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RACP Submission to the MRAC Post Implementation Review of MBS Telehealth items

November 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Foreword

There is no denying that telehealth has become an integral part of Australia's health system. The expansion of telehealth services during the pandemic enabled many practitioners to provide care. Between March and July 2022 alone, around 118 million telehealth services were delivered to 18 million patients across Australia; more than 95,000 medical practitioners have engaged in telehealth services[1].

The broadening use of telehealth in Australia presents a unique opportunity to transform our health system, address unmet needs, and reduce health inequities; the development of ongoing MBS telehealth arrangements is critical for Australia to capitalise on this opportunity and edge toward these goals.

The RACP welcomes the opportunity to provide a submission to the MBS Review Advisory Committee's (MRAC) second stage of post implementation review of MBS Telehealth items.

The RACP thanks the MRAC for considering our comments with respect to original Telehealth Principle 5 in the first stage of the review and for making a revision to it. We note the proposed reinstatement of specialist phone consult for MBS item 116 in the consultation report and thank the Government for accepting our advice. It is imperative to regularly review and update the MBS telehealth guidance and arrangements to keep pace with the evolving landscape of telehealth use and to ensure its ongoing safety, quality and effectiveness.

In this submission, our central focus is on aspects of the MBS telehealth arrangements that are most relevant to or concerning our members and the RACP affiliated speciality societies, namely use of video and phone for initial consult (recommendation 9 of the consultation report).

1. Summary of RACP position and recommendations

Ensuring equitable and timely access to specialist care is central to the RACP position on telehealth arrangements. The RACP views that the present telehealth arrangements do not fully support telehealth use in ways that promote optimal patient outcomes and equity of access. Our key areas of concern are the cessation of initial and complex specialist phone consult items in July 2022, and the current proposed removal of all initial specialist video or phone consults. These blanket restrictions will inadvertently widen the gap in access to specialist services, further disadvantaging and marginalising priority and underserviced population groups. A rethink on these two restrictions is warranted from the patient care perspective.

While face-to-face consult is the preferred standard of care, the RACP holds that the wide availability of phone and video-based specialist consults is highly valuable and can help address the significant issue of disparity in access by expanding the reach of specialist care and including a wide range of specialist services, particularly in rural and remote areas and for priority populations. The RACP rapid telehealth review shows that both phone and video are appropriate modalities for consults enabling a range of clinical activities and the delivery of good patient outcomes when used in a clinically appropriate way. The utility of telehealth across a wide range of specialities has been proven during and beyond the pandemic; more funding should be considered to support specialist telehealth service delivery to ensure the viability of these services and help bridge the gap for rural and remote health care.

To ensure equitable and timely access to specialist care, the RACP calls on the Australian Government to:

- Reinstate full range of phone-based specialist consults and retain current video-based initial specialist consults, especially crucial for rural, regional and remote patients with geographical barriers to accessing medical specialist services
- Add a core principle of exemptions as a part of the MBS telehealth principles, allowing flexibility and protection for vital access to telehealth services

[1] Data from the Australian Digital Health Agency: Telehealth. Available at: https://www.digitalhealth.gov.au/initiatives-and-programs/telehealth

- Permit choice of telehealth modality at the discretion of medical specialists, including initial and subsequent consults
- Invest in trialling new models of telehealth to strengthen remote service delivery linking secondary and primary care settings, including telehealth hubs in rural, regional and remote areas
- Reinstate equivalent MBS telehealth items for palliative medicine specialists and consider introducing consultant physician equivalent complex assessment and review items
- Engage and consult with key specialities before any withdrawal of MBS telehealth items to capture vital speciality specific impacts
- Fund videoconferencing technology packages to bolster capacity building especially for patients in priority and underserviced groups, rural or regional areas, and aged care settings

2. Video-based and phone-based consults

The Australian Government ceased a range of initial and complex specialist phone consults in July 2022 to reflect its view that face-to-face and video services support better patient care and outcomes and should be the preferred form of consultation with patients, particularly for more complex clinical services[2].

While the RACP agrees that video is generally preferable and necessary in some circumstances, especially where physical examination of patient is critical and direct observation of patients is required, this should not have been the sole reason to cease the phone modality.

In the context of growing demands of our healthcare system, the traditional care model comprising of referral, triage and subsequent face-to-face consult can no longer cope with an increasing volume of referrals and the needs of underserved populations[3]. Referrals from GPs to medical specialists have increased by 13% between 2006–07 and 2015–16[4]. 28% of patients waited longer than 4 weeks to access specialist services and 14% of patients waited more than 2 months[5]. Delayed access is a substantial issue in rural and remote communities and is contributing to deteriorating patient health and avoidable hospital admissions[6].

Telehealth (including video and phone) has been playing a key role in Australia's health services and are valued by both patients and physicians. In the second quarter of 2023, a Centre for Online Health report found that telehealth consultations accounted for 17 per cent of Medicare Benefit Schedule (MBS) services delivered, representing 8.7 million consultations. The share for phone and video consults were 87% and 13% respectively. The latest ABS Patient Experience Survey Report revealed that 30.8% of people had a telehealth consultation in 2021-22, including 7.5% with a specialist in 2021-22 financial year[7].

An Australian study found that consumers cherish the availability of telehealth and having choice and flexibility to use telehealth when appropriate given that telehealth has enabled them to access care that they would otherwise not have available[8]. An interview conducted with 14 RACP members from the Adult Medicine Division shows support for the establishment of an eConsult model of care within their own clinical practice to improve access and GP-specialist relationships[9]. Our member feedback underscores that the availability of telehealth has improved access to specialist care, increased practice capacity,

[2] Factsheet-specialist-telehealth.06.07.22.PDF (mbsonline.gov.au)
[3] Bureau of Health Information (2016) How does New South Wales compare? 2016 Commonwealth Fund International Health Policy Survey of adults [online]. Available at https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0004/384421/bhi-commonwealthfund-survey-questionnaire.pdf
[4] Petre J et al. Supporting complex care in general practice via an eConsultant model of care: the Australian specialist perspective. Aust J Prim Health. 2023 Oct;29(5):455-462.
[5] Petre J et al. Supporting complex care in general practice via an eConsultant model of care: the Australian specialist perspective. Aust J Prim Health. 2023 Oct;29(5):455-462.
[6] Australian Institute of Health and Welfare. Australia's health 2018. Australia's health series no. 16. AUS 221
[7] Patient Experiences in Australia: Summary of Findings, 2020-21 financial year | Australian Bureau of Statistics (abs.gov.au)
[8] Toll K et al. Consumer preferences, experiences, and attitudes towards telehealth: qualitative evidence from Australia. PLoS One. 2022 Aug 31;17(8):e0273935.
[9] Petre J et al. Supporting complex care in general practice via an eConsultant model of care: the Australian specialist perspective. Aust J Prim Health. 2023 Oct;29(5):455-462.

reduced health inequities, supported patient-centred care and generally improved patient attendance and experience.

Telehealth is favourable for cost and health outcomes and contributes to a greener health system. There is evidence indicating that telehealth is cost-effective, though the current evidence base is limited[10][11]. A study revealed that the Queensland Health telehealth services resulted in productivity benefits of over A$300 for every telehealth consult conducted and that the societal cost-benefit increases as the use of telehealth increases[12]. A pilot study showed that compare with usual care, the telehealth monitoring for chronic diseases resulted in a significant improvement of 0.09 in health-related quality of life at 12 months with the cost of AUD$714 extra per patient[13]. Virtual care delivered through telehealth is increasingly relied upon. When optimising models of care, climate resilience must be an important consideration. Evidence reveals that telehealth does reduce the carbon footprint of healthcare services, primarily in transport-associated emissions[14].

From the equity, access, patient, and evidence perspectives, the RACP argues that both video and phone modalities are justified to be available for initial, long and complex consults and that choice of modality be at the discretion of physicians factoring in patients' presenting concerns, circumstances and preferences. Our specific considerations include:

- The current phone consult restrictions have inequity implications. The restrictions risk cutting off access to much needed specialist services by patients who find it a challenge to attend face to face appointments such as those with mobility issues, immune-suppressed patients, those living in rural and remote areas and those Aboriginal and Torres Strait Islander patients who feel more culturally safe attending appointments in their own environment.
- Phone consults are preferred by many patients or essential for patient-specific circumstances, for instances lack of access to technology, lack of capability in digital health literacy, disability, geographical barriers, and inability to access in-person care. The lack of telehealth modality might lead to some patients deferring or foregoing care.
- A large body of evidence, including the RACP rapid telehealth review (**section 2.1**) suggests that clinical effectiveness of telehealth is comparable or better than usual care, though the available evidence is very discipline specific[15] [16]. This is confirmed by the Bond University's report on telehealth in primary care commissioned by the Department of Health in 2021, where equivalent outcomes were found between video and phone consults in the dimensions such as patient satisfaction, clinical effectiveness or cost-effectiveness.

With respect to complex clinical services, phone consult is considered a viable modality. Medical specialists should be able to conduct complex consult through face-to-face, video or phone with the same rebates. While it is important to allow flexibility to provide care for patients with complex needs who live in remote areas or are unable to travel, the RACP acknowledges that complex clinical presentations or issues often cannot be adequately dealt with through phone consults and should be reserved for certain circumstances. However, this should be a matter for the judgment of the relevant medical specialist.

[10] Jiang X et al. The Cost-Effectiveness of Digital Health Interventions on the Management of Cardiovascular Diseases: Systematic Review. J Med Internet Res. 2019 Jun 17;21(6):e13166.
[11] Gentili A et al. The cost-effectiveness of digital health interventions: A systematic review of the literature. Front Public Health. 2022 Aug 11;10:787135.
[12] Snoswell CL et al. Quantifying the societal benefits from telehealth: productivity and reduced travel. Value in Health Regional Issues. 2022 Mar 1;28:61-6.
[13] Mudiyanselage SB et al, Cost-effectiveness of personalised telehealth intervention for chronic disease management: A pilot randomised controlled trial. PLoS One. 2023 Jun 15;18(6):e0286533
[14] Purohit A et al. Does telemedicine reduce the carbon footprint of healthcare? A systematic review. Future Healthc J. 2021 Mar;8(1):e85-e91.
[15] Agency for Healthcare Research and Quality (US). The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic. 2020 May. Report No.: 20-EHC015
[16] Snoswell CL et al. The clinical effectiveness of telehealth: A systematic review of meta-analyses from 2010 to 2019. J Telemed Telecare. 2023 Oct;29(9):669-684.

It has been pointed out that the use of telehealth is vital for community and hospital palliative care services. Both reduce unplanned hospital admissions and emergency department attendances. The lack of available MBS telehealth items for palliative medicine specialists will undermine the viability of palliative care clinics and specialist community palliative care services. Further, palliative care can be highly complex, involving a high degree of care coordination and various difficult discussion in relation to setting goals of care and advance care planning in addition to complex symptom and psychosocial management. It is thus important to reinstate equivalent MBS telehealth items for palliative care specialists and conduct a MBS review of palliative medicine specialist items, with the view to introducing consultant physician equivalent complex assessment and review items.

2.1 RACP rapid review of evidence

The RACP has conducted a rapid review of evidence (**Appendix A**) to evaluate video and phone modalities and to inform our telehealth recommendations.

Our review subsumes 30 moderate-quality to high-quality national and international studies between 2016 and 2023. Over 50,000 patients with various range of health conditions or needs such as complex, chronic or acute conditions, palliative care, and rehabilitative care were sampled. The methodological designs of the studies included: randomised controlled trials, systematic reviews, quasi experiments, interrupted time series, retrospective reviews, prospective pilot studies, surveys and interviews.

Our key findings are briefly summarised as follows:

- Technical problems were often more common in video consultations, disrupting consultation commencement, flow or completion
- Video consults had raised significantly more barriers to patient participation and access over phone consults, especially to older patients, economically disadvantaged populations, patients with poor internet access, regional, rural and remote patients, patients from culturally and linguistically diverse backgrounds, and patients with lower digital health literacy
- There is no difference in the clinical outcomes, mortality or hospitalisation rates of patients accessing phone versus video consultations in most investigated settings
- Patient satisfaction with and demand for telephone consults is either equivalent to but more often than not higher than video consults
- Both video and telephone consults significantly cut down travel, appointment waiting times and transport barriers to medical care. Both have been found to reduce patient health care appointment attendance costs

Although existing evidence is of low to moderate quality and the gaps in telehealth research remain, our rapid review concludes that:

- Phone and video are two appropriate modalities for consults – both have been shown to enable a range of clinical activities including history taking, diagnosis, referral, and medication-based management, and can improve access to health care and deliver good patient outcomes when used in a clinically appropriate way.
- Prioritising video over telephone consults can therefore have the effect of reinforcing and exacerbating existing health and social inequities rather than reducing them, risking unintended negative outcomes. Telephone consults have promoted equity of access to medical care for older people, First Nations communities, culturally and linguistically diverse communities, rural, regional and remote communities and other priority populations.

These findings support the RACP's call for both video and phone consults to be available in the best interest of patients. Please refer to **Appendix A: RACP Telehealth Rapid Review** for detailed information.

3. Recommendation 9: need for initial consultations with medical specialists to be available through phone or video

While the RACP is supportive of the reinstatement of phone consults for the MBS item 116 (as recommendation 9 contemplates), the RACP opposes the proposed change to restrict initial specialist consults to only face-to-face so as to align with the 1-in-12-rule currently applied to General Practitioner (GP) telehealth services.

The proposed change is equivalent to a blanket restriction, which means there will be no alternative option for medical specialists to see new patients besides face-to-face, be they in metropolitan areas or regional and rural areas.

The major cause of our concern is its unintended consequences of reducing patient access and care. Around 28% of the Australian population are based in rural and remote areas where access to and use of health care services are poor[17]. The proposed change fails to appropriately consider the clinical needs of those living in regional and rural areas whose access to specialist services are severely limited by their geographical locations and the scarcity of specialist services. It will prolong patient waiting times for specialist diagnosis and treatment and / or remove the access completely if patients are unable to travel. Forcing patients to travel for specialist services will consequently increase barriers to accessing care and costs, unfairly disadvantaging and further marginalising regional patients seeking to access specialist services. Not only will the regional patients be affected by the proposed change, metropolitan patients who are in aged care facilities and people with physical limitations will also be affected.

The RACP urges that the MRAC not to proceed with the proposed change. If MRAC insists on its implementation, exemptions must be made for some circumstances where geographical distance or patient factors (e.g., frailty, illness) prevent the conduct of a face-to-face consult in a clinically appropriate timeframe and for situations whereby a GP is in attendance with the patient to support consult with a medical specialist.

The RACP also wishes to highlight that the alignment with GP's 1-in-12-rule to ensure continue of care is not a valid reason to justify the proposed change. The 1-in-12 rule curtails the risk of overservicing through the commercialisation of telehealth business models. Specialist services by nature are distinct from GP services in that rebates for specialists are conditional on GP's referral. This distinction together with the different organisation of the MBS telehealth items make it inappropriate to equate specialist telehealth services with GPs through 1-in-12 rule extension.

Further, while having a face-to-face consult might be desirable for an initial GP consult, this does not necessarily hold true for the subsequent referred specialist consult, where a physical examination may not be required at the outset. A telehealth consult in this instance would be equally beneficial and not disadvantage patients who might otherwise have to travel for that consult. This is within the context of no cost difference to Medicare whether the first specialist consult is conducted via face-to-face or video.

3.1 Specialty specific considerations

Several comments and issues have been identified by our members from a number of specialities, including addiction medicine, cardiology, cancer genetic, paediatric medicine, palliative medicine, public health, rehabilitation medicine, oncology. A summary of internal feedback is provided below:

[17] Rural and remote health - Australian Institute of Health and Welfare (aihw.gov.au)

- Telehealth has been integrated into modern clinical practice especially to initiate timely care with regional and urgent patients. The proposed restriction overlooks specific circumstances where telehealth consults can be as good as or sometimes better for patient centred care. The proposed change will completely remove the ability of medical specialists to triage new patients who cannot travel, much less to arrange the downstream investigations and streamline care for them.
- The revised MBS telehealth principles should be the guide for MBS telehealth arrangements, yet the proposed change is not in harmony with the revised MBS telehealth principles 1, 4 and 5 which emphasise on fulfilling patient needs, not creating unintended consequences, and offering both video and phone modalities. It also runs counter to the Australian Government's Rural Health Strategy.
- The proposed change denies the medical autonomy of patient and the discretion of physician to determine the best way to deliver optimal patient care.
- Insisting on face-to-face consults pushes optimal patient care back to pre-telehealth era and presents a backward step. Telehealth was introduced in 2002 with the acknowledgment that these consults, including initial consults, were safe and effective. It also allowed the inclusion of a patient-end doctor or health care provider if necessary.
- The use of telehealth allows continuity of care for and timely engagement with palliative care patients (cancer or non-cancer) who may not be able to attend face-to-face consults due to their unstable or symptomatic states and declining performance function. The clinical experience highlights that palliative patients engage better when initial consults are phone-based.
- Many patients with neurological conditions cannot travel long distances in particularly the elderly. Telehealth allows metropolitan based neurology services to be accessed by patients in remote and rural communities (where there are no local neurologists) within a shorter time frame. Many common neurological conditions such as Parkinson's disease, and dementia can be diagnosed and treated through video consults. The diagnosis of Parkinson's disease via initial telehealth consults is a good case in point which is supported by a number of leading movement disorders neurologists internationally[18] and a large national US randomized control trial[19].
- There is a very limited number of cancer genetic specialists who provide specialist services to large geographical areas. Their services are primarily concerned with assisting genetic diagnosis through family history, which does not entail face-to-face consult. The majority of the patient cohort are young people who have difficulty travelling by themselves (because their parents are working). From the perspective of these patients, the proposed changed will either take away their choice to access cancer genetic services or force them to pay out of pocket for video consults.
- Rehabilitation medicine specialists commonly work in a multi-disciplinary team environment. The availability of video consults allows rehabilitation of concussion to be provided to those living in remote areas who have difficulty travelling to clinics or who cannot wait for specialists to travel to a visiting clinic near them. There is no concern over potentially missing important abnormalities in this group of patients, who have already been examined in either ED or acute medical facility. A video consults can appropriately assess concussion-like headache, anxiety and mood issues, though not subtle abnormalities like reduction or loss of senses.

[18] International Parkinson and Movement Disorder Society. Can we make a new diagnosis and treat Parkinson's disease by telemedicine? March 2021.
[19] Beck CA et al. Parkinson Investigators. National randomized controlled trial of virtual house calls for Parkinson disease. Neurology. 2017 Sep 12;89(11):1152-1161

- It is likely that a rural patient still opts for initial specialist telehealth consult and forgo the Medicare rebates. Without initial telehealth attendance items for 132 or 110 being available, there will be no subsequent telehealth attendance items for 133 or 106. This means that patient will not be able to get their Medicare rebate(s) for their whole treatment course.
- There is potential risk for the proposed change to create perverse incentives in encouraging telehealth business models be established as a primary care modality, posing real risk in general consulting practice in primary care.

There is a strong need for initial specialist telehealth consults to be available in Australia, especially in rural and remote areas. Initial specialist telehealth consult enables enhanced clinical care in general and is associated with a multitude of benefits:

- Enabling a larger group of supporting people including elders to be in the room with the patient from regional and rural areas during the consult; Otherwise, the long journey is often undertaken by the patient alone
- Enabling a timely initial discussion with and assessment on patient from regional and rural areas, followed by further tests to be conducted locally prior to travelling to metropolitan areas for treatment.
- Enabling streamlined care
- Enabling patients with rare conditions to gain expert opinion from specialists and then being managed by their own doctors
- Enabling one-off geriatric assessment for older and vulnerable population groups in regional areas to be conducted to enhance care provided locally (note: this is demonstrated in a geriatric oncology model in the Goulburn Valley)
- Enabling patients with COVID related illnesses who need to stay home to access needed care when face to face consult is not an option
- Enabling palliative patient who are too unwell to travel to receive end of life care at home, though many palliative care services do home visits
- Enabling teletrials (which should be considered as a standard of care) and increasing the availability of trials to patients in rural and regional areas in particular

The proposed change will obliterate these benefits, with older and underserved groups in regional areas being most adversely impacted.

3.3 Successful telehealth model of care

The usefulness of telehealth at the health system and community levels have been underestimated. Initial specialist telehealth consults hold crucial importance in certain circumstances:

- A new diagnosis in a frail or vulnerable patient who needs an expert opinion from a specialist to determine if further investigation or interventions are feasible or warranted, but travel for a face-to-face consult will be difficult, deleterious or impossible for the patient. In such case, video consult is categorically a better alternative.
- Supported consultations in which GP or other health worker is in attendance with the patient to communicate their findings and gain the expert opinions from the specialist in real time through the videoconference.
- Patients from regional and remote areas require expert opinions from metropolitan based specialists due to less or no availability of local specialist services, and then receive treatment close to their home.
- Patients from regional and remote areas gain expert opinions from metropolitan based specialists in a bid, enabling and facilitating more streamlined care received in the metropolitan location.

The abovementioned circumstances underscore the paramount importance of telehealth for initial specialist consults in improving patient access and care and argue against the less convincing statements in the consultation report that *telehealth is likely to be less effective for new diagnoses* (pg6) and that *telehealth may appear to improve access* (pg. 11). It is also important to note that pathology and imagining tests are vital part of all consultations, not just telehealth services.

Two successful examples of telehealth models of care are delineated in detail to demonstrate the crucial importance of initial specialist telehealth consults in meeting the needs of underserviced and priority patients:

Example 1: Townsville Cancer (TCC) model[20]

The TCC model was designed to address two key problems in cancer care in Townsville: 1) the need for inpatient interhospital transfers from Mt Isa (which is 900km west of Townsville) to Tonwsville and 2) the disparity in waiting times from date of referral to clinical reviews between rural and Townsville patients. The TCC model aimed to provide cancer care closer to home in a timely and equitable manner for cancer patients in Mt Isa.

In this model, oncologists from Townsville provide their services to rural sites through videoconferencing, including writing the care plan, with the support from locally based doctors, nurses and allied health professionals. The scope of practice for this model include:

- all new patients in Mt Isa being seen initially via videoconferencing to ensure future care was coordinated if and when patients travel to Townsville
- all solid tumour chemotherapy regimens being administered in Mt Isa
- all inpatient admissions to Mt Isa hospital being notified to the Townsville oncologists to ensure regular video-based patient assessment during their hospital stay.

The TCC model enabled 70 new patients received cancer care from Mt Isa between 2009 and 2011, 93% of them were seen within one week of referral. All 17 urgent patients were seen within 24 hours of referral and managed locally without leaving Mt Isa. This proved that teleoncology model can realise equity of access for rural patients.

Example 2: Palliative Care Virtual Model[21]

Palliative Care Virtual (PCV) is a telehealth model of palliative care at Monash Health for oncology outpatients, implemented during the COVID-19 pandemic. The PCV model is operated with medical oncology outpatient clinics in real time to promote interdisciplinary collaboration and early referral to palliative care.

Between October 2020 to September 2022, the PCV model provided care to 423 patients, with lung, upper gastrointestinal and genitourinary cancers comprised 50% of the patient cohort. A total of 1384 consults were conducted, with 37% of patients consulted via phone and 63% via video. The median timeframe from referral to initial consults were reduced to 11 days.

Patient reported experience had been very positive and the clinic has had profound beneficial outcomes in health service metrics such as early engagement of palliative care supports for oncology patients.

[20] Sabesan, S et al (2014) Timely access to specialist medical oncology services closer to home for rural patients: experience from the Townsville Teleoncology Model. Australian Journal of Rural Health, 22 (4). pp. 156-159.
[21] Internal audit data from a AChPM fellow: available upon request

4. Revised MBS Telehealth Principles

MBS telehealth principles play a pivotal role in establishing core values in designing MBS telehealth items, setting the benchmark standard of telehealth care, as well as shaping the development of telehealth services in Australia into the future.

As general principles, and with the clear exception of recommendation 9, the RACP by and large supports the adoption of the revised MBS telehealth principles. We acknowledge the detailed additions and revisions to the original MBS telehealth principles and agree with the incorporation of newly added elements, such as:

- the patient's needs will be determined by both the clinician and patient
- quality and safety standards applied to face-to-face services must be met, be it synchronised or asynchronous telehealth models
- continuity of care must be supported especially after episodes of care with another clinician
- both the treating clinician and patient-end clinician should be renumerated
- any change to telehealth items must be given adequate notice to stakeholders concerned to accommodate change.

None of these elements would be undermined by telehealth being available for initial medical specialist consults, and they are entirely consistent with this mode of care.

The most appropriate consultation modality should be discussed and negotiated between practitioners and their patients based on their individual circumstances, recognising the competence of doctors and their extensive training. The Medical Board of Australia's 2023 *Revised telehealth guidelines* require the standard of care provided in a telehealth consultation to be safe and as far as possible meet the same standards of care as provided in a face-to-face consultation.[22] The revised guidelines also obligate practitioners to continuously assess the appropriateness of the telehealth consultation and whether a direct physical examination of the patient is necessary. These requirements are a regulatory line for risk management that promote reflective patient-centred practice, supporting the RACP's recommendation for both phone and video consults to be available, considering care needs, applicable procedures or tests and the most appropriate and timely way to facilitate access for practitioners and patients. Beyond these requirements, there should not be additional MBS restrictions on use of telehealth for specialist consults.

The RACP supports revised principle 6: *Should support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation.* This would optimise telerehabilitation specialist services where the presence of a therapist or clinical nurse specialist with the patient would assist rehabilitation medicine specialists with examination (such as spasticity assessment or other functional assessment) and to provide additional information about the progress of that patient at the time of the consultation.

The RACP especially welcomes the revision of original principle 5 to: *Must offer both telephone and video along with face-to-face consultations, although the modality for any service is subject to Principles 1 and 2. Video should be encouraged over phone where it will provide a better patient and/or clinician experience*.

With respect to revised principle 7, the RACP wishes to underline that careful review and engagement with specialties concerned are warranted before removal of any MBS telehealth items as the impact could vary remarkably from one clinical area to another and could extend to the viability of effective and patient centric telehealth care.

[22] Medical Board of Australia, *Draft revised guidelines: Telehealth consultations with patients* [online]; Medical Board of Australia - Current Consultations, February 2023

5. Asynchronous telehealth

Asynchronous telehealth has been gaining presence in Australia. The RACP does not support asynchronous telehealth on the grounds of good medical practice. This telehealth model does not require the presence of the patient and health practitioner in real time to make a diagnosis and treatment recommendations, nor does it encourage ongoing therapeutic relationship and interactive information exchange.

Although asynchronous telehealth can provide scale and improve efficiency, it risks communication gaps, bypassing necessary clinical examination, delinking patients to their usual care, and depersonalising the patient care experience[23]. The fact that medical practitioners have never consulted with the patient before further increase risks associated with asynchronous telehealth.

6. Other Comments

- The Australian & New Zealand Society of Palliative Medicine (ANZSPM) supports *recommendation 10: Reintroduce GP patient-end support, and extend it to include nurse and allied health patient-end support for telehealth with a GP*. The reality of rural practice is that face-to-face services for house-bound palliative care patients is not always possible. For this reason, patient end-support must be extended to palliative medicine specialists.
- Recommendation 10 should extend to support sub-specialist Telehealth delivery for example general paediatricians (or related registrars).
- In the context of telehealth use in real world, the word choice 'effectiveness' is considered to be more appropriate than 'efficacy'. The concept of efficacy refers to the extent to which an intervention does more good than harm under ideal circumstances, whereas effectiveness assesses whether an intervention does more good than harm when provided under usual circumstances of healthcare practice[24].
- Claiming for extended telehealth consult time should be supported as a principle to ensure that high-quality health services are delivered to patients from culturally and linguistically diverse (CALD) backgrounds, patients with a disability (such as cognitive, hearing or speech impairment) and patients who have English as a second language and require interpreters. These patient groups usually require longer consultation time than usual.
- One of the key considerations for telehealth is data security. Cybersecurity breach risks exposing sensitive patient information, particularly condition specific MBS item numbers such as bloodborne virus and sexual and reproductive health (BBV) and mental health, and making them vulnerable.

The RACP welcomes the opportunity to work collaboratively with the Department and the Government to optimise telehealth care. We are looking forward to further engagement on this and related matters.

[23] Stephens J et al.. Asynchronous telehealth. Primary Care: Clinics in Office Practice. 2022 Dec 1;49(4):531-41.
[24] Haynes B. Can it work? Does it work? Is it worth it? The testing of healthcare interventions is evolving. BMJ. 1999 Sep 11;319(7211):652-3.

Appendix A: RACP Telehealth Rapid Review

Summary of findings

Healthcare consultations by video and telephone: a rapid review and policy recommendations

The RACP has conducted a rapid review of 30 moderate to high quality evaluations of telephone and video consultations in health care published between 2016-2023. The conclusions that can be drawn from the rapid review are that:

- Telephone and video are two appropriate modalities for consultations. Both have been shown to enable a range of clinical activities including history taking, diagnosis, referral, and medication-based management. Both modalities can improve access to health care and deliver good patient outcomes when used in a clinically appropriate way.
- Technical problems, service difficulties and platform connectivity issues have been more common in video than telephone consultations.
- The use of video over phone consultations raises significant equity and access concerns. Video conferencing cannot be relied on as a replacement of telephone due to digital infrastructure deficits and the continuing socioeconomic inequalities that characterise Australia. Poor quality broadband exists in many parts of regional and rural Australia in particular. Many socioeconomically disadvantaged communities do not have the necessary technology or data packages to support video consultations, nor the digital literacy to participate. Video consultations have typically benefitted more metropolitan patients with higher levels of wealth, access to resources and education.
- Prioritising video over telephone consultations can therefore have the effect of reinforcing and exacerbating existing health and social inequities rather than reducing them, risking unintended negative outcomes. Telephone consultations have promoted equity of access to medical care for older people, First Nations communities, culturally and linguistically diverse communities, rural, regional and remote communities and other priority populations.
- Patient perceived clinical outcomes and objective clinical outcomes have been generally consistent between video and telephone consultations; patients have reported that their clinical needs have been met with video and phone consultations. Both modalities have been shown to reduce preventable mortality, hospitalisation and support routine care.
- Both consultation modalities significantly cut down travel and associated costs, appointment waiting times and transport barriers to in-person attendance. Both modalities enable health care delivery to be balanced with childcare and work-related commitments.
- Patient satisfaction with and demand for telehealth consultations is either equivalent to, but often higher than for video consultations. Patients have reported that they would like to have ongoing access to a range of consultation modalities to meet their current and future healthcare needs.
- Individual doctors and patients have their unique needs and preferences for phone or video consultations due to health-related, geographic, communication and technology-based circumstances. A one-size-fits-all approach has no place in the equitable delivery of quality health care services.
- Prior to the COVID-19 pandemic, telehealth was used very infrequently in Australia and many other countries. In Australia, this had been because of strict limitations that applied to MBS rebates until the pandemic. Evidence is therefore still emerging on how telehealth might affect health outcomes and access to care, both in Australia and internationally. While face-to-face consultations will remain the gold standard for some services, the current state of knowledge shows that neither phone nor video is inherently superior across all patients, health concerns or settings.
- Flexibility in patient and doctor choices will be required for the foreseeable future to accommodate differing levels of access to face-to-face, video and telephone services.

Emerging evidence on use of phone and video in telehealth

As part of preparing this brief, the RACP investigated the current literature on the efficacy of phone and video telehealth consultations. This is a rapid review of available evidence and should not be interpreted as a systematic review. Nevertheless, the RACP sought to include studies of at least moderate quality wherever possible.

Thirty moderate-quality to high-quality studies were included in this review. Studies published between 2016 and 2023 were considered acceptable because of their currency and relevance. Thirteen studies are Australian; the rest come from the United States, Canada, Europe and Asia. There is no significant difference between the findings of Australian and remaining studies; however, there remain gaps in the existing research on telehealth and telemedicine more generally.

Telephone and video consultation use and efficacy has been evaluated in a wide range of health care settings: primary care practices, tertiary care settings, outpatient settings, community health centres, rehabilitation centres, palliative care services, abortion services, anxiety and mental health services, psychiatry services, residential aged care settings, otolaryngology–head & heck surgery centres, cardiological centres, vascular centres, urology centres, and Aboriginal Community Controlled Health Organisations (ACCHOs). Comparative efficacy and value have been evaluated within metropolitan, rural, regional and remote areas of Australia and countries abroad.

A large number of patients and care needs are captured in the studies. Well over 50,000 patients were sampled across the included studies. Patients had conditions including complex or chronic conditions acute conditions, diabetes, neck and head conditions, mental health conditions, cardiovascular conditions, urological conditions, palliative care needs, rehabilitative care needs, ageing health needs, opioid dependency care needs, and elective care needs. Represented demographics included children, adult females and males, families, older adults, rural, regional, remote and metropolitan patients, culturally and ethnically diverse patients, as well as patients from various socio-economic backgrounds.

The methodological designs of the studies included Randomised Controlled Trials (RCTs), systematic reviews of RCTs, quasi experiments, interrupted time series, retrospective reviews of patient or health facility records, prospective pilot studies, patient and practitioner surveys and interviews. Some of the included evaluations cover multiple outcome indicators, while others centre on only one outcome. Key findings are presented below.

Key Findings

See Attachment: Studies Log for a detailed summary of reviewed studies.

Consultation length and components- a comparison

- Five evaluations (Hammersely et al 2019; Lived Experience Australia 2021; Zurynski 2021; Chang et al 2021; Scott et al 2021) identify that telephone only and video only consultations had the same mean time duration, exceeded only by in-person appointments. A range of activities occurred in both modalities, like in face-to-face consultations, for example checking patient understanding, shared decision making, patient safety netting, clinical history taking, referrals, and medication reviews.

Technical disruptions- a comparison

- Seven evaluations (Hammersely et al 2019; Lived Experience Australia 2021; Zurynski 2021; Chang et al 2021; Scott et al 2021; Nguyen et al 2022; Dennett et al 2022) identify that technical problems were often more common in video consultations, disrupting consultation commencement, flow or completion.

Consultation access and equity- a comparison

- Seven evaluations (Rodriguez at al 2021; Darrat et al 2021; Scott 2021; Savira et al 2022; Savira et al 2023; Wagermann et al 2022; Barsom et al 2021) report that video consultations had raised

significantly more barriers to patient participation and access over telephone consultations. Older patients, single parents, divorced and widowed households, economically disadvantaged populations, uninsured patients, patients with poor internet access, regional, rural and remote patients, patients from culturally and linguistically diverse backgrounds, and patients with lower digital health literacy have had more barriers accessing video consultations than telephone consults. Video consultation use has typically been skewed toward higher socioeconomic groups with greater access to resources and education.

- Two evaluations (Parker et al 2021; Rowe et al 2021) identify that telephone consultations were more likely to be used by very elderly patients and a broader range of socio-demographic groups than video consultations. Younger patients were more likely to use video consultations overall. We highlight this as a key implication for government to consider for Australia's demographically diverse and ageing population.
- Two evaluations (Savira et al 2022; Savira et al 2023) demonstrate there have been persistent barriers to the uptake of video consultations as an alternative to telephone only consults in rural, regional and remote areas of Australia.
- One evaluation (Couch et al 2021) identified that phone services had significantly boosted health care service utilisation within an Aboriginal Controlled Community Health Organisation during COVID-19.

Comparative health care/clinical outcomes

- Eight evaluations (US Agency for Healthcare Research and Quality 2016; Rush et al 2018; Middleton Green et al 2019; Totten et al 2020; Krzyżaniak et al 2021; Hullick et al 2022; Carrillo de Albornoz et al 2022; Rowe et al 2021) report no difference in the clinical outcomes, mortality or hospitalisation rates of patients accessing telephone only versus video consultations in investigated settings. Both formats allow provision of quality care to patients in place and prevent avoidable hospital admissions without observable variations.
- One systematic review (Totten et al 2020) reports that across clinical issues, outpatient telehealth consultations, irrespective of modality, consistently reduced the number of visits and hospital admissions; some studies reported improved clinical or psychiatric outcomes.
- Two evaluations (Seymour et al 2022; US Department of Health and Human Services 2019) report that in some contexts, patients accessing telephone consultations had better clinical outcomes than counterparts accessing video consultations and in-person care. These evaluations highlight that video should not be assumed to be an inherently better care option by default.
- One evaluation (Carrillo de Abornoz et al 2022) identifies no difference in the patient discontinuation rate for telephone and video consultations, noting that the rate was higher than in-person consultations overall, but that the clinical outcomes achieved through both modalities were equivalent to in-person care. A recent Australian evaluation in cardiological outpatient care settings (Rowe et al 2021) has however reported that patients seen via telephone consultation were more likely to follow up- in person by comparison, highlighting the potential for telephone to enhance continuity. A third evaluation (Parker et al 2021) specifically found that both video and telephone consultations supported patients with opioid dependence to remain engaged with primary care.
- One evaluation (Dennett et al 2022) identifies that there were no differences in patient perceived clinical outcomes between video and telephone consultations, and that consistently high percentages of patients rated their clinical outcomes as met. One evaluation (Rowe et al 2021) reports that patients consulted via video and telephone have not experienced any clinical safety issues or adverse outcomes, underlining a low rate between the two modalities.
- Only one evaluation (Barsom et al 2021) identifies that for post-surgical patients, surgeons specifically preferred video consultations to assess a patient post-surgery, highlighting the

importance of availing both modalities and relying on practitioners and patients to negotiate the appropriate consultation based on circumstance.

Comparative social and economic outcomes

- Four evaluations (Totten et al 2020; Chang et al 2021; Lived Experience Australia 2021; Contractor et al 2022) found that both video consultations and telephone consultations significantly cut down travel, appointment waiting times and transport barriers to medical care. Both enabled balancing of childcare and work-related time commitments, and for this were highly valued by patients.
- Both telephone and video consultations have been found to reduce patient health care appointment attendance costs (e.g., Totten et al 2020; Nguyen et al 2022). Both modalities could therefore support cost appropriate healthcare in inflationary economic environments given appropriate service coverage and access. However, due to the infeasibility of video consultations for many Australians, it is likely that that their cost benefits have been distributed toward better resourced patient groups able to participate in extended video consultations, further entrenching inequality.

Patient preference and responsive person-centred practice

- Eleven evaluations from Australia and aboard report that patient satisfaction with and demand for telephone consultations is either equivalent to but more often than not higher than video consultations; this finding applies across patient groups, demographics and is replicated in small, medium and large patient samples (Hammersely et al 2019; Lived Experience Australia 2021; Zurynski 2021; Chang et al 2021; Scott et al 2021; Australian Health Care Index Report 2022; ABS 2022; Carillo de Albornoz et al 2022; Contractor et al 2022; Dennett et al 2022; Barsom et al 2021).
- Two evaluations (Contractor et al 2022; Dennett et al 2022) report that patients appreciated their experience of telephone and video consultations during COVID and in the recovery phase and wish to have both consultation modalities continue into the future, with the ability to negotiate depending on their circumstances and purpose for the consultation.
- Only one evaluation (Nguyen et al 2022) reported that video consultations produced a higher rate of patient satisfaction despite that cost benefits were associated with both modalities by patients.
- Of special significance, a nationally representative Australian Health Engine Health Index Study of over 11400 patients from November 2022 identified most had a telehealth appointment in the last six months overwhelmingly via phone due to convenience or because an illness prevented them from leaving the home and were generally satisfied. Telehealth phone consultations were used in roughly equal proportions by rural, remote and metropolitan patients surveyed. Only 16% of patients said they would prefer a video consultation over a telephone consultation.
- Also of special significance, the nationally representative ABS Patient Experience Report (November 2022) analysis of 23,949 survey participants 15 years and above shows that 85.4% reported that they would use telehealth for a consultation again if it was offered, up from 83.4% in 2020-21.

Need for further research

- As confirmed by the Bond University report on telehealth in primary care commissioned by the Department of Health in 2021, consultations by either video or phone provide equivalent outcomes for many types of clinical encounters, particularly for ongoing care.
- While there is more research on the effects of video consultations, there is a growing body of evidence for the benefits of telephone only consultations. More research is needed to understand the benefits of phone consultations for patients and the differential outcomes for phone and video for specific settings and conditions.

RACP position on phone and video

Telehealth has improved access to health care for many patients; the July 2022 cessation of most telephone items reduced access for many in need. Over time, it may reduce telehealth use among some priority populations, increase the burden of chronic disease and hospital admissions and worsen health outcomes.

The most appropriate consultation modality should be discussed and negotiated between practitioners and their patients based on their individual circumstances, recognising the competence of doctors and their extensive training. The Medical Board of Australia's 2023 *Revised telehealth guidelines* require the standard of care provided in a telehealth consultation to be safe and as far as possible meet the same standards of care as provided in a face-to-face consultation.[25] The revised guidelines also obligate practitioners to continuously assess the appropriateness of the telehealth consultation and whether a direct physical examination of the patient is necessary. These requirements are a regulatory line for risk management that promote reflective patient-centred practice, supporting the RACP's recommendation for both telephone and video consultations to be available, considering care needs, applicable procedures or tests and the most appropriate and timely way to facilitate access for practitioners and patients.

The recently released Strengthening Medicare Taskforce Report (December 2022)[26] makes a special commitment to invest in and address inequities in access and outcomes, including for First Nations Australians, people in rural and remote areas, culturally and linguistically diverse people, people with disability and people on low incomes. As pointed out in this rapid review, these groups benefited the most from phone telehealth items and were the most set back of all communities after their removal in July 2022. Restoring these items would represent a practical commitment to achieving the vision of the report.

In line with the provided evidence, the RACP continues to advocate for:

- **Reinstatement of all telephone-based specialist consultations**, including those for complex consultations
- To reduce the negative impacts of the digital divide, **funding of videoconferencing technology packages** to support capacity building for patients, especially those in priority and underserviced groups.

[25] Medical Board of Australia, *Draft revised guidelines: Telehealth consultations with patients* [online]; Medical Board of Australia - Current Consultations, February 2023
[26] Australian Government, *Strengthening Medicare Taskforce Report* December 2022 [online]; Strengthening Medicare Taskforce Report (health.gov.au)