RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

# Telehealth Initiatives for Consideration

Via email:

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## RURAL DOCTORS ASSOCIATION OF AUSTRALIA

The Rural Doctors Association of Australia (RDAA) is a national body representing the interests of all rural medical practitioners and the communities where they live and work. Our vision for rural and remote communities is accessible, high quality health services provided by a medical workforce that is numerically adequate, located within the community it serves, and comprises doctors and other health professionals who have the necessary training and skills to meet the needs of those communities.

## AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE

The Australian College of Rural and Remote Medicine is accredited by the Australian Medical Council (AMC), for setting professional medical standards for training, assessment, certification and continuing professional development in the specialty of general practice.

We are the only College in Australia dedicated to rural and remote medicine, and we play an important role in supporting junior doctors and medical students considering a career in rural medicine.

We are committed to delivering sustainable, high-quality health services to rural and remote communities by providing:

- quality education programs
- innovative support, and
- strong representation for doctors who serve those communities.

## INTRODUCTION

RDAA and ACRRM are strong advocates for telehealth medicine. ACRRM has lead Australia in the development of clinical telehealth services and resources and has a strong reputation as a leader in this field.

Telehealth is considered a key part of the solution to increase access to health services for people living in rural and remote communities across Australia. However, telehealth has yet to reach its full potential, or met the initial expectations, and we continue to struggle with the issue of people living in rural and remote Australia continue to have poorer access and use of health services than people in major cities.[1]

RDAA and ACRRM have developed two key initiatives for the Government's consideration, which are outlined in this proposal.

## Background

The International Organisation for Standardisation defines Telehealth as the 'use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance', while drawing a distinction between this and telemedicine, which is defined as the 'use of advanced telecommunication technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers'.

The since 1 July 2011 the MBS Schedule included rebates in the following situations for telehealth:

- Specialist to patient within RA2-5 and the specialist and patient must be a minimum of 15km apart at the time of consultation.
- There are also additional rebates where an approved health practitioner, including GP, is in attendance with the patient while the specialist is at the other end.

As of 1 November 2017, psychologists, social workers and occupational therapists will be able to provide up to seven services via telehealth, which will attract a Medicare rebate for patients living in rural and remote communities.

Under the current RA classification rankings for rural and remote, it is highly unlikely that people living in major regional centres with local access to specialists require access to telehealth services but for many in rural and remote locations, access continues to be a challenge across all services.

ACRRM and RDAA are aware that the Digital Health Agency is progressing the delivery of the strategic plan priorities. The new initiatives outlined in this proposal align with the strategy of increased delivery and uptake of telehealth services.

For people living in remote communities or locations across Australia, it is not only specialist consultations which they must travel many kilometres for, but it can also be to visit the local General Practitioner.

The overall number of medical practitioners significantly decreases per 100,000 population head as people live more remotely, and that reflects that the majority of the specialist workforce is based is major cities or large regional centres. While the GP numbers increase per 100,000 population by approx. 24 in comparison to major cities, this needs to be considered with the geographical spread of the population and the GPs.[2] This means that while many people living rurally and remotely may be able to access an appointment with a GP, the tyranny of distance does impact on whether a patient will make the trip. We hear many stories anecdotally that patients won't travel two hours to the GP, unless they are really sick. This aligns with data where emergency hospital admissions involving surgery is highest for people living in very remote areas 22 per 1,000 compared to major cities where it is 12 per 1,000.

With data from the many organisations across Australia continuing to report using the Remoteness Area (RA) 1-5 classification, there continues to be an ongoing challenge to paint a picture of what the reality is on the ground for people living in rural and remote Australia. This has been recognised and Government introduced the Modified Monash Model (MMM) in response to concerns raised by organisations such as RDAA and ACRRM. It is critical that the MMM is used consistently across Government departments and other organisations when reporting on workforce, health service access and other issues and the rural and remote impacts.

## New Initiatives

This proposal outlines mechanisms to increase the uptake of telehealth and provide rural and remote GPs and patients with additional options to increase access, improve patient compliance with care plans, and improve the health outcomes. These proposals have also been developed with consideration to ensuring a patient's GP remains central to the provision of care coordination for patients, and that there are safe guards for the system from corporatisation of a service which should be patient centred It is essential for ongoing patient care and the retention of a range of medical services in rural and remote communities that the viability and sustainability of rural practices is strongly protected.

These proposals represent a significant new policy proposal. As with any new proposal, RDAA and ACRRM would expect that there would be a thorough and rigorous analysis of its potential implications, and that this analysis would be done in close consultation with relevant stakeholders.

- Retain the RA2-5 geographical areas for specialist consultations.
    - This will ensure there is no reduction in the current provision of telehealth services by specialists.
    - Alternatively, an MMM 2 – 7 classification could be implemented, subject to an analysis of the potential impact.

- Allow GPs to provide consultations via telehealth direct to patients:
    - It is proposed that access would be limited to people living in MMM 4-7 locations who would be given access to consultations with General Practitioners and other health professionals based on the current consultation and care management MBS item numbers.
    - The treating General Practitioners would also need to be located in MMM 4 -7 location.
    - The telehealth consultation would be part of a cycle of care of a specified period such as 28 days or 90 days. The eligible telehealth consultations could only occur following a face-to-face consultation, and would cease at the end of the cycle of care period.
    - The next face-to-face consultation would reset the cycle of care period.
    - Telehealth consultations may include a range of modalities, including videoconference, telephone etc.
    - It is also proposed that to introduce this, rather than create a new suite of MBS item numbers, a item number to identify a telehealth service would be appropriate to be claimed in conjunction with the relevant current MBS item number.
    - Telehealth has significant potential to play an important role in the Health

Care Home model, and to improve outcomes for participating patients. However due to the block funding arrangements, additional support for infrastructure and ongoing data costs which will be incurred to provide such a service will need to be considered in relation to this model. These are a new elements not captured in the previous funding arrangements.

- To further support this model, expansion of the current MBS item numbers for a health professional who is located with the patient for telehealth consultations with a specialist to also include consultations with the General Practitioner.

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[1] Australia's Health 2016 – Australian Institute of Health and Wellbeing

[2] AIHW 2015 Medical Workforce Data