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ABN: 68 480 848 412

National Rural Health Conference
Australian Journal of Rural Health

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Submission to the Department of Health and Ageing on Medicare rebates for online consultations - telehealth initiative

February 2011

This Paper represents the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies.

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Submission to the Department of Health and Ageing on Medicare rebates for online consultations - telehealth initiative

Executive summary

The new Medicare items for online consultations provide another way to improve access to specialists for people who live in rural and remote communities - a significant part of their massive unmet primary care need. Those people are a priority patient group for the new initiative.

These items should complement and add to existing services, such as those provided under the Medical Specialist Outreach Assistance Program (MSOAP). Services based on the new item numbers must not be seen as an accepted substitute for services provided close to home or for personal interactions with health professionals.

Primary care providers and specialists must ensure that referral and coordination processes for online consultations with specialists are fully integrated with ongoing primary and acute care for rural and remote health consumers.

Rural and remote health consumers in situations where there is no doctor must be provided with online specialist consultations by other means, perhaps with the support of a remote area nurse.

Rural and remote primary care providers need to be involved in a systematic approach to the development of clinical protocols and practice standards by relevant professional bodies. Online consultations must be provided within a safety, quality and technology framework that balances the risks of this approach to service delivery against the risks of having no service at all.

Rural and remote primary care providers will need support to establish fit for purpose video-conferencing facilities and to maintain the facilities, as well as ongoing training and support in telehealth applications as they expand.

While quick runs on the board and early adoption will be of some benefit, the goal must be the systematic adoption of telehealth across all rural and regional areas and all areas of need.

Developed in this way, online consultations can be a significant part of action to progress robust and technologically advanced solutions for improving rural and remote health into the future.

Submission to the Department of Health and Ageing on Medicare rebates for online consultations - telehealth initiative

Introduction

The National Rural Health Alliance strongly supports the introduction of Medicare rebates for online consultations with specialists as one way to improve access to much needed health care for people who live in rural and remote areas. (We recognise that the initiative will also apply to Outer Metropolitan areas.)

Good quality health care as close to home as possible for rural people, where tertiary hospitals are at a distance and Medicare services may be in short supply, often involves new ways of supporting locally available health professionals to work in effective, but not necessarily co-located, multidisciplinary teams. The telehealth initiative provides a further stimulus to modernise both the technological and the clinical connectivity between specialists and rural and remote health care professionals, including remote area nurses and Aboriginal Health Workers, as well as GPs, nurse practitioners and practice nurses.
To ensure that new telehealth applications reach the people in rural and remote communities in greatest need there will need to be affordable, high speed, commercial grade broadband to all parts of Australia so that practitioners and consumers can access them wherever they live. Without this, the proposal risks further enshrining those elements of rural and remote disadvantage that are based on poor communications.

The Alliance sees this telehealth initiative as one of a suite of complementary actions to improve access for people who are at a distance from services and service providers. Other policy approaches include increased recruitment of medical specialists to rural centres, regular clinics through specialist outreach services, assistance with transport for those who need to travel for their health care, and follow up care after discharge from urban hospitals, including rehabilitation services and step down care.

While the telehealth initiative has the potential to minimise unnecessary travel and the associated health and cost impacts for consumers, the enduring policy aim must be to improve local access to quality health care through additional services targeted to those in need. Improvements in telehealth must not be at the expense of the interpersonal interactions with health professionals that are proven to be necessary to support good health.

In this submission to the Department's discussion paper the Alliance focuses on the delivery of online specialist services in rural, regional and remote areas.

We argue that the online services that are given the highest priority should be those that:

- are fit-for-purpose to improve access to specialist care for under-served patients;
- complement existing services, workforce and referral patterns to avoid further service fragmentation;
- include access to specialist allied health care, at least where Medicare items exist already (eg psychologist, rehabilitation, chronic conditions), and extend to aged care;

- are delivered within a safety, quality and technology framework that balances the risks of this approach to service delivery against the risks of no service at all;
- acknowledge both the highest priorities for service improvement (eg mental health, dental health, aged care) and the technical readiness of services to go online; and
- address practicalities of coordination, scheduling and support from the patient's perspective to improve their continuity of care.

The facts behind poor access to specialists in rural and remote communities

Specialist medical services are in short supply in rural and remote communities. The AIHW has recently reported that in 2006-07, for every consultation Medicare provided for a resident of a Major city, only 0.74 and 0.59 consultations were provided for residents of Inner and Outer Regional areas, while only 0.38 and 0.30 consultations were provided for residents of Remote and Very Remote areas respectively. [1] (See Table 1 below from the AIHW, 2011 report.)

Table 1: Medicare, specialist services—out-of-hospital by remoteness, 2006–07

ASGC remoteness(a)						
Measure	**Major cities**	**Inner regional**	**Outer regional**	**Remote**	**Very remote**	**Australia**
Services (millions)	12.8	2.9	1.1	0.1	—	17.0
Services per 1,000	898.1	706.6	549.1	322.6	225.4	813.4
Services per 1,000 age-standardised(b)	912.2	671.3	534.8	346.0	271.6	813.4
Services per person indexed(c)	1.00	0.74	0.59	0.38	0.30	0.89

(a) ABS ASGC remoteness categorisation is according to the residential address of the service recipient.
(b) Indirectly age-standardised.
(c) Expressed as a multiple of the *Major Cities* value.
Source: AIHW health expenditure database.

The Alliance calculated that this translates into 2.1 million fewer specialist services for people outside Major Cities in 2006-07 than would have been expected if they received these services at the same rate as people who live in Major Cities.[2] It is highly likely that this shortfall in specialist services continues. In 2010, rural and remote consumers completing an online survey rated poor access to medical specialists as one of the largest gaps in access to health care.[3]

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[1] Australian Institute of Health and Welfare 2010. Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure. Health and welfare expenditure series no. 50. Cat. no. HWE 50. Canberra: AIHW. http://www.aihw.gov.au/publications/hwe/50/11458.pdf

[2] National Rural Health Alliance, 2011. An overview of the shortage of primary care services in rural and remote areas.
http://nrha.ruralhealth.org.au/cms/uploads/publications/primary%20care%20deficit%2014%20jan%202011.pdf

[3] National Rural Health Alliance, 2010. Caring for the country. *Partyline 40:*13
http://nrha.ruralhealth.org.au/cms/uploads/publications/partyline_40_nov10_08-web-sml.pdf

Not only is there a shortage in specialist services, but country people missed out on 25 million primary care services from doctors, specialists, diagnostic services and PBS scripts in 2006-07. This is equivalent to more than three and a half services and scripts a year for every man, woman and child in rural and remote areas.

These glaring current shortfalls in primary health care delivery, including specialist services, are borne by a rural population where socioeconomic disadvantage is also high. The AIHW report notes that 45 per cent of rural people held a government health concession card in 2006-07, compared with 30 per cent of the residents of Major Cities. This all translates into demonstrably poorer health outcomes and higher incidence of risk factors among the people who live outside Major Cities.[4]

The shortage of medical practitioners and other health professionals in rural and remote communities – which in general worsens with remoteness (Table 2 below) – along with transport challenges and the distances involved for both patients and healthcare providers, limitations in telecommunications and in infrastructure and facilities, will mean that flexible arrangements are essential.

Table 2: Persons employed in health occupations, per 100,000 population, by Remoteness Areas, 2006

Occupation	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Medical practitioners	324	184	148	136	70	275
Medical imaging workers	58	40	28	15	5	51
Dental workers	159	119	100	60	21	143
Nursing workers	1,058	1,177	1,016	857	665	1,073
- Registered nurses	978	1,056	886	748	589	979
- Enrolled nurses	80	121	129	109	76	94
Pharmacists	84	57	49	33	15	74
Allied health workers	354	256	201	161	64	315
Complementary therapists	82	82	62	40	11	79
Aboriginal and Torres Strait Islander health workers	1	4	10	50	190	5
Other health workers	624	584	524	447	320	602
Other health services managers	32	33	28	28	18	31
Total health workers	2,777	2,536	2,166	1,827	1,379	2,649

Source: ABS, Census of Population and Housing, 2006.

[4] National Rural Health Alliance, 2010. Measuring the metropolitan- rural inequity. http://nrha.ruralhealth.org.au/cms/uploads/factsheets/Fact-Sheet-23-rural-inequity.pdf

The telehealth initiative must be applicable to the existing models of health care and the mix of health professionals in rural and remote communities in order to have an early impact on current unmet need, with flexibility to expand and improve into the future.

Practice models that work in rural and remote communities

The Discussion Paper outlines the typical model envisaged for online consultations under the telehealth initiative as involving a GP or other health professional and the patient in the GP's rooms in a rural, remote or outer metropolitan area, video-linked to a specialist in his or her rooms. In most cases the specialist will be in a city or major regional centre.

This model relies on a GP or nurse practitioner with a Medicare provider number being available locally, with suitable video-conferencing facilities within a 'bricks and mortar' structure, to host the consultation for the patient, although not necessarily participating in the video link themselves. The Alliance notes that there will be many instances in rural and remote communities where a specialist consultation may be highly advisable for the patient, but this model cannot be applied.

The Alliance is concerned that the purpose of the online consultation – to improve access to specialist services for the patient – should not be lost to rural and remote patients in need, simply because there is not a GP, nurse practitioner or practice nurse available locally to host the consultation. We therefore welcome the fact that the Department is keen to explore the full range of viable models, including a range of appropriate settings for online consultations, and has recognised the potential role of practice nurses and Aboriginal Health Workers in online consultations with specialists.

For example, where there is no GP locally, a community or remote area nurse or suitable allied health professional may be available to facilitate a routine follow-up consultation online for a local client at the discretion of the specialist, either in a local community health setting or as part of a client visit by the local professional. In the city, a patient continues to make follow-up appointments with their specialist for the duration of their GP referral, often up to 12 months. While acknowledging the role of rural GPs in patient follow-up between specialist visits, for rural people who cannot easily travel to see either their GP or their specialist it may be appropriate to conduct certain of these specialist appointments online with the local health professional support available. Indeed this outcome is likely to be better than a cancellation because the patient simply cannot manage to get to the specialist appointment.

A 'fit for purpose' consulting arrangement should be accommodated. The Medicare arrangements should not exclude the possibility that the specialist and local health professional agree that it is important for the patient's health and wellbeing for the consultation to go ahead in a timely way, using (for example) an adequate video hook up through a trusted local health professional's computer, rather than to delay until arrangements can be made for the patient to travel to a video-conference facility in a regional centre.

An aged care service, or a Multi-Purpose Service, where acute care and aged care services have been cashed out by State and Commonwealth governments, in order to retain a viable health centre in the town, may also provide an appropriate venue for a resident or a community member

to participate in an online consultation with a specialist in rural and remote communities. Once again, the local staff involved may not be recognised Medicare providers.

A number of Aboriginal Community Controlled Health Organisations already participate in telehealth and are key health service providers in remote communities. The role of Aboriginal Health Workers in providing the local support for the patient will need to be recognised in the arrangements for online specialist consultations under Medicare.

The Alliance believes that professional bodies should have a role in developing practice guidelines and requirements to meet the challenges of online consultations. Those organisations should involve their rural and remote interest groups, sub-specialties and members to ensure that the arrangements are fit for purpose.

In the usual city scenario, it is up to the GP and the specialist to maintain appropriate clinical contact and keep each other informed – and an online consultation would be no exception. The involvement of a local health professional in establishing an online consultation with the specialist is an opportunity to strengthen the team-based approach, but their involvement could range from as little as facilitating the appointment and making sure that the facilities are open and the technology required is functioning, especially where they are not a Medicare provider, to full participation in the consultation with the agreement of the patient and the specialist, or even in a case conference with other health care providers.

Another scenario may be that the patient and the specialist decide to have a confidential discussion online – as would be the case in the specialist's rooms – but it will be important that the patient is not left unattended after an emotion laden consultation.

The nature of the collaboration between the local health professional(s) and the specialist, provision of relevant records before the consultation to participating health professionals and appropriate record keeping should follow professional practice guidelines.

Specialties and patient groups

The Discussion Paper seeks to further explore which specialties are most readily adaptable to online consultations and which patient groups stand to benefit most from online access to specialists. The Government's election announcement noted that telehealth services may be especially beneficial for patients of consultant physicians, surgeons, endocrinologists, dermatologists, ophthalmologists and psychiatrists. Also due to travel restrictions relating to age, mobility and independence, patients of paediatricians and geriatricians may find remote consultations of particular value.

While non-procedural applications for online consultations seem most applicable given current technology and knowledge, some procedurally related telehealth applications are already in use including wound management and dermatology screening and management. The Medicare initiative should be designed to support the uptake of good practice as the technological capacity and evidence for the benefits and risks of online consultations improves. Specifying relevant specialties and applications through the Medicare item has the potential to restrict sensible access to an online consultation, as agreed by the specialist and local health care provider, to under-served people in rural and remote communities.

However, the Medicare items for online consultation with specialists should not become a substitute for interpersonal interactions with health professionals for rural people, nor for health care provided as close to home as possible.

The Alliance recommends that professional practice requirements be developed through peer consultations and consumer input to provide a safety and quality framework for online consultations that complement existing services, workforce and referral patterns, promote best practice and balance the risks of online consultations against the risks of no service.

The barriers to uptake of the current Medicare items for online psychiatry, which were introduced some years ago based on evidence for the value of such interventions, should also be considered and addressed by the Department in developing the broader items for online consultations with specialists and the professions in developing professional practice requirements.

In addition, the Medicare items should be usable within and complement the Medical Specialist Outreach Assistance Program (MSOAP) which provides a framework for improving access to specialists for people living in rural and remote communities – who are a priority patient group for the online consultation initiative.

Remuneration models

Generally Medicare payments are based on a face-to-face interaction between a patient and a single health professional – usually a medical practitioner. Allied health professionals can receive Medicare payments in certain circumstances, including optometry and through GP referrals of the patient to programs such as Access to Allied Psychological Services, or Chronic Disease Management to support team-based care. More recently, Medicare has been extended to nurse practitioners and to midwives in collaborative care arrangements with medical practitioners. Some Medicare items are payable to a GP for a practice nurse acting on their behalf.

The remuneration model for online consultations will need to accommodate payments of more than one health professional for a single interaction with a patient. The patient will generally be face-to-face online, but not in the same physical space as the specialist. It is likely that the local health professional and their staff will be involved to different extents in consultations of various types and remuneration should reflect this. In some cases the local health professional may be just the administrator and personal support, while in others they may actually have a professional role in the consultation.

Remuneration might be composed of a facility fee and payments based on the time and complexity for both the provider and the facilitator at the patient's end. The facility fee should take account of the need for rooms and space, as well as hardware and software, and on-site IT support will also be essential.

The importance of the presence of a trusted health professional, available to support the patient before and/or after the consultation if needed, should also be considered even when they are not directly involved in the consultation. Such reassurance would normally be provided through attendance at the specialist's rooms, but is transferred at least in part to the local setting for an online consultation.

Scheduling of appointments between the specialist and the participating local health professional(s) and the patient warrants particular consideration. An unavoidable delay at one end or the other could result in the need to reschedule, or for a follow-up arrangement between the clinicians involved, so that the patient does not have to come in again. The role of the coordinator is clearly more than simply re-scheduling an appointment.

As discussed above, in rural and remote communities in particular, the local coordinator may not always be a Medicare provider or practice nurse – for example, in the case of a remote area nurse or community nurse. While the Alliance recognises that hospital services are outside Medicare funding arrangements, additional consideration needs to be given to online consultations coordinated through health professionals in aged care facilities and Multi-Purpose Services which are important parts of the health care landscape in rural and remote communities. The Alliance is concerned to ensure that a specialist will be reimbursed through Medicare for an online consultation in these cases where the only (or the most appropriate) health professional available locally to support the online consultation is salaried - for example through a State-funded rural health or community services scheme or through aged care - and will not be claiming Medicare themselves.

In order to ensure that Medicare items for online consultations are targeted effectively to improving access to specialists for under-served people in rural and remote communities, the Alliance is clear that the items should not be seen as an additional remuneration stream for usual communications and exchanges between health professionals regarding patient care. The follow-up phone calls the specialist and/or their staff might make at present to rural and remote patients and/or the referring doctor's practice, for example to see how an obstetric patient is going, or to advise on a test result, in order to minimise unnecessary travel for the patient, should also remain part of usual service.

Savings on out-of-pocket travel costs for consumers are not an appropriate component of costing considerations for the Medicare online consultations initiative, given the massive unmet primary care needs of people living in rural and remote communities that have already been described.

Financial incentives

The establishment costs for 'state of the art' telehealth facilities are likely to be quite high and recurrent costs too are likely to be significant. Start-up costs may include purpose-built facilities to include a private 'online consulting room', waiting room and restroom facilities, high tech video-conferencing requirements and specialised medical monitoring equipment, along with office space and accommodation for administrative and local health professionals. Such infrastructure investment lends itself to longer term planning.

In the short term, for more immediate improvements in access to specialists for rural people, further consideration needs to be given to reasonable expectations of 'fit-for-purpose' telehealth facilities, which share many of the attributes described above with existing health or ageing facilities and are sufficient for many circumstances. In addition, more makeshift arrangements that are fit for purpose for a particular need or small throughput should not be ruled out.

However, in all cases it will be important to acknowledge the technological and other equipment requirements, as well as ongoing maintenance, upgrade and administrative costs, including

telecommunications to the local facility, in addition to the specialist rooms. This will be a particular issue for the smaller services in rural and remote communities with lower revenue due to fewer patient numbers and higher proportions of concessional payments, coupled with higher overheads for fit-out and delivery and fewer opportunities for economies of scale. Any funding round should take rurality into account with a preference for needs-based funding rather than the competitive funding rounds that tend to favour larger, more centralised services.

It would be desirable for initial financial incentives to assist with staff time and equipment costs for upgrades to processes and equipment to accommodate telehealth in established facilities or outreach type services, as well as some recognition of ongoing costs.

Training and support

The Medicare initiative for online consultations includes funding to support the delivery of clinical teaching and training projects for health professionals using new technologies, including technical training in the use of broadband to deliver telehealth services. This is critically important for health professionals in rural and remote communities, where technical support is less readily available and telecommunications are less reliable. In addition, for smaller practices and isolated outposts, the opportunities for peer support or working out how to use new technology in consultation with colleagues are diminished. Health students have also made it plain to the Alliance that they do not want to go to places where they are isolated from peer support and/or technological connections.

The avenues relevant to training and support for rural and remote health professionals regarding this initiative include the University Departments of Rural Health and the Rural Clinical Schools, ongoing clinical professional development through professional bodies as part of ongoing registration, as well as training and capacity building in the work place within local communities and practices. In the past the Divisions of General Practice have taken a role at a regional level, primarily for medical practitioners. Very soon now the new Medicare Locals should also have a role in providing such support across a broader range of health professionals.

There are a number of rural scholarship programs which would benefit from special consideration in targeting the program. These include the Rural Health Continuing Education (RHCE) program and the new locum schemes for allied health professionals and nurses.

Online learning is part of undergraduate training and has been taken up in rural practice, for example through the Australian College of Rural and Remote Medicine medical education and online learning platform, RRMEO, which combines online resources, education activities and discussion groups with telemedicine services. However, such online resources for people in rural practice do not yet apply across all professions.

The managers of health services, aged care facilities and practices are another important target group in this shift in culture to allow and support online consultations, as well as the health professionals more directly involved.

Technical issues

The Alliance supports the implementation of online consultations using fit-for-purpose technology, recognising that some applications will require highly sophisticated video-conferencing facilities and instrumentation, whereas other consultations may be suitably facilitated through a health professional's computer at either end.

The great variations in telecommunications capabilities in rural and remote communities must also be taken into account. Contingency plans to overcome interruptions to online consultations due to line failures, slow communication speeds and weather events will need to be allowable through the Medicare arrangements, so that isolated patients and their local health professionals are not left unsupported or with unfinished consultations. For example, the option to switch to a teleconference may be a better outcome than a consultation that has to be aborted half-way through when the video-link fails or becomes unworkably slow.

However, issues such as security, privacy and information for consumers about the new approach are fundamental to the successful uptake of the initiative and need to be systematically addressed through health professional networks, health service managers and administrative support arrangements, software vendors and Medicare services alike.

The Alliance recommends that a collaborative approach to simple guidelines and standard protocols be developed in collaboration with these key stakeholders to support rural and remote practitioners in meeting the technological requirements for online consulting at a basic level in the first instance. Such support and guidance should become a fundamental part of each new technical application for online consultations as it is developed.

Conclusions

The new Medicare items for online consultations provide another way to improve access to specialists for people who live in rural and remote communities, a significant part of their massive unmet primary care need. These items should complement and add to existing services, not replace them, and must not be seen as a substitute for services as close to home as possible or for personal interactions with health professionals.

Integration of e-health services with primary care in rural areas is vital if we are to have a cost effective system that supports the consumer. Telehealth services must therefore be provided in close collaboration with existing providers in State Health Departments, with special schemes such as MSOAP, and in collaboration with GPs and the Aboriginal Community Controlled health sector.

While quick runs on the board and early adoption will be of some benefit, the goal must be the systematic adoption of telehealth across all rural and regional areas and all areas of need.

Developed in this way, online consultations can be a significant part of action to progress robust and technologically advanced solutions for improving rural and remote health into the future.

Attachment 1:

Member Bodies of the National Rural Health Alliance

ACAP (RRSIG)	Australian College of Ambulance Professionals (Rural and Remote Special Interest Group
ACHSM	Australasian College of Health Service Management
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	CRANAplus – the professional body for all remote health
CHA	Catholic Health Australia (rural members)
CRANAplus	Council of Remote Area Nurses of Australia Inc
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors' Association of Australia
RDN	Rural Dentists Network
RHWA	Rural Health Workforce Australia
RFDS	Royal Flying Doctor Service of Australia
RHEF	Rural Health Education Foundation
RIHG (CAA)	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RNMF (RCNA)	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
ROG (OAA)	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health