AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | ama@ama.com.au
W | www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Expansion of Telehealth Services

AMA submission to the Australian National Audit Office – Expansion of Telehealth Services

via: ANAO Performance Audit Consultation Hub

The AMA welcomes the opportunity to provide input into the Australian National Audit Office's (ANAO) audit into the expansion of telehealth services, as it has worked closely with the Government to try to negotiate the full and seamless integration of telehealth services into general and other specialist medical practice, for the benefit of patients.

The AMA has always strongly advocated that telehealth services should be available:

- as an adjunct to usual medical practice
- for regular patients of the practice
- when it is clinically appropriate for the patient's circumstances.

While telehealth is not and never will be a complete substitute for face-to-face visits to the doctor, it is the norm in many parts of the world, providing patients with a convenient option to access care where when it is not physically feasible, necessary, or appropriate to attend the practice in person.

In recent years, the use of telephone and video consultations has enabled the ongoing provision of patient care outside of physical attendance during both natural disasters and the COVID-19 pandemic. However, although the AMA was pleased that the government quickly recognised the need for telehealth in response to the pandemic, funding of MBS telehealth items for general practice was long overdue.

Furthermore, whilst the AMA appreciated the Department's willingness to consult and engage with us and other key stakeholders during the roll-out of telehealth, its staged introduction and some ambiguity and frequent changes to the rules created confusion, disruptions and increased administrative costs for general practices during a time of crisis.

Most importantly, significant issues of concern around the implementation of telehealth remain to be resolved. These include the need to provide the same rebates for telephone items as are provided for face-to-face and video consultations given patients' overwhelming preference for phone services, the restoration of MBS rebates for Level C and D phone consultation items, mental health care and chronic disease management items, and the reinstatement of the rural

telehealth bulk-billing incentives for mental health care as part of the permanent telehealth model.

Performance audit questions: management of the extension of telehealth

The AMA recognises that the ANAO is seeking comment on how efficiently and effectively the Department of Health has '*managed the expansion of telehealth services during and post the COVID-19 pandemic*.' Key issues of concern in relation to these issues are outlined below.

COVID-19 and its effects are not over: restrictions on telehealth from 1 July 2022 are bad policy

Despite the way the Audit Office has worded the objective of this audit, it is important to recognise that Australia is *not* 'post the COVID-19 pandemic'. A cursory glance at the statistics shows the reality that the COVID – 19 death toll in Australia this year to date is more than double that of the first two years of the pandemic combined.

Secondly, the lifting of COVID-19 restrictions combined with lowered exposure to and hence lowered immunity to influenza over the past two years means that this winter, GPs and hospitals across Australia are dealing with an unusually high flu case load[1] on top of tens of thousands of new COVID-19 cases every day.[2]

Given this, the AMA and other health sector stakeholders believe that the restrictions to telehealth services that came into effect on 1 July 2022, which were first announced by the former Government and then implemented by the current Government, are unwarranted and place the health of both vulnerable patients and health practitioners at risk. The AMA has repeatedly advised both the current and former Federal Ministers for Health of this view.

Although Minister Butler has made one concession – delaying the introduction of the new 30/20 rule for phone services and application of the 80/20 rule to telephone and video services until 1 October 2022 - the removal of the capacity for GPs to bill Medicare for Level C (longer) telephone consultations, is unjustified given:

- the continuing pressures on general practice and hospitals arising from a high COVID-19 and influenza case load, which are likely to get worse as the winter progresses given that the antibodies triggered by vaccination or earlier variants of COVID – 19 are less effective at blocking infection with the new Omicron BA.4 and BA.5 variants;[3]
- the continuing need to minimise the infection risk both to GPs (who are already over-burdened and in short-supply in rural and remote areas) and to patients, particularly those with complex and chronic health conditions that make them vulnerable to worse COVID – 19 of influenza outcomes, and who may require longer (Level C) consultations;

[1] https://www1.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-ozflu-flucurr.htm
[2] https://www.covid19data.com.au/states-and-territories
[3] Callaway, E. What Omicron BA.4 and BA.5 variants mean for the pandemic, *Nature*, 2022; 606, 848-9. Retrieved on 2 July 2022 from https://www.nature.com/articles/d41586-022-01730-y

- the fact that GP's often need longer consultations to treat newly infected COVID patients, particularly those who are older or who have pre-existing conditions, in order to establish whether they are eligible for antivirals, any contraindications to antiviral treatment and which antiviral might be best for them, and to develop a treatment plan;
- the understandable continuing preference of many patients for phone consults over video consults when they are ill, bed-ridden, or immobile, cannot travel or wish to reduce the risk of infection; and
- the *inability* of many patients to have video consults, particularly those living in rural areas, given their lack of access to the necessary technology or reliable high-speed broadband.

The reality is that many patients who cannot access their preferred mode of consultation or afford to do so in the absence of a Medicare rebate will not get the care they need and become sicker. Some will inevitably increase the strains on a hospital system that is already seriously over-burdened.

Obviously, a policy change that will simply transfer some costs from the Medicare system for primary care to the public hospital system, whilst also placing GPs and some of the most vulnerable and isolated patients at the country at risk, is not only a false economy, but grossly unfair.

The Government has acknowledged the ongoing impact of COVID-19 by extending the COVID-19 National Partnership Agreement covering hospital funding until the end of year. At the very least, Medicare funded COVID-19 telehealth services should be treated in the same way.

The AMA believes that in the interests of equitable patient access to high quality continuity of care, the appropriate use of telehealth as set out in the AMA's 10 Minimum Standards for Telemedicine, with fair and equitable MBS subsidies for both phone and video consultations, must become a permanent feature of the Australian health system.

A messy staged roll-out

Since their introduction in March 2020, rules and requirements for telehealth items have changed frequently[4], with extensions to the availability of certain items frequently occurring at the last minute following concerted advocacy from the AMA and other health sector organisations.

Incremental extension to telehealth items, uncertainty around the likelihood of extensions to items due to expire, and ambiguity around some aspects of eligibility/exemptions and the definition of "COVID – 19 impacted area" during 2020 often created confusion and a significant additional administrative workload for a general practice sector already reeling from the extra workload created by COVID-19 cases, and delivery of COVID-19 vaccines and boosters.

Amongst other things, it necessitated frequent re-education of staff and patients on new items and whether they had to be bulk-billed, difficulty in knowing whether telehealth appointments could be booked with patients in advance, and frequent changes to billing systems that some

[4] See the chronology of all of these changes here

practice software vendors were unable to keep up with. This not only increased the possibility of billing errors, but also resulted in loss of income to some practices.

Given all this, a mass telehealth compliance campaign commencing in March 2021 during the roll-out of the COVID-19 vaccine, examining billing between July 2020 and January 2021 was ill-timed.

Usual GP or general practice rule

When COVID-19 telehealth items were introduced in March 2020, there was not initially a requirement that the patient had an existing relationship with a general practitioner. As 85% of patients see a GP each year, with over 95% attending the same practice,[5] most telehealth consultations *were* between GPs and practices that had an existing relationship with the patient. However, the lack of any regulation to this effect also allowed the emergence of 'pop-up' and pharmacy telehealth models of telehealth.

Such models of care are suboptimal on many levels. Firstly, they undermine the foundations of quality primary care: continuous patient-centred care from a GP or practice aware of the patient's medical history and with access to their medical records. Secondly, pharmacy models blur the important distinction between the prescribing and dispensing of medicines which otherwise protects patients from an obvious conflict of interest where the pharmacy has a financial interest in selling medicines that it is both prescribing and dispensing.

In July 2020, following advocacy from the health sector, rules were tightened to restrict access to Medicare-funded telehealth items mostly to circumstances where the patient has had a face-to-face consultation with the GP, or with another GP in the same practice, within the previous 12-month period. (There were a range of exceptions to this rule including but not limited to situations where the patient was a child aged under 12 months, homeless, or living in COVID-19 hot-spots).

The AMA supports this change, as the available evidence suggests that the potential benefits of telehealth are best realised, and risks best reduced, where it occurs between a patient and their usual general practitioner or general practice.[6]

Bulk-billing requirement

When COVID-19 telehealth items were announced in March 2020, the initial requirement was that GPs must bulk-bill all patients billed using these items. Although this requirement was

[5] Australian Bureau of Statistics. Patient Experiences in Australia: Summary of Findings, 2017-18. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by Subject/4839.0~2017-18~Main Features~General practitioners~2; Britt, H., Miller, G. C., Henderson, J., Bayram, C., Harrison, C., Valenti, L., Charles, J., Pollack, A.J., Wong, C., & Gordon, J. General practice activity in Australia 2015–16. Sydney University Press, 2016. (General practice series no.40.) Retrieved on 27 June 2022 from https://ses.library.usyd.edu.au/handle/2123/15514

[6] Ackerman SL, Gleason N, Shipman SA. Comparing patients' experiences with electronic and traditional consultation: Results from a multisite survey. *J Gen Intern Med* 2020;35(4):1135–42; McKinstry B, Watson P, Pinnock H, Heaney D, Sheikh A. Telephone consulting in primary care: A triangulated qualitative study of patients and providers. *Br J Gen Pract* 2009;59(563): e209–18.

partially relaxed for GPs from April 6, 2020, and then removed from 1 October 2020, other medical specialists and allied health providers were allowed to privately bill all COVID–19 telehealth consultations from 20 April 2020.

This was inequitable, of questionable legality, and had a significant impact on the viability of many general practices given the long-term impacts of the Medicare freeze on practice financials. It meant that practices had to bulk-bill many patients who would otherwise have been able to afford being privately billed, and this significantly affected the viability of many general practice clinics, most particularly those that are smaller and privately owned.

The temporary doubling of the bulk billing incentive payments for vulnerable patients receiving care in person or via telehealth was insufficient to cover the expenses of many such practices.

Importantly, the bulk-billing requirement also contributed to a worsening of morale in a profession that is already struggling to find sufficient medical students and graduates who want to become GPs to replace those who are leaving the profession or retiring early. This supply/demand imbalance is a direct result of the undervaluing and underfunding of general practice that has characterised health funding policy in recent decades.

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Contact

Dr Fiona Taylor
Senior Policy Advisor
General Practice and Workplace Policy Section
Ph: (02) 6270 5400
ftaylor@ama.com.au