Submission to the

Queensland Parliament
Health and Community Services Committee

Inquiry into Telehealth Services in Queensland

May 2014

Introduction

The Australian Healthcare & Hospitals Association (AHHA) welcomes the opportunity to provide a submission to the Queensland Parliament Health and Community Services Committee Inquiry into Telehealth Services in Queensland.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, universities, and individual health professionals and academics. We are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

In developing its submission, the AHHA has focussed on a selection of the issues identified in the Inquiry's Terms of Reference.

Technology and communication systems capacity and capability

Technological advances in recent times have improved the availability of suitable technology to support telehealth activities and have also reduced the associated costs. What was once a complex and expensive exercise can now be conducted with relative ease with effectively 'off-the-shelf' equipment and programs.

The Queensland Health approach to telehealth has avoided where possible the use of proprietary products which lock users into a particular piece of equipment or software. The more open access approach taken by Queensland Health gives providers and users a wider choice of products, including free downloadable software, with which to engage with the Queensland Health telehealth network.

While bandwidth remains important to the effective use of telehealth, improvements in technology and the selection of appropriate systems are enabling the use of low bandwidth solutions. The coverage and structure of the National Broadband Network will also have an influence in relation to broadband issues and the roll-out of the NBN, while not critical will be an important factor in the capacity of telehealth to address the needs of people in rural and remote areas.

The breadth of applications for telehealth is extensive. While the focus can be on its role as a replacement or adjunct to the traditional face-to-face consultation, its potential in other areas cannot be understated. Remote monitoring of patients has the potential to reduce the need for unnecessary face-to-face consultation and to provide early warning of changes or deterioration in patient's conditions. Monitoring of patients may involve assessment of a specific physiological measure such as blood-pressure or may be a broader measure such as overall mobility as an indicator of health in an older person.

While all governments are acutely conscious of the need to reduce health expenditure this should not come at the expense of innovation, particularly when focussed on health promotion, prevention and early intervention as investment in maintenance of health will clearly deliver savings when compared to the cost of treating the sick.

The effective use of telehealth can help reduce the challenge of a '9-5' workplace. Demand for health services is an around the clock scenario. Partnering across time zones with a 'follow the sun' approach has the capacity to provide 24 hour access to a broad range of services. Even with the relatively small time zone differences across Australia and New Zealand there is capacity for linkage of telehealth programs to increase the availability of services and timeliness of access.

Recommendation: A continued focus on non-proprietary systems and solutions is encouraged

Recommendation: Cost-effectiveness analysis of telehealth programs should consider the long-term benefits available through the application of telehealth to prevention and early intervention and improvements in access

Access to health services, particularly in rural and remote locations.

Telehealth is critical to improving access to health services in rural and remote areas and addressing the inequities in health outcomes for rural and remote residents compared to those in urban areas.

Residents of regional and remote areas face multiple challenges when accessing health care. To receive the care they need they must be able to:

- **perceive their need for service**: this depends on their health literacy, health beliefs, trust, and expectations
- **seek the service they need:** this depends on their personal and social values, culture and gender, and autonomy
- **reach the service**: this depends on their living environment, available transport, and their mobility and social support
- **pay for the service**: this depends on income, assets, social capital and health insurance
- **engage effectively with the service** this depends on having sufficient confidence and information, a common language and cultural values, and where relevant, caregiver support.

Telehealth applications have the capacity to address all of these criteria.

Component of access	Telehealth application
perceive their need for service	Remote monitoring providing early alerts, use in community and individual education
seek the service they need	Provides greater flexibility and alternative mechanisms/providers
reach the service	Reduced dependence on long-distance travel, Capacity to engage from remote locations including their home
pay for the service	Reduced direct costs associated with travel, reduced opportunity-cost associated with time spent visiting city-based specialists
engage effectively with the service	Enables engagement from familiar surroundings, with local support

Recommendations: While the availability of services locally should remain a priority, expansion of telehealth programs to improve access in rural and remote areas should be continued

Examine the factors that support successful implementation of telehealth services and identify any barriers to successful implementation

To facilitate broader engagement of the primary care sector and general practitioners in the use of telehealth services and improved equity of access, a more appropriate funding model is required.

Currently private specialists can make claims for Medicare eligible specialist services provided via videoconference mechanisms. Clinical support services provided at the patient-end during the video consultation by GPs, medical practitioners, nurse practitioners, a participating midwives, Aboriginal health workers or practice nurses, can also be claimed.

However patient-end services can only be claimed where a Medicare eligible specialist service is claimed. This means that a GP participating in a video-consultation and providing associated services to the patient cannot claim those services if the consultation is being undertaken with a public specialist.

Thus despite the general practitioner committing the same time, providing the same care, incurring the same costs, seeking and receiving similar advice, and at times engaging with the same specialist clinician, the reimbursement the general practitioner receives is dependent on the employment status of the specialist to whom they connect.

This creates a significant dis-incentive and results in inequities in access for the patient and the broader community. Further it creates a perverse incentive resulting in increased costs by funding engagement with private specialists (who will claim rebates from Medicare) rather than public specialists (who will not).

Recommendation: The eligibility criteria for telehealth related Medicare Benefits Schedule claims should be reviewed to remove unnecessary restrictions

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