the Australian population living in regional, rural and remote areas.³⁹

Data shows that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and also have poorer access to, and use of, primary health care services, than people living in metropolitan areas.⁴⁰ Australians outside major cities are three times more likely to rate access to general, specialist and mental health services as poor.⁴¹ They also utilise Medicare up to 40% less than those in major cities.⁴²

In both developed and developing countries, technology has been found to increase both access to and continuity of care in rural and remote areas⁴³ with consistent findings of increased uptake of health services in rural areas with telehealth.⁴⁴ Telehealth has been found to give patients improved access to services and improved quality of clinical services with lower costs and reduced inconvenience, and to give health care professionals increased access to continuing education and professional development, experiential learning, networking and collaboration.⁴⁵

³⁶ Barnett, Amandine, Wright, Charlene, Stone, Christine, Ho, Nikki Nok Yin, Adhyaru, Pooja, Kostjasyn, Sarah, Hickman, Ingrid J., Campbell, Katrina L., Mayr, Hannah L., and Kelly, Jaimon T. (2022). Effectiveness of dietary interventions delivered by digital health to adults with chronic conditions: systematic review and meta-analysis. *Journal of Human Nutrition and Dietetics*. <https://doi.org/10.1111/jhn.13125>

³⁷ Fakhri El Khoury C, Karavetian M, Halfens RJG, Crutzen R, Khoja L, Schols JMGA. The effects of dietary mobile apps on nutritional outcomes in adults with chronic diseases: a systematic review and meta-analysis. *J Acad Nutr Diet*. 2019; 119(4): 626– 51. Kelly JT, Allman-Farinelli M, Chen J, Partridge SR, Collins C, Rollo M, et al. Dietitians Australia position statement on telehealth. *Nutr Diet*. 2020; 77(4): 406– 15.

³⁸ Kelly JT, Reidlinger DP, Hoffmann TC, Campbell KL. Telehealth methods to deliver dietary interventions in adults with chronic disease: a systematic review and meta-analysis. *Am J Clin Nutr*. 2016; 104(6): 1693– 702.

³⁹ Calculations by the National Rural Health Alliance based on the National Health Workforce Dataset and population figures provided by the Australian Government Department of Health.

⁴⁰ Australian Institute of Health and Welfare, Rural and remote health, available at:

<https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health>

⁴¹ Health Research Institute. 2018 Regional Wellbeing Survey data tables – Australian general population (Table 7). University of Canberra; 2020 Jan. Cited in *Rural Health in Australia Snapshot 2021*, available at:

<https://www.ruralhealth.org.au/rural-health-australia-snapshot>

⁴² Gardiner F, Bishop L, de GraaB, et al. Equitable patient access to primary healthcare in Australia [research repo-]. The Royal Flying Doctor Service of Australia. 2020 Dec. Available at: <https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/>

⁴³ World Health Organization. Telemedicine: Opportunities and developments in member states: Report on the second global survey on eHealth. Geneva: WHO; 2010. www.who.int/goe/publications/goe_telemedicine_2010.pdf.

⁴⁴ Moffatt JJ, Eley DS. The reported benefits of telehealth for rural Australians. *Aust Health Rev*. 2010 Aug;34(3):276-81. doi: 10.1071/AH09794. PMID: 20797357.

⁴⁵ Moffatt JJ, Eley DS. The reported benefits of telehealth for rural Australians. *Aust Health Rev*. 2010 Aug;34(3):276-81. doi: 10.1071/AH09794. PMID: 20797357; Sevean P, Dampier S, Spadoni M, et al. Patients and families experiences with video telehealth in rural/remote communities in Northern Canada. *J Clin Nurs* 2008;18:2573-2579; and Duplantie J, Gagnon M, Fortin JP, et al. Telehealth and the recruitment and retention of physicians in rural and remote regions: A Delphi study. *Can J Rural Med*. 2007;12:30-36.

Telehealth can be used effectively in collaborative and cooperative primary and community care practices to expand both specialized, and location-specific health care models. For example, in north-central British Columbia, Carrier Sekani Family Services (CSFS) used telehealth to develop a sustainable, high-quality, community-based primary care model addressing the challenges presented by geography, high client need, and the difficulties of recruitment and retention of physicians to rural and remote First Nations communities, many of whom have complex care needs.⁴⁶

Prior to the introduction of telehealth, Carrier Sekani communities relied on the services of fly-in physicians and the residents' health problems were grossly underappreciated. With no access to care between visits by fly-in physicians, individuals typically had no primary care home. Instead, they travelled to other providers and accessed primary care services from community clinic nurses who rotated through the communities.

The study evaluating the use of telehealth by CSFS found increased access to care and improved continuity of care by reducing the need for travel and associated costs. 77% of respondents who had made use of telehealth services had been able to see their doctor more regularly and 82% indicated that they were able to attend more appointments since telehealth became available in their community.⁴⁷ Similarly, the study found that use of telehealth reduced the number of visits to the ER for health services, and helped users better manage their chronic conditions.⁴⁸

The primary aim of the CSFS model is to build relationships with patients who have historically received fragmented care and viewed doctor-patient interactions with mistrust. The study results indicated that using telehealth at a CSFS clinic rather than seeing a physician face-to-face did not have a negative impact on a patient's level of medical trust.⁴⁹

The CSFS model and the outcomes of the evaluation study are relevant to the key drivers or indicators used in three of the 19 national *Closing the Gap* socio-economic outcomes and targets:

- drivers of *Outcome 1 Aboriginal and Torres Strait Islander people enjoy long and healthy lives* and the target of closing the gap in life expectancy by 2031 includes: rates of accessing/utilisation of health services such as GP visits, chronic disease care items (Team Care arrangement and GP Management Plan) and Aboriginal and Torres Strait Islander-specific health checks or assessments as well as the prevalence of health risk factors such as smoking, alcohol and drug use, overweight and obese, dietary factors and physical activity;
- the proportion of people reported experiencing one or more barriers accessing health services is also a supporting indicator for *Outcome 14 Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing* and the target of Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero; and
- use of antenatal care by pregnant women is a driver for *Outcome 2 Aboriginal and Torres Strait Islander children are born healthy and strong* and the target of increasing the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent by 2031.

Nationally in 2018-19, one in eight Aboriginal and Torres Strait Islander people reported not seeing a GP or clinic doctor on at least one occasion when needed in the previous 12 months. Physical accessibility and time, work, personal and family responsibilities were among the top three barriers reported.

⁴⁶ Travis Holyk, EdD, John Pawlovich, MD, Chris Ross, MA, Alison Hooper, BA. The role of telehealth in improving continuity of care: The Carrier Sekani Family Services primary care model. *BCMJ*, Vol. 59, No. 9, November, 2017, Page(s) 459-464.

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ Ibid.

2. Differentiating between telehealth modalities

The most recent data on telehealth uptake throughout Australia published by the University of Queensland Centre for Online Health (COH) shows that 88% of telehealth consultations were conducted by telephone and 12% by videoconference. Uptake of videoconferencing is higher for psychiatrist consults and mental health consults.⁵⁰

Different telehealth modalities are not equivalent. While telephone-based interventions can be highly effective in some clinical circumstances⁵¹ (especially for triaging⁵² and the management of chronic disease⁵³), video consultations generally improve diagnostic accuracy and decision-making accuracy when compared to the telephone.⁵⁴

Video was also found to be superior in a recent study of pharmacist telehealth consultations for the purposes of obtaining cancer patients' medication histories where video-based consultations had a higher successful completion rate when compared to telephone consultations.⁵⁵

On this basis, we suggest that the guidelines would be a more relevant and useful resource if they include some differentiation between modalities and the capacity of each to meet the same standards of care as a face-to-face consultation. For example, in some clinical disciplines, disease states and patient types, video-based telehealth consultations are more likely than telephone (voice only) consultations to be an appropriate or effective substitute for a face-to-face patient relationship.

3. Clarify ambiguous language for non-real time care

Bupa is concerned that the prescribing section of the draft guidelines on pages 10-11 is confusing and may lead to unintended and undesirable consequences, such as reduced willingness by medical practitioners to undertake clinically appropriate telehealth consultations or reducing the uptake of evidence-based innovation.

We submit that on its current broad wording, this section could be interpreted as discouraging prescribing during a first real time telehealth consultation with a new patient.

Any ambiguity about the appropriate use of telehealth is to be avoided, as clinician willingness and acceptance can be a major barrier to telehealth uptake and sustainability.⁵⁶

We are also concerned that the current drafting could exclude evidence based and clinically appropriate use of asynchronous communication modalities by specialists, such as the use of store-and-forward for tele dermatology.

⁵⁰ Snoswell, C.L., Caffery, L.J., Taylor, M.L., Haydon, H.M., Thomas, E., Smith, A.C. Centre for Online Health, The University of Queensland. Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia. <https://coh.centre.uq.edu.au/telehealth-and-coronavirus-medicare-benefits-schedule-mbs-activity-australia>. Accessed on 9 February 2023

⁵¹ Downes MJ, Mervin MC, Byrnes JM, et al. Telephone consultations for general practice: A systematic review. *Syst Rev* 2017; 6: 128.

⁵² Boggan JC, Shoup JP, Whited JD, et al. Effectiveness of acute care remote triage systems: A systematic review. *J Gen Intern Med* 2020; 35: 2136–2145.

⁵³ Krishna S, Boren S, Balas E. Healthcare via Cell Phones: A systematic review. *Telemed e-Health* 2009; 15: 231–240.

⁵⁴ Rush KL, Howlett L, Munro A, et al. Videoconference compared to telephone in healthcare delivery: A systematic review. *Int J Med Inform* 2018; 118: 44–53.

⁵⁵ Ryan M, Ward EC, Burns CL, et al. An evaluation of telephone versus videoconference consults for pre-treatment medication history taking by cancer pharmacists. *Journal of Telemedicine and Telecare*. 2022;28(10):750-756. doi:10.1177/1357633X221122140

⁵⁶ Wade VA, Elliott JA, Hiller JE. Clinician acceptance is the key factor for sustainable telehealth services. *Qual Health Res* 2014; 24: 682–694.

We recommend that this section of the guidelines be redrafted to differentiate and distinguish between:

1. real-time telehealth modalities and those which are asynchronous;
2. the context of the clinical relationship or its absence, direct to patient or via a referrer; and
3. specialist use of modalities with demonstrated equivalent or superior clinical outcomes.

For example:

In the absence of a clinical relationship with the patient or a referring healthcare professional; prescribing or providing care outside a real-time consultation and based solely on an asynchronous communication method such as text or email, is unlikely to be good medical practice.

Practitioners who prescribe for patients in these circumstances must have sufficient knowledge, experience and understanding of the application and limitations of the modality used in the clinical discipline, disease state and patient type, to be satisfied that the standard of care provided is safe and equivalent or superior to that of conventional care.

Conclusion

Telehealth has demonstrably improved access to primary and secondary care in Australia's health system over the last three years. Now, every jurisdiction's health system is under severe pressure, access to GPs is more difficult than ever, and public hospital emergency departments are at capacity.

Any change to telehealth guidelines that discourage or create uncertainty about its continued level of usage would put unreasonable pressure on the other parts of our health system at a time when it can least be afforded. Rather, the guidelines must facilitate the continuing growth of clinically appropriate telehealth to increase the capacity and productivity of our system. All stakeholders should ideally be learning and working together on developing telehealth for the best results for every patient.

As we return to business as usual in the wake of COVID-19, a critical juncture lies ahead: return to using previous care models as the desired benchmark or create new, patient centric models of care integrating telehealth delivery. Innovation, co-ordination and willingness to practice telehealth are crucial to enable health system adaptation to ongoing workforce challenges. Care needs to be taken to ensure the guidelines do not stymie this unintentionally.⁵⁷

⁵⁷ Thomas EE, Haydon HM, Mehrotra A, et al. Building on the momentum: Sustaining telehealth beyond COVID-19. *Journal of Telemedicine and Telecare*. 2022;28(4):301-308. doi:[10.1177/1357633X20960638](https://doi.org/10.1177/1357633X20960638)