Aboriginal Health Council of Western Australia

Submission Response

ANAO Performance Audit – Expansion of Telehealth Services

14 July 2022

The Aboriginal Health Council of Western Australia (AHCWA) is the peak body for 23 Aboriginal Community Controlled Health Services (ACCHS) in Western Australia (WA). WA ACCHS are located across geographically diverse metropolitan, regional and remote locations. They deliver the most effective model of comprehensive primary health care for Aboriginal people[1], and are in a unique position to identify and respond to the local, cultural and health issues of Aboriginal people and their communities across WA. AHCWA exists to support and act on behalf of its 23 Member ACCHS, actively representing and responding to their individual and collective needs.

AHCWA welcomes the opportunity to provide a submission to the Australian National Audit Office (ANAO) performance audit of the expansion of telehealth services (the Telehealth Performance Audit), to ensure the needs of Aboriginal people and their communities are reflected in Medicare Benefits Schedule (MBS) telehealth service options. Given the experience of health professionals in the ACCHS sector utilising MBS telehealth service options, the sector is in a unique position to comment on the expansion of telehealth services, and its impacts on patient outcomes and clinical shared care for Aboriginal people across WA.

AHCWA's submission to the Telehealth Performance Audit will focus on the accessibility of telehealth consultations, and the effects of the expansion of telehealth services on patient quality of care. However, before turning to these issues, AHCWA would like to reiterate the necessity of adequate funding to 'provide information technology infrastructure to support improved connectivity, data security and increased remote consultations using telehealth'[2]. The Closing the Gap Health Sector Strengthening Plan, also notes that the 'provision of health care by Aboriginal and Torres Strait Islander community-controlled services [must] occur in modern, accredited physical facilities equipped to offer telehealth and other digitally enabled services irrespective of location or socioeconomic status of the community'[3]. More generally, AHCWA are informed that there are significant barriers to the uptake of telehealth service options. Therefore, greater consideration must be given to determine whether there is adequate infrastructure to facilitate telehealth consultations by the health professional and patient, and to acknowledge specific consent/cultural concerns with video conferencing/recording. The effectiveness of the expansion of telehealth cannot be assessed without also considering these other issues.

[1] Throughout this submission, AHCWA uses the term 'Aboriginal' to respectfully refer to all Aboriginal and Torres Strait Islander people across Australia.

[2] https://coalitionofpeaks.org.au/wp-content/uploads/2021/12/Health-Sector-Strengthening-Plan.pdf (pg. 11)

[3] Ibid (pg. 21)

Introduction

Given over half of the Aboriginal Australian population resides in regional to very remote locations[4], telehealth services have transformed healthcare delivery. Notably, telehealth services enable individuals to access quality healthcare, irrespective of the location of the patient[5] or the healthcare provider. This is particularly the case for remote communities with infrequent access to visiting GPs, specialists and allied health providers. Additionally, evidence has shown that telehealth services reduce 'avoidable hospitalisations' and 'patient transport costs', and shorten clinical wait-lists[6]. This enables patients to access healthcare faster, and without long-distance travel and significant costs. As indicated in the National Aboriginal and Torres Strait Islander Health Plan 2021–2031, 'Telehealth services support the delivery of care on Country', and enable individuals to access culturally safe care from an ACCHS, irrespective of their geographic location[7]. Hence, the inaccessibility of telehealth services undermines 'an important opportunity for […] ensuring primary care is available to communities who may be harder to reach'[8], making it harder to achieve the aim of the National Agreement on Closing the Gap, which is to 'overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to all Australians'[9]. Any reforms in telehealth services must reflect the goals of the National Agreement, which include ensuring quality and culturally safe healthcare is accessible to all Aboriginal people.

The WA ACCHS sector has advocated extensively for changes to telehealth service options, to ensure Aboriginal people have every opportunity to gain access to quality healthcare. Much of the WA ACCHS sector's concerns with telehealth services were reflected in the MBS Review Taskforce Telehealth Recommendations 2020 report[10]. However, AHCWA considers that these recommendations were overlooked in the recent changes to the MBS (instigated by the COVID-19 pandemic that brought a rapid 'transition to telehealth'[11]). While AHCWA welcomed the expansion of telehealth MBS items, limited consultation was undertaken with AHCWA regarding how changes to telehealth services may affect Aboriginal people, and the unique challenges of the WA ACCHS sector. As per Priority Reform One of the National Agreement, which outlines the need for 'formal partnerships and shared decision-making'[12], AHCWA suggests there be greater consultation and genuine partnership with Government when implementing telehealth service reforms. Consistent with Priority Reform One, decision-making that concerns accessibility to healthcare for Aboriginal people must be 'shared

[4] Figure 2: Estimated Indigenous population by geography, 2021 https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians

[5] https://www.infrastructure.gov.au/sites/default/files/2018-regional-telecommunications-review-getting-it-right-out-there.pdf (pg. 48)

[6] https://www.digitalhealth.gov.au/sites/default/files/2020-11/Australia%27s%20National%20Digital%20Health%20Strategy%20-%20Safe%2C%20seamless%20and%20secure.pdf (pg. 43)

[7] https://www.health.gov.au/sites/default/files/documents/2021/12/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031_2.pdf (pg. 58)

[8] The impact of telehealth on patient attendance and revenue within an Aboriginal Community Controlled Health Organisation during COVID-19. (2021). https://www1.racgp.org.au/getattachment/83ed218c-7472-4e4b-870a-de5a02e6f4a3/Aboriginal-community-telehealth-during-COVID.aspx (pg. 853)

[9] https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf (pg. 3)

[10] https://www.health.gov.au/sites/default/files/documents/2020/12/taskforce-recommendations-telehealth-telehealth-recommendations-2020.pdf

[11] The qualitative experience of telehealth access and clinical encounters in Australian healthcare during COVID-19: implications for policy. (2022). https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-021-00812-z (pg. 4)

[12] https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf (pg. 5)

between government and Aboriginal and Torres Strait Islander people'[13], and must take account of state and regional differences.

Patient-end support for specialist telehealth consultations

Prior to the recent changes in MBS telehealth items, the sector advocated extensively to remove the requirement for specialists to be MBS-billing (for telehealth consultations) in order for General Practitioners (GPs) to be able to bill for 'patient-end support'[14]. This requirement means that ACCHS GPs cannot submit a MBS claim for the support they provide when the specialist is consulting from a publically funded health service (such as hospitals), where specialists (in WA) typically do not submit MBS claims. This is noted by the National Aboriginal Community Controlled Health Organisation (NACCHO) as problematic, as specialists based at hospitals are most often 'the specialists who work with ACCHOs'[15]. Support by a GP during a specialist consultation can be highly valuable clinically (for example, in performing examinations, ordering tests, writing scripts); and culturally, in that GP support can facilitate a culturally safer environment for Aboriginal patients, due to their existing relationship.

However, despite the MBS Review Panel report supporting 'optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation'[16], this requirement appears to have been overlooked in the rapid transition to telehealth during the COVID-19 pandemic. This omission has the potential to undermine access to quality healthcare, as primary health care providers are not compensated for the provision of patient-end support. Consequently, this may result in patients from (typically) regional and remote areas losing access to these crucial supports. AHCWA suggests that Medicare and other funding models work more cohesively to ensure that primary health care providers are able to receive Medicare compensation regardless of funding for other partner agencies.

Furthermore, as of 1 January 2022, GPs were removed from the 'patient-end support' item. This requirement restricts patient-end support to practice nurses, Aboriginal Health Practitioners or Aboriginal Health Workers, 'but not by a GP, medical specialist, other medical practitioner, midwife or nurse practitioner'[17] (with the specialist billing requirement still in place). This restriction drastically undermines access to shared, quality healthcare; and particularly impacts shared decision-making and partnership opportunities between GPs and specialists. For example, WA ACCHS and Royal Perth Hospital (RPH) developed a collaborative *Care Coordination Model*, which aims to guide 'inter-organisational care coordination' to improve and support 'the patient's specialist outpatient journey'. Given this model prioritises shared care between GPs and specialists, the removal of the GP 'patient-end support' MBS item acts as an additional barrier to existing shared care models present at the State level. It is essential that MBS telehealth items support the critical role of GPs, recognising that GP medical care differs from the care provided by other health professionals.

[13] Ibid (pg. 6)

[14] Provision of clinical support by a health professional for their patients during video consultations with a specialist: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=MN.12.5&qt=noteID

[15] https://www.naccho.org.au/app/uploads/2022/04/NACCHO-Indigenous-Digital-Inclusion-Plan-Submission.pdf (pg. 4)

[16] https://www.health.gov.au/sites/default/files/documents/2020/12/taskforce-recommendations-telehealth-telehealth-recommendations-2020.pdf (pg. 13)

[17] https://www.health.gov.au/sites/default/files/documents/2021/12/changes-to-mbs-specialist-telehealth-from-1-january-2022.pdf (pg. 1)

The WA ACCHS Model of Care[18], which 'is built around the delivery of comprehensive, holistic and culturally secure primary health care services', references the need for a multi-disciplinary team approach to allow for a comprehensive overview of the client's 'complex care needs', and 'longer appointments' to ensure that clients 'feel safe, welcome, and empowered'. Therefore, AHCWA considers the recent changes to the MBS (which exclude GPs from patient-end support items and longer telephone items) have the potential to act as additional barriers to existing models of care in the WA ACCHS sector.

AHCWA recommends that this limitation be removed to enable GPs to engage in shared care, and to ensure there is clinical continuity of care. Specifically, AHCWA suggests that GPs be reinstated as a health professional that can provide 'patient-end support', and that the specialist billing requirement be removed. This is consistent with Australia's Primary Health Care 10 Year Plan 2022-2032, which notes that there should be a 'boost [in] multidisciplinary team based care', 'focus on […] continuity of care', and 'patient-end supports readily available to people who need them'[19]. As indicated in the MBS Review Panel report, continuity of care is essential to increasing 'patient satisfaction'; 'adherence to medical advice'; 'take-up of health promotion'; and 'decreased use of hospital services' and 'lower mortality'[20]. AHCWA considers that both of these recommendations are supported by Principle 2 from the MBS Review Panel report, which details that ongoing reviews are necessary to ensure that telehealth MBS items result 'in quality clinical outcomes' and 'are acceptable to both patients and providers'[21].

Aboriginal people utilising telehealth services outside of the ACCHS sector

Currently, there is a requirement for individuals to have had a recent (within the last 12 months) face to face consultation with a GP in order to be eligible for a MBS-billed telehealth consultation. However, this rule is waived for patients of Aboriginal Community Controlled Health Services[22]. AHCWA strongly supports this exemption – however, we also acknowledge that there are Aboriginal people that do not attend ACCHS clinics and will not be recognised under this exemption. In light of the higher mobility among Aboriginal people[23], the requirement that an Aboriginal person attends an ACCHS clinic to be able to access the exemption is too restrictive. AHCWA suggests that this exemption be extended to all Aboriginal people, in an effort to improve telehealth access for Aboriginal people attending mainstream general practices.

Telephone consultations

As of 1 July 2021, telephone consultations for GP Health Assessments 'for Indigenous People' (715/92004), and 'Chronic Disease Management' items under GP Management Plans & Reviews (721/92024 & 732/92028 respectively) were removed[24]. These telephone MBS items

[18] http://kams.org.au/wp-content/uploads/2019/10/AHCWA_ModelofCarePoster_OCT18_output2.pdf

[19] https://www.health.gov.au/sites/default/files/documents/2022/03/australia-s-primary-health-care-10-year-plan-2022-2032-future-focused-primary-health-care-australia-s-primary-health-care-10-year-plan-2022-2032.pdf (pg. 27-31)

[20] https://www.health.gov.au/sites/default/files/documents/2020/12/taskforce-recommendations-telehealth-telehealth-recommendations-2020.pdf (pg. 11)

[21] Ibid (pg. 10)

[22] https://www.health.gov.au/sites/default/files/documents/2022/03/askmbs-advisory-existing-relationship-clarification-askmbs-advisory---existing-relationship-clarification.pdf (pg. 4)

[23] Mobility of Aboriginal and Torres Strait Islander people: A literature review. (2012). https://nintione.com.au/resource/CW004_MobilityOfAboriginalandTorresStraitIslanderPeople_ALiteratureReview.pdf (pg. 12)

[24] http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2211355D5611CA3DCA2587A70006FF09/$File/Factsheet-telehealth-GPs-OMP.v.13.04.22.pdf (pg. 7)

were initially available during COVID[25], but have since been removed. Given both these GP MBS items are frequently used in the WA ACCHS sector, their removal will impact patient healthcare accessibility, specifically for patients that do not have reliable internet connectivity. Despite 'Telehealth items via video-conference' remaining and having general clinical superiority, AHCWA considers telephone consultation options still have an important place, specifically in chronic disease care management. Telehealth uptake for chronic disease management has been shown to positively 'influence […] the health and wellbeing of Indigenous peoples experiencing inequitable access to health care'[26]**.** Telehealth services have also been crucial in 'maintaining continuity and coordination of care' for chronic disease management[27], specifically via frequent telephone check-ins.

Not all individuals have adequate digital literacy, nor access to adequate internet connection and infrastructure to facilitate video consultations[28]. Moreover, there is evidence to suggest that GPs, in particular, are more inclined to use telephone options rather than video telehealth consultations[29]. This is exemplified by the fact that approximately 2 per cent of COVID-19 GP telehealth items claimed during 2020-2021 were video-based[30]. This indicates that despite the clear push to increase video consultations, there remains barriers to the uptake of video consultation options. Given there is a significant 'digital divide' between metropolitan and regional areas[31], enforcing telehealth video consultations creates an additional barrier to health services for many Aboriginal people living in regional to remote locations (that may have inadequate access to appropriate infrastructure).

Restricting the use of telephone consultations risks exacerbating the burden of disease among Aboriginal people, which is 2.3 times that of non-Aboriginal Australians[32]. Therefore, AHCWA recommends that MBS items for telephone consultations are reintroduced to ensure all individuals have access to telehealth options, irrespective of their location, access to digital technologies, and socioeconomic status. This aligns with the National Aboriginal and Torres Strait Islander Health Plan 2021–2031, which highlights the importance of follow-up care in disease management, and notes that improvements are required to address barriers in care, including cost, transport, and service infrastructure[33]. AHCWA's recommendation is also supported by RACGP's submission to the Telehealth Performance Audit, in which they assert that 'Telehealth – by either video consultation or phone consultation – appears to provide

[25] https://www.practiceassist.com.au/PracticeAssist/media/Coronavirus-(COVID-19)/200406-Medicare_MBS-COVID-19-Telehealth-Services-Quick-Guide-GPs.pdf (pg. 1-2)
[26] Use of telehealth for health care of Indigenous peoples with chronic conditions: a systematic review. (2017). https://search.informit.org/doi/pdf/10.3316/INFORMIT.153740664477860 (pg. 2)
[27] The impact of COVID-19 on chronic disease management in primary care: lessons for Australia from the international experience. (2022). https://www.mja.com.au/system/files/issues/216_09/mja251497.pdf (pg. 446)
[28] 11% of the Australian population are deemed highly digitally excluded: https://h3e6r2c4.rocketcdn.me/wp-content/uploads/2021/10/ADII_2021_Summary-report_V1.pdf (pg. 5)
[29] "A decade's worth of work in a matter of days": The journey to telehealth for the whole population in Australia. (2021). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8103781/pdf/main.pdf (pg. 7)
[30] https://www1.health.gov.au/internet/main/publishing.nsf/Content/Medicare%20Statistics-1
[31] https://www.digitalinclusionindex.org.au/key-findings-and-next-steps/
[32] https://www.indigenoushpf.gov.au/getmedia/f61f0a50-f749-4045-b58f-b2c358db2c6b/2020-summary-ihpf-2.pdf?ext=.pdf (pg. 23)
[33] https://www.health.gov.au/sites/default/files/documents/2021/12/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031_2.pdf (pg. 57)

equivalent clinical outcomes for many types of clinical encounters, particularly for ongoing clinical care'[34].

Although AHCWA acknowledges that in many circumstances telehealth video consultations are clinically superior, there are barriers for both health professionals and patients utilising video consultations. For example, video consultations are not as seamless and time efficient as a phone call, and require significantly more effort to facilitate. Specifically, barriers to the uptake of video consultations include a 'lack of necessary equipment, limits in expertise and capability, and technical disruptions'[35]. This extra time and effort to prepare for a telehealth video consultation was recognised when telehealth options were first introduced in 2011, as there were financial incentives to increase medical practitioners' uptake of telehealth MBS items[36]. However, this extra payment has since been removed. Given the barriers described above, AHCWA suggests that there be an inclusion of some supplementary fee for telehealth services to reflect the increased effort and costs required to facilitate a telehealth video consultation.

Modified Monash Model

On 1 July 2022, longer GP consultations (20 minutes +) by telephone were removed, except for medical practices located in Modified Monash (MM) 6 & 7 areas[37]. AHCWA welcomes the re-introduction of MBS items for 'GP telephone services for consultations longer than 20 minutes in remote and very remote regions'[38]. Access to this MBS item should be expanded to acknowledge other rural towns across the country that may also benefit from the option of longer phone consultations. Given that an estimated 389,230 Aboriginal people reside in inner and outer regional areas[39], and are also subject to compromised healthcare due to 'geography, time and distance'[40], and connectivity issues, AHCWA recommends this longer consultation telephone MBS item be extended to at least MM3-MM7 areas, to include the large, medium, and small rural towns across Australia. This aligns with the National Strategic Framework for Rural and Remote Health, which notes that 'rural and remote communities and the health challenges they face are significantly different from those that confront metropolitan Australia'[41]. Additionally, this expansion will support instances where ACCHS GPs require longer telephone consultations 'due to considerations of comorbidities, language and culture'[42]. AHCWA considers this expansion necessary to ensure health professionals are adequately compensated for their time when delivering services to Aboriginal communities, whom often require a greater level of time and care.

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[34] https://www.racgp.org.au/getmedia/e31df995-8b95-4d91-87bc-b10d5192318c/RACGP-submission-to-ANAO-Expansion-of-telehealth-services.pdf.aspx (pg. 14)

[35] "A decade's worth of work in a matter of days": The journey to telehealth for the whole population in Australia. (2021). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8103781/pdf/main.pdf (pg. 7)

[36] http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/63CDBE743351A0CCCA257CD20004A3AC/$File/Telehealth%20discussion%20paper.pdf (pg. 1-4)

[37] http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2211355D5611CA3DCA2587A70006FF09/$File/Factsheet-telehealth-GPs-OMP.v.13.04.22.pdf (pg. 7)

[38] https://www.health.gov.au/sites/default/files/documents/2021/12/ongoing-telehealth-strengthening-primary-care.pdf (pg. 1)

[39] Figure 2: Estimated Indigenous population by geography, 2021 https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians

[40] Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability. (2016). https://www.rrh.org.au/journal/download/pdf/3808/ (pg. 2)

[41] https://www.health.gov.au/sites/default/files/documents/2020/10/national-strategic-framework-for-rural-and-remote-health.pdf (pg. 18)

[42] https://www.naccho.org.au/app/uploads/2022/04/NACCHO-response-DraftPHC10YrPlan.pdf (pg. 3)

Furthermore, longer telephone consultations are only available if the *medical practice* is located in MM 6 & 7 areas[43], rather than where the *patient* resides. Given most WA ACCHS are located in large to small rural towns, in which they service patients living in remote to very remote locations, AHCWA considers that this restriction undermines the accessibility to quality healthcare for patients located in remote communities. AHCWA recommends that the availability of longer telephone consultations should depend upon the patient's home location to ensure that remotely-located patients do not face additional barriers to accessing quality and culturally safe healthcare.

[43] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=91894&qt=ItemID