ANZSOG CASE PROGRAM

Please cite this case as: ***Padula, Marinella. (2023). Ten years of reform in 10 days: Australia's telehealth revolution. Australia and New Zealand School of Government, John L. Alford Case Library: Canberra.***

Ten years of reform in 10 days: Australia's telehealth revolution

An ANZSOG Teaching Case by Marinella Padula

Keywords: strategic management, public value, policy development, implementation and delivery, healthcare reform, crisis management, technology, telehealth, telemedicine.

Please note this case has a Teaching Note associated with it. To access a copy, please email caselibrary@anzsog.edu.au with a request and citing the title.

Along comes COVID

After emerging in late-2019, the novel coronavirus (SARS-CoV-2) led to an outbreak of respiratory illness the world would come to know as COVID-19. Before long, it was overwhelming hospitals across the northern hemisphere. Australian health departments monitored developments regarding the severe acute respiratory syndrome and confirmed the nation's first official cases in January 2020. On 11 March 2020, the World Health Organization (WHO) declared a global pandemic.

Just weeks earlier on February 24, Caroline Edwards had been recalled to the Health Department to step in as Acting Secretary – a date embossed in her memory. Over the next fortnight, it became increasingly clear that COVID would require swift countermeasures to curb its worst effects and preserve access to health services. Approximately 50% of Australian GP visits are for chronic conditions (Snoswell, Mehrotra et al., 2020) making many people vulnerable to any disruption of care. Over a long holiday weekend in early March, Edwards and her colleagues put together the

core elements of the health system plan. This would include expanding access to telehealth[1] services, i.e., consultations via phone or video call. 'It arose out of two things,' she said, 'How can we provide care to people who were potentially very contagious? Also, how can we protect health practitioners from being infected?'

Making telehealth happen

Although telehealth was already part of the Medicare system (Exhibit A), with an established legal framework, scaling up at speed still presented a mammoth challenge. Ordinarily, altering the Medicare Benefits Schedule (MBS) (Exhibit A) was not a simple undertaking. Changes to items could easily take 12 to 18 months and involved processes such as stakeholder consultations, impact assessments, system updates, regulatory changes, and education campaigns. New items also had to be tabled in federal parliament.

Even with a compressed timeframe, Health Department officials still had to ensure changes were reasoned and justifiable. First, were critical discussions about what kind of services could be offered remotely and how. 'Initially we started with a view that we really wanted to emphasize video [calls] and really try to make sure that we provided some visual cues for both patients and the doctors,' recalled the Health Department's First Assistant Secretary of Benefits Integrity & Digital Health, Daniel McCabe. Advice from the MBS Taskforce and the department's own research suggested that videocalls were the preferable substitute. Utilised properly, they offered care of a comparable quality to in-person visits. Then there was the issue of reimbursement to consider, noted Louise Riley. Responsible for primary health reform at the DoH, she recalled many conversations considering the question: 'Do we have the same level of rebate for face-to-face, versus video, versus telephone?'

As Health Department officials fleshed out a telehealth plan, the window of time left to buttress the healthcare system was narrowing fast. Case numbers were rising rapidly around the world, and social distancing was one of the few tools they had to curb a large-scale outbreak in Australia. Enabling the ill and vulnerable to get health care at home now seemed not just advisable but essential. The Government, in consultation with the states, prepared to launch a $2.4 billion healthcare package to combat COVID-19, including a $100 million expansion of telehealth services (Dalzell and Macmillan, 2020).

Telehealth had the green light.

BACKGROUND

Evidence for telehealth

Pre-COVID, there was a sizable body of telehealth research but relatively little of quality. Evidence for telehealth's efficacy and feasibility needed work, observed Roland Balodis (then a director in the Medicare Reviews Unit) – particularly in relation to primary care. The literature suggested that more work was also needed on implementation and cost-effectiveness (Armfield et al., 2014, p.530-531, Totten et.al, 2020, pp.4-5). Most developed nations offered some form of telehealth before the pandemic, but few had substantive experience with population-wide services.

However, several reviews indicated that telehealth could offer benefits such as convenience, accessibility, choice, privacy and efficiency with outcomes/patient satisfaction comparable to usual care (Orlando et. al, 2019; Flodgren et. al, 2015; Totten et. al, 2020). One review of more than 100 Australian telehealth studies concluded that 'telehealth has the potential to address many of the key challenges to providing health in Australia' (Bradford et al., 2016, p.1) – particularly those posed by distance. They found that successful telehealth services were realistic in scope, responsive to patients and stakeholders, provided value, and prioritized the user experience (Bradford, 2016, pp.7-8).

Telehealth use

Forms of telehealth have existed in Australia for decades. Medicare-rebated services, however, were restricted to specific services and patient groups, such as people living in rural or remote areas. From 2017, this included subsidised psychology sessions via video. In 2018, there were approximately 150,000 telehealth consultations for rural/remote area patients (Snoswell, Mehrotra et al., 2020, n.p).

[1]Telehealth can refer to any health care service delivered remotely via technological means and encompasses a range of modalities. However, in this context, telehealth refers to real-time telephone or video consultations between practitioner and patient for clinical purposes. Common uses for telehealth include diagnosis, screening, monitoring, education and counselling. Telehealth is one of several terms such as telemedicine which may be used interchangeably in some contexts or have distinct definitions in others.

Psychiatrists were the doctors most likely to use telehealth, although it was far from common practice (Centre for Online Health, 2022, n.p). In the year before COVID-19, only 0.7% of specialist consultations were telehealth consultations (De Guzman et al., 2021, p.612). For general practitioners (GPs), the proportion of telehealth consultations was negligible (Snoswell, Caffery, et al., 2021, p.738).

Barriers to uptake

Its many disparate communities should have placed Australia at the forefront of telehealth adoption. Yet, 'despite high unmet demand for health services across rural Australia', uptake of telehealth had been described as 'slow, piecemeal and ad hoc' (Warr, 2021). Telehealth was rarely used in metropolitan centres, even though Australians generally embraced technology related services like online banking enthusiastically.

Research indicated issues with both supply and demand. Although the average household had 17 devices connected to the internet (Thompson, 2019), inadequate internet access and difficulties using technology still impacted many patients. Ignorance of telehealth services and lack of Medicare coverage were also barriers (St Clair and Murtagh, 2019, p.174). Problems could be caused or compounded by factors like age, disability, socioeconomic status and language proficiency. Almathami et al. (2019) mapped a variety of factors influencing telehealth uptake (Exhibit B).

For practitioners, uncertainty about risks and benefits, unfamiliarity, limited MBS eligibility, interoperability issues and cost concerns discouraged telehealth use (Armfield et al 2014, p.530-531). Doctors tended to be late adopters when it came to tech, Edwards observed, and were amongst the last hold-outs still using fax machines. There was also considerable variability in ICT infrastructure and support between medical practices, noted Paul Creech, then managing health programs and payments at Services Australia[2]. At one end of the spectrum were large corporate practices with multiple branches, at the other, small outfits run by sole traders.

Conversely, most clinicians had few incentives to adopt telehealth. Costs and inconveniences associated with attending in-person appointments were usually borne by patients, for example. Wade et al.'s 2014 study of telehealth services concluded that, 'clinician acceptance explains much of the variation in the uptake, expansion, and sustainability of Australian telehealth services, and that clinician acceptance could, in most circumstances, overcome low demand, technology problems, workforce pressure, and lack of resourcing,' (p.682).

Yet practitioners were far from homogenous. 'The medical profession is quite powerful politically,' observed Creech, 'Yet it's also quite fragmented, different members have different views. Some of the sector fully embraced telehealth because they were ready for it'. This especially applied to clinicians who already had telehealth experience.

Other factors

At the beginning of 2020, the rollout of the National Broadband Network (NBN) was 90% complete (Ryan, 2020) making telehealth increasingly viable. Yet not uniformly so. Some areas enjoyed high speeds and reliable connections while others contended with variable speeds and regular dropouts. Growing data consumption threatened to heighten the disparity.

My Health Record, the federal government's electronic personal health record program, meanwhile facilitated information sharing between providers on behalf of patients. Although enrolment went from optional to compulsory in 2019, still fewer than 10% of health records were being accessed (McCauley, 2019) and more than a quarter of GPs were not yet using the system (Digital Health Agency, 2019).

Telehealth policy

Barriers notwithstanding, plans to expand telehealth were already under consideration. Since June 2015, the Government's Medicare Benefits Schedule Review Taskforce had been reviewing the full slate of 5,700+ MBS items to determine what should be changed, added or dropped. Telehealth was a particular area of focus: specifically, how innovations in telecommunications could be harnessed to improve affordability, accessibility and outcomes for patients and the broader healthcare system. The Taskforce's final report was due in late-2020.

Towards the end of 2019, the federal government also began work on a new 10-year plan for primary health. Data and technology was a major pillar and involved MBS funding for mainstream telehealth services. As with the MBS

[2] Services Australia (formerly the Department of Human Services) is the department responsible for delivering welfare, health and child support payments, including Medicare rebates.

review, telehealth was not viewed as a potential replacement for face-to-face appointments but as an adjunct to usual care.

Scaling up at speed

The dangers of COVID quickly cured any qualms about telehealth amongst the medical profession. The public was also very anxious to maintain access to healthcare. Doctors' associations and other peak bodies now backed rapid and widespread telehealth adoption. 'It's amazing what you can do in any kind of policy setting when there's a pragmatic preparedness to actually agree a way forward,' said Creech. 'Basically, the risk equation changed,' remarked Balodis in explaining why a normally conservative profession agreed to such radical change. Although they also had little choice.

In order to help the most vulnerable as soon as possible, the Health Department devised a telehealth plan (Exhibit C) to be rolled out in stages and adjusted according to the evolving situation. During the initial phases, Medicare funded telehealth would be available to available to GP patients and/or practitioners at elevated risk of COVID. Certain specialists and allied practitioners would also be able to offer telehealth appointments. By the end of March 2020, telehealth would be open to all eligible Medicare recipients in Australia, with the range of services to be expanded in April.

Practitioners could use whatever equipment they chose for telehealth consults, so long as it was clinically appropriate and compliant with privacy laws. 'We quickly got strong feedback from the medical profession that they weren't well equipped to handle video, both in terms of what they had in their practice with their software, and broadband – especially in rural towns.' recalled McCabe. They wanted 'a really easy method for doctors to have the consult without having to worry about any technological barriers or whether their patients had access to a video device,' he said.

From an administrative perspective, the Health Department concluded that the quickest way to enable telehealth was to create telephone and videoconference analogues of select Medicare items. These 'mirror' items were given individual billing numbers, so they could track usage, and would be reimbursed at the same rate as in-person visits. Officials began by assessing which MBS items would work remotely and best fulfill the needs of patients. Fortunately, the MBS's governing legislation (the *Health Insurance Act*, 1973) allowed the Health Minister to quickly add new items on a short-term or interim basis.

Meanwhile, Services Australia (previously the Department of Human Services) had responsibility for distributing Medicare benefits, which involved updating the payment system. Adding a couple of new items was one thing, adding hundreds at a time to a somewhat antiquated system was another matter entirely, Health officials recalled.

Initially, practitioners were required to bulk-bill all telehealth consults to encourage patients to remain at home, wherever possible, without financial penalty. At the same time, the Health Department established an incentive payment to enable practices to stay open for on-site appointments where needed. While doctors were initially willing to comply, their response was not positive.

'We know that general practice viability is pretty marginal,' commented Dr Michael Wright of the Royal Australian College of General Practitioners, 'A lot of practices only work on a margin of 2–3% profit, and a simple change like introducing these bulk-billing restrictions will make many practices unprofitable and not viable in the long term.' Dr Maria Boulton, GP and an Australian General Practice Alliance director, said: 'The Government has basically turned us into bulk-billing clinics, [but] we don't want to be bulk-billing clinics because we don't want to have to see 8 to 10 patients an hour in order to continue to provide patients with all the services they get,' (Tsirtsakis, 2020).

Yet consultations were only one part of the equation, noted Daniel McCabe. 'When suddenly, you had doctors and patients in lockdown, we quickly worked out that paper-based [processes] for managing and supporting patients just wasn't going work. So, there was a huge coming together across the sector to do things that we had thought about for a long time.' This included fast-tracking electronic prescriptions, in conjunction with the pharmacy sector. Electronic prescribing had been mooted for some time, but COVID made it a reality in a matter of weeks. The Health Department also provided funding for medicine home-delivery, said Roland Balodis.

Meanwhile, Health officials were mindful of compliance risks. For privacy reasons, the Health Department had relatively little insight into the substance or quality of doctor-patient consultations, as compared to other government-funded services. Would the convenience of telehealth encourage improper billing or inappropriate practice? In 2019–20, there were 126 referrals to the Department's Professional Services Review (PSR) unit and repayment orders exceeding $21 million. For the previous 5 years, PSR received an average of ~100 referrals per annum (Professional

Services Review, 2020, pp.11-12). A 2020 Australian National Audit Office (ANAO) noted several reports which estimated the cost of non-compliance to be somewhere between $366 million and $2.2 billion in 2018-2019 (ANAO, p.22). It also described the Health Department's approach to dealing with non-compliance as 'partially appropriate' (ANAO, p.7).

Investigations were prompted by tip-offs or data analysis. Doctors/practices making unusual or excessive claims (when measured against comparable practices) could be referred for audit. In addition, investigations could also be triggered by breaching the "80/20" rule: i.e., 'when a medical practitioner has rendered or initiated 80 or more professional attendance services on each of 20 or more days in a 12-month period,' (Department of Health and Aged Care, 2022). However, fraud and inappropriate practice were not the only reasons for non-compliance. Billing errors, due in part to the complexity of the Medicare system, were a notable problem.

To begin with, the department planned to monitor new MBS telehealth items in the same way as other Medicare services.

A nationwide experiment

As March rolled over into April, the risk of COVID-19 showed no signs of abating, and many Australian towns and cities were now subject to strict lockdowns. A vaccine was thought to be a year or two away, at the earliest, and there were few COVID treatments besides supportive care. Minimising physical interaction was imperative, so Australian clinicians and patients embarked on the great telehealth experiment.

It had taken a mammoth effort to get to this point. Health officials created more than 270 new Medicare items within weeks, something that would normally take over a year, Creech observed. Looking back, Health Minister Greg Hunt remarked: 'There was a 10-year plan to roll telehealth out. We put that together in 10 days,' (Burton, 2021). Though not quite accurate, it wasn't far off.

After years in the policy backwoods, telehealth had suddenly gone from niche to mainstream. Doctors and patients meanwhile had to navigate new processes, platforms and/or technologies amidst considerable upheaval. Analysis by the University of Queensland's Centre for Online Health found that of the 16.2 million Medicare consultations during April 2020, over 35% were telehealth consultations. The vast majority of appointments (~91%) occurred over the phone (Exhibit D). GPs and specialists both used telehealth at comparable levels, however mental health and psychiatric consults were significantly more likely to occur remotely (Exhibit D).

In April 2020, the Australian Bureau of Statistics (ABS) found that 17% of its household survey respondents had used telehealth, rising to 20% in June 2020. Close to 50% indicated that they were likely to continue using telehealth services after COVID-19 restrictions were lifted. This number increased to over 50% for women and respondents under 65 (Australian Bureau of Statistics, 2020). The main reasons people offered for continuing to use telehealth were: convenience (69%), saving time (37%) and not having to travel (37%) (ABS, 2020). People who didn't envisage using it post-COVID either preferred in person visits or had a condition that precluded telehealth use (ABS 2020, n.p).

In terms of a policy journey, it's a really interesting one,' Caroline Edwards reflected, 'because it started off as an idea that had been kicked around for years, then brought in in a small way, then accelerated to universal. Of course, once you get to universal then the policy issue is do you leave it there? Or do you pull it back?'

Growing pains

Although uptake was rapid, adjusting to telehealth wasn't necessarily easy. One survey of medical industry professionals found that many felt that telehealth had been a 'forced adoption' which required persistence to feel comfortable and confident in using (Taylor et al., 2021, p.1). Research by White et al. (2022) also identified some of the challenges clinicians experienced. 'Most of our patients don't have mobile phones or [aren't] confident managing of them… a lot of them don't have somebody that can help them to set it up,' noted one specialist. 'It takes about 10 minutes for us to get the person prepared, and 10 minutes is a long time for us to waste,' remarked another (p.4). Although telehealth consultations were usually shorter than regular appointments, clinicians reported that they took more preparation time (p.7).

Clinicians were also frustrated that patients didn't always treat telehealth the same as in-person visits and were often late, unprepared or distracted. Said one GP, 'I had a consultation with someone who was in the middle of a paddock, and we have had conversations with people that were shopping,' (White et al., 2022, p.5). Meanwhile, doctors

lamented the loss of information gleaned from their patients' gait, stance and other physical cues. Said one GP, 'The consultation starts in the waiting room, so you are missing out on that completely,' (White et al., 2022, p.5).

On the positive side, Taylor et al. (2021) reported, 'perceived significant changes in managerial and medical culture, and the legitimisation of telehealth services as a mode of access to care,' (p.1). Moreover, time and growing familiarity with remote consultations meant that 'old fears surrounding telehealth had, 'in many cases been proven to be baseless,' (p.6). Said one respondent: 'The external huge risk of COVID made inroads into the status quo... the nature of normal risk aversion and standard fear of change got beaten to death by the much larger imposed risk profile,' (p.6).

Not what the doctor ordered

'Originally, we started with a model that you could only bulk bill telehealth items. If you wanted to charge out-of-pocket that had to be done by face-to-face,' recalled Daniel McCabe. Health Minister Greg Hunt was keen to ensure that GP appointments, in particular, were as accessible as possible.

However, revenue loss due to compulsory bulk billing and the cost of COVID compliance had further squeezed practices already under pressure. Declining business across many specialties saw some practitioners lobby the Health Department hard to make more telehealth items available, sometimes questionable ones. Remarked one official: 'I kept joking to people that I was just waiting for the call from the cardiology association to argue that you can do a triple bypass over the phone.'

Doctors' representatives did however argue that mandatory bulk billing was unconstitutional due to Section 51(xxiiiA) which permitted the Commonwealth to provide medical and dental services but not compel any form of civil conscription (Mendelson, 1999, n.p). That is, practitioners could not be forced to work for the government – a provision designed to protect the professional independence of practitioners and the doctor–patient relationship.

Following industry pushback, compulsory telehealth bulk billing for all was rescinded in early April 2020 – though GPs were still obliged to bulk bill for children, concession card holders and vulnerable patients (Exhibit A). (Mandatory bulk-billing for specialists and other allied health professionals using telehealth was discontinued later that month.) At the same time, the government doubled the bulk billing incentive and Practice Incentive Payment to further encourage GP clinics to stay open. However, general practitioners claimed that the bulk-billing requirements were still too broad and threatening practice viability. Eventually, the government relented and from October 2020, doctors were permitted to resume discretionary bulk-billing (Exhibit E).

That wasn't the only issue that cropped up, as Edwards recalled: 'During the course of the year, there were numerous reports that corporate clinics were basically just swooping in and poaching patients [to create] purely telehealth practices. This was very damaging to the pre-existing business of doctors and it posed a risk to patient care.' Added McCabe, 'We didn't want Medicare or general practice to become completely commoditized to the point where the continuity of care for patients was lost because we had these new businesses set up as online channels only.'

In response, explained Louise Riley, the Health Department introduced a new eligibility requirement: from July 2020 patients needed a pre-existing relationship with their doctor/clinic. This meant that patients must have attended the practice in person at least once during the prior 12 months (Exhibit E). Yet McCabe noted: 'We then had to answer questions like: "How do we manage homeless people that may not have a GP?" "How do we manage sensitivities around domestic violence and sexual health where patients may not want to use their normal practice?"' The Department created a list of limited exemptions which also included infants, residents under lockdown, new arrivals and people with exigent circumstances.

Here to stay

At the beginning of October 2020, the federal government announced that telehealth would be funded to the end of March 2021, later extended to the end of the year. In December 2021, the government decided to make telehealth services a permanent part of the MBS (Exhibit E). The move was broadly welcomed, especially since COVID was far from over. By late 2022, there had been approximately 111 million telehealth consultations since the beginning of the pandemic (Exhibit F).

'What we've got now is we've got a system where telehealth is deeply embedded into the into the system, very popular and very good for productivity,' Caroline Edwards reflected, 'but some real issues about the increasing

number of services and whether that's good or not.' The overall number of GP consultations, for example, had risen from pre-pandemic levels and were yet to subside more than two years later (Exhibit G).

The fact that telephone consultations still far outweighed video was another issue. A Royal College of General Practitioners survey (RACGP) found that in April 2020, 30% of GPs had attempted video consulting at least once; by June 2020 it was 55% (RACGP, 2021, p.7) Despite that, video calls were still only a small fraction of telehealth appointments. GPs who had never attempted to use video most frequently cited lack of technology, no perceived benefit over phone consultations, and patient preference as their reasons for avoiding video calls (RACGP, 2021, p.7).

Though Edwards had since moved on from the Health Department, she described the questions officials faced: Going forward, how do we make sure, both for quality of care and for financial reasons, that the right people are getting the right sort of services?", "Are we pushing more services than are needed, or are we meeting unmet demand?" I think they're things they're still trying to work through'. Noted McCabe, 'We don't want to end up in a situation where we push patients further down the "food chain" [to specialists] because they're not having a physical consult with a GP.'

Compliance was also an ongoing concern. Two years on from the beginning of COVID, Health officials hadn't detected any significant change in fraudulent activity or inappropriate practice. One theory was that the rise in services was because GPs were now being compensated for some of their work between appointments, such as calling patients with test results. Recalled Edwards, 'I remember when I had pneumonia a few years ago that my doctor rang to check if I was ok. That sort of good practice was not reimbursed at all by Medicare. The way the system was set up, it was a disincentive.'

Several changes to telehealth were made in July 2021, the main one being that most GP telephone telehealth items were dropped except for brief consultations.[3] While this prompted an immediate videoconferencing boost, the effect was short-lived (Guzman et al., 2020, n.p). Meanwhile, patients seeking GP telehealth services for mental health, eating disorders and sexual/reproductive matters were also exempted from existing relationship requirements. Proposed changes to Medicare compliance rules applying stricter limits to telehealth claims were deferred.

Looking back and ahead

As difficult as the past few years had been, they had provided the impetus needed to take telehealth mainstream 'I think the pandemic in many ways exposed some of the myths that we all shared: "Well, things have always been this way, so they have to continue being this way." The pandemic showed a lot of people that we actually can do things differently,' said Daniel McCabe. It also helped, Edwards noted, that Health Minister Greg Hunt was prepared to give Health officials wide scope and flexibility in the implementation of telehealth.

Fortunately, they didn't have to start from scratch. 'It's fair to say that we probably had a lot of the right tools that we needed at our disposal,' noted Medicare Reviews Unit Director Roland Balodis, 'though some of them might have been used in an unorthodox way to achieve the right outcome.' Services Australia's then manager of health programs and payments Paul Creech took a similar view: 'Australia does have a pretty good national health system when it comes to Medicare, and it's a really good fee-for-service model. So that was a helpful foundational piece and we had a couple of other key pieces of national infrastructure like the Pharmaceutical Benefits Scheme (PBS) and the My Health Record.'

'COVID has been a catalyst for a whole heap of things that have needed to happen,' remarked Balodis, 'But now we need to think about: Does it change where we might have thought we were headed?' Because scaling up telehealth had overtaken other priorities, Caroline Edwards reflected that it may have derailed broader primary care reform. Yet she wasn't sure telehealth would have happened without a triggering event like COVID: 'If you hold things up till you've got all your ducks in a row, chances are you will miss the moment. And this is a good example of that,' she said. The consequences of going too slowly on reform or missing the window for change were often underestimated, Edwards observed, 'Perhaps the way we look at the risk matrix has to be adjusted.'

Telehealth had served its purpose in keeping primary care services running and reducing the risk of infection during the most dangerous stages of the pandemic. By the end of August 2022, telehealth consultations had fallen to 22% of all MBS services, down from nearly 36% in April 2020 (Exhibit F). Yet it had proven to be more than a stopgap measure. It also had multiple flow-on benefits, including the opportunity McCabe noted, to advance new models of

[3] Protest from advocacy groups led to the reinstatement of longer telephone consultations in specific circumstances.

care that didn't require face-to-face consultations such as virtual hospital wards and outpatient visits. Telehealth was also generating a huge bank of data to better evaluate telehealth itself and coordinate care.

However, Creech cautioned, it was incumbent on governments to use that information wisely, 'Rightly or wrongly, people have always seemed to be a little bit fearful of what government does with their data. And we as a government have got quite a bit of work to do to build that trust and, because the benefits that could come with the proper use of health data could be absolutely amazing.'

Realising those benefits though, would also require governments to address the digital divide between those with the skills and tools to utilise telehealth fully, and those without. Many Australians still missed/delayed important medical appointments during 2020-2021, despite government messaging urging patients not to. For example, Cancer Australia research found that there had been an 8% drop in diagnostic procedures across 14 types of cancer (Cancer Australia, 2021, p.vii). Difficulties accessing or using telehealth amongst vulnerable cohorts may have contributed to the problem.

Practitioners would also require support. One study of a Brisbane clinical network found that, 'Telehealth is unlikely to be sustained without a clear strategy including determination of roles and responsibilities across the organisation. Clinician resistance due to forced adoption remains a key issue. The main motivator for clinicians to use telehealth was improved consumer-centred care. Benefits beyond this are needed to sustain telehealth and improvements are required to make the telehealth experience seamless for providers and recipients,' (Thomas et al., 2022, p.1).

Louise Riley observed that the pandemic and telehealth experience had forced Health officials and stakeholders to communicate much more frequently, improving working relationships. It had also been an occasion for government to pull together, uniting different areas in a common cause. Yet harnessing the momentum also entailed personal hardship. Said Edwards, 'The human costs to public servants and others over the pandemic has been huge. So, you can do "telehealth in 10 days", but you can't run at that pace all the time.' 'COVID really did provide the disruption needed to roll out [telehealth] in a hurry,' Creech reflected, 'but we're still only three quarters of the way down that journey, there's still an awful lot that has to be done.'

Feedback on case use
To assist with continual improvement, if you've used this case, we'd greatly appreciate your feedback and suggestions for improvement. To do so, please email caselibrary@anzsog.edu.au with the name of the case and your comments. Many thanks in advance.

Exhibit A: The Medicare system

The Australian government introduced universal health care through Medicare in 1984. The program is funded by general tax revenue and government levy and represented more than 40% of total federal healthcare expenditure in 2019-2020 (Phillips et al., 2019). The increasing number and use of Medicare services was the greatest source of rising health care costs.

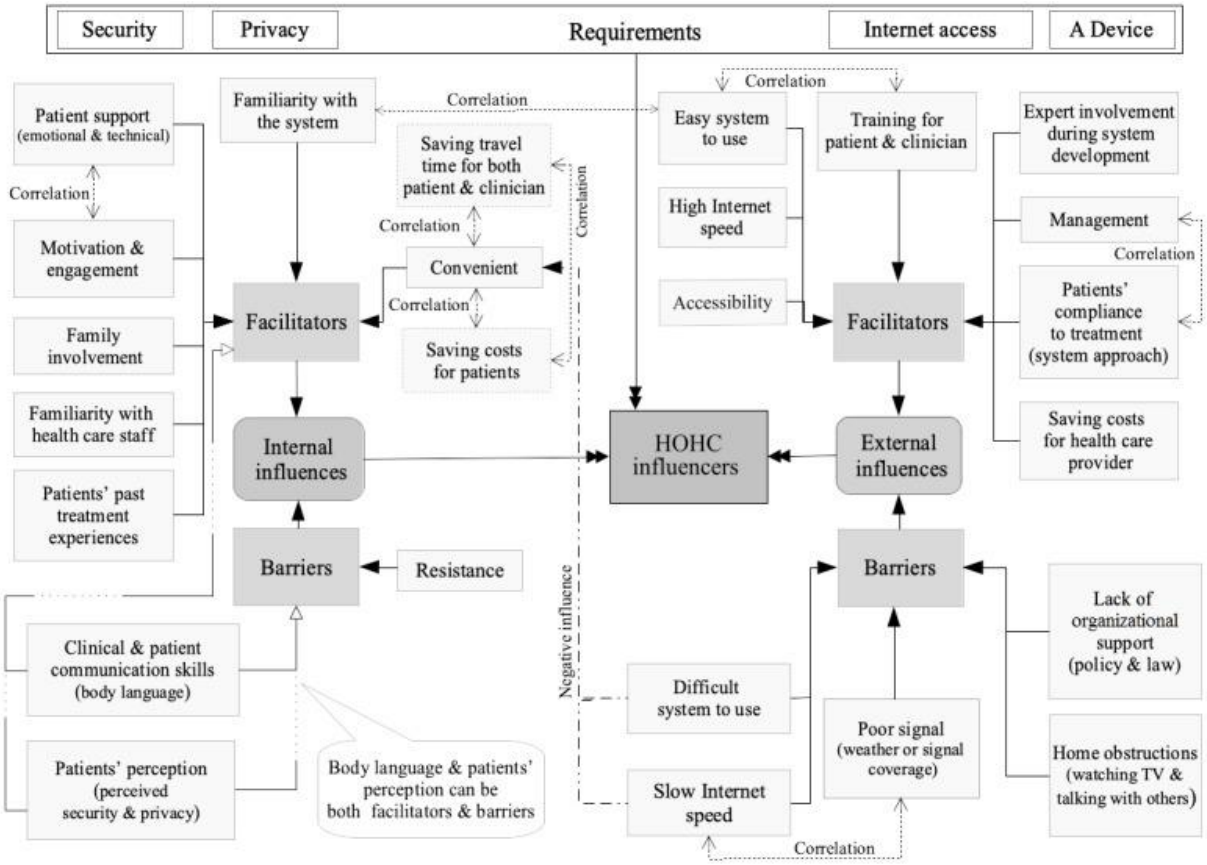
Medicare provides free hospital care to all citizens, and eligible residents, in conjunction with the states and territories. It also covers or subsidises a wide range of medical consultations, tests, procedures and treatments via the Medicare Benefits Scheme. These benefits are assigned to the patient who transfers them to their practitioner, usually via an automated payment system. Alternatively, the patient pays for the service upfront and then claims the benefit back through Medicare.

The Medical Benefits Schedule (MBS) lists the government designated fees for eligible medical services. Most items listed are remunerated on a fee-for-service basis, though several other types of payments have been introduced in recent years. General practitioner (GP) visits are paid at 100% of the scheduled fee; specialist visits are reimbursed at 85%, with patients contributing the remainder. Medical services provided without any out-of-pocket expense to patients are described as 'bulk billed'. However, practitioners in private practice are at liberty to charge above the scheduled fee. According to government figures, 86% of GP visits in 2019 were bulk billed (Department of Health, 2019).

However, that number referred to services rather than patients. An Australian Institute of Health and Welfare report found that only 66% of GP patients had all their services bulk billed. Meanwhile, some 50% of Australians using Medicare services outside hospital had incurred additional costs. These costs could vary considerably depending on locality and specialty (Australian Institute of Health and Welfare, 2018, p.1).

Doctors had for many years complained that MBS fees did not adequately cover the burgeoning costs of practicing medicine and the increasingly complex cases they treated. Describing the situation, Royal Australian College of General Practitioners President Dr Karen Price said, 'General practice is the most efficient element of the healthcare system and performs an invaluable service to the community, yet many clinics are struggling to stay afloat due to a lack of investment in primary care and the ongoing effects of the Medicare freeze… The current fee-for-service system is weighted in favour of high-volume, low-value care and is not sustainable,' (Woodley, 2021). The Medicare freeze referred to the government's hold on raising scheduled fees, first introduced in 2013 and expected to continue until 2020 (Dickinson, 2019).

Exhibit B: Factors influencing telehealth.



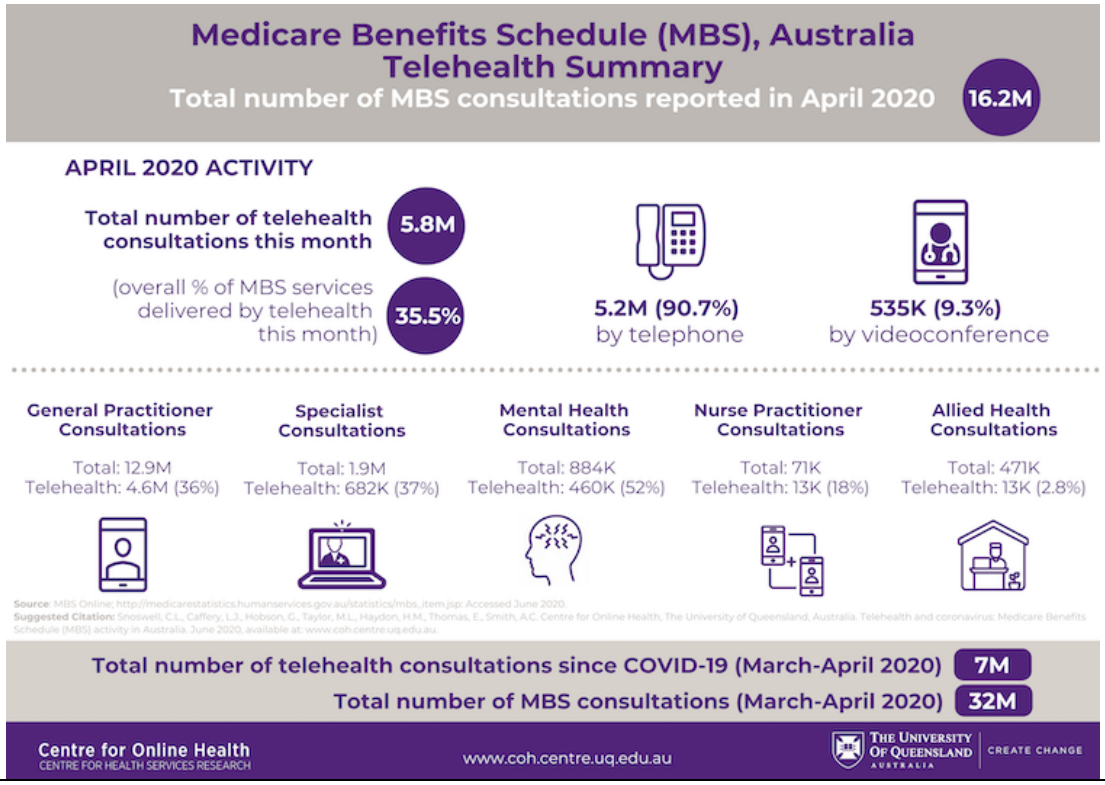
Note: HOHC = Home Online Health Care
Source: Almathami et al., 2019, n.p.)

Exhibit C: Telehealth rollout schedule

Stage/date	Description
Stage 1 (13 March 2020)	General practitioner consultations using telehealth for patients aged at least 70 years, Indigenous people aged at least 50 years, pregnant women, parents of children under 12 months of age, and those who are immunocompromised or have a chronic medical condition resulting in increased risk from coronavirus infection
Stage 2 (16 March 2020)	Supporting telehealth consultations by obstetricians, midwives, nurse practitioners, and some mental health providers
Stage 3 (23 March 2020)	Enabling vulnerable GPs and other medical specialists (in the same categories as in Stage 1) and providers authorised to use telehealth item numbers to provide care for their patients using telehealth
Stage 4 (30 March 2020)	Extending existing telehealth items to all Australians. This included a substantial investment in mental health support, with specific commitments to children and young people, older Australians, and health care workers
Stage 5 (6–20 April 2020)	Supporting expanded telehealth for many specialist medical services and allied health services, including consultant physicians, psychiatrists, geriatricians, public health physicians, neurosurgery, chronic disease management by nurses and Indigenous health workers, and group psychotherapy

Source: Desborough et al., 2020, p.105.

Exhibit D: Medicare Benefits Schedule Telehealth Summary April 2020



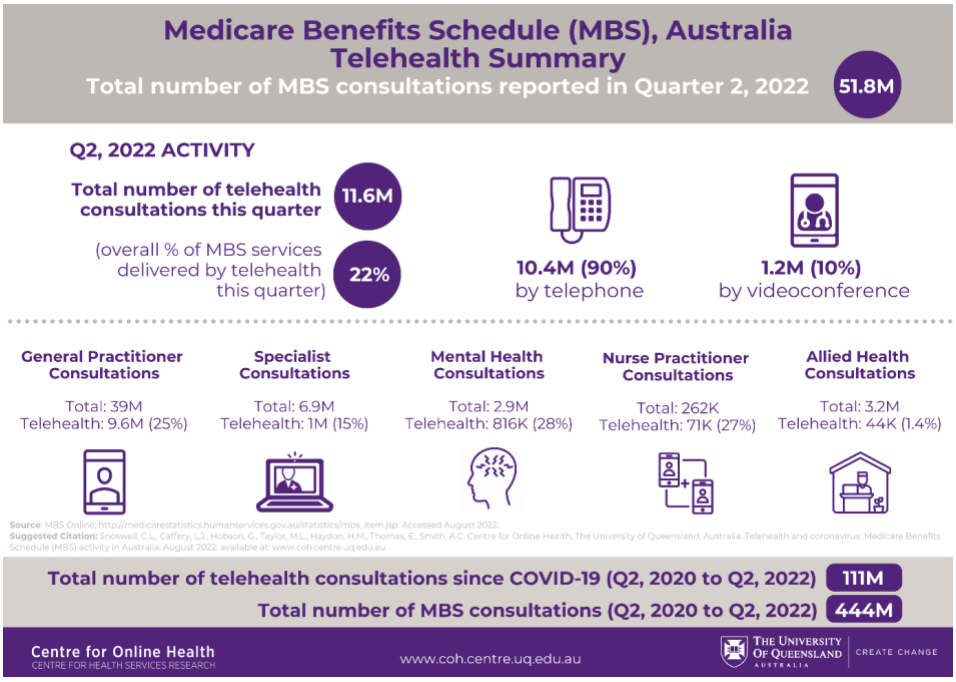
Source: Smith et al. (2020), n.p.

Exhibit E: Changes to telehealth March 2020- January 2022

Date	Details
13 March 2020	Telehealth services must be linked to a patient's regular GP
16 March 2020	Telehealth expanded to include regular practice as well as GP
23 March 2020	All vulnerable GPs able to use telehealth for all consultations with all their patients
30 March 2020	Telehealth becomes accessible to all Australians
6 April 2020	GPs no longer required to bulk bill all patients, however telehealth services must continue to be bulk billed for concession card holders, children under 16 and patients more vulnerable to COVID-19
20 April 2020	Non-GP specialists and allied health professionals no longer required to bulk bill telehealth services
20 July 2020	Telehealth services provided by GPs must be linked to a patient's regular GP or practice
1 October 2020	Extension of telehealth MBS items to 31 March 2021, GPs no longer required to bulk bill telehealth services for any patients
26 April 2021	Government announces that telehealth will be extended until 31 December 2021
1 July 2021	Majority of GP telephone items removed, new telehealth items (video and phone) introduced for blood borne viruses, sexual or reproductive health services
13 December 2021	Government announces that telehealth will become a permanent feature of primary healthcare
1 January 2022	Patient access to telehealth services will be supported by ongoing MBS arrangements

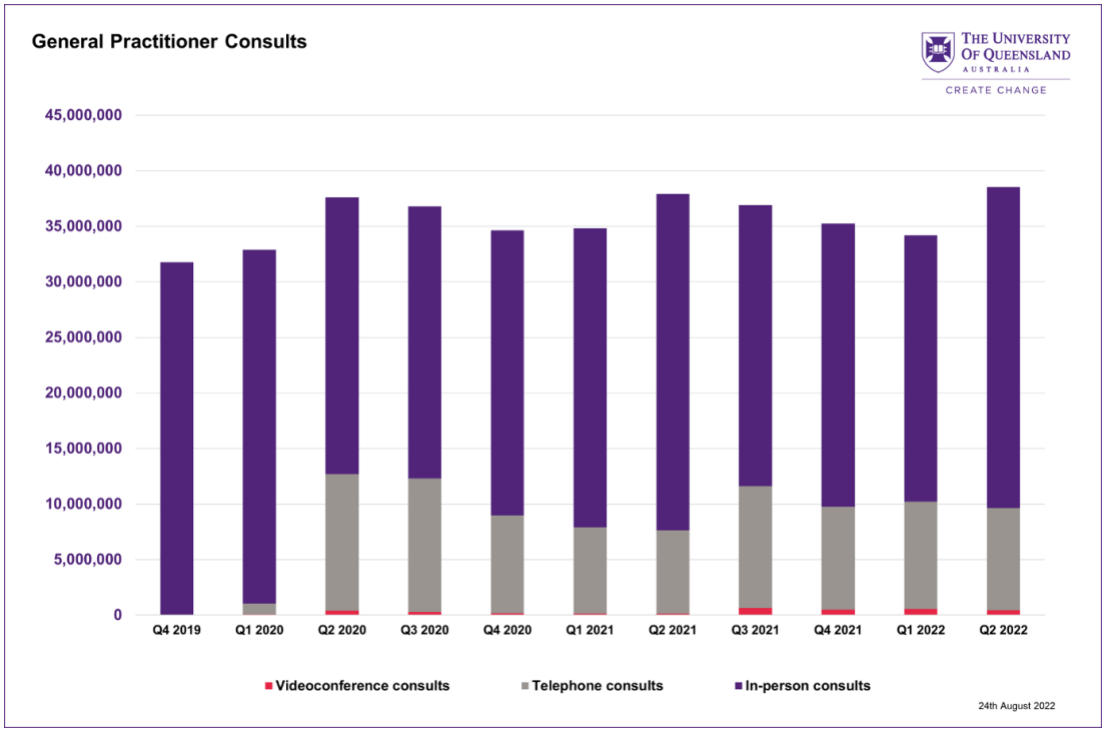
Source: Royal Australian College of General Practitioners (2022), p.1.

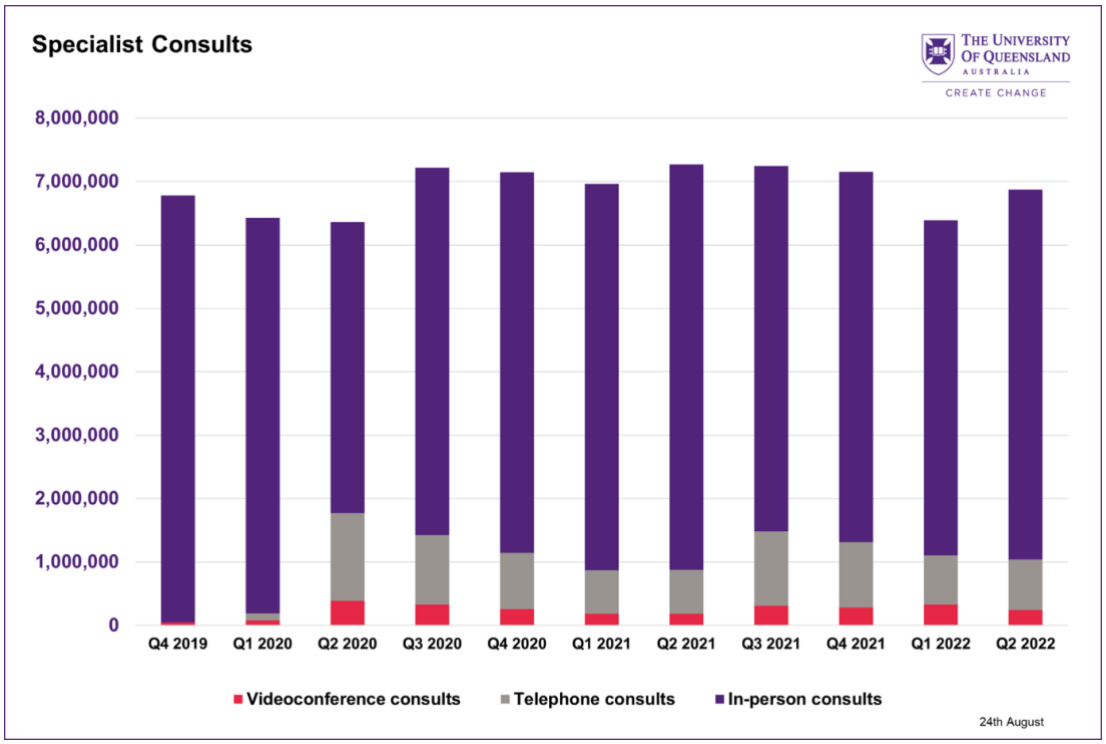
Exhibit F: Medicare telehealth activity, (Quarter 2) 2022



Source: Snoswell et al. (2022) n.p. Accessed 7/8/2022

Exhibit G: Quarterly breakdown of GP and specialist consultations





Note: *Specialists does not include psychiatrists
Source: Snoswell et al. (2022) n.p. Accessed: 7/8/2022

References

Agency for Healthcare Research and Quality. (2020, May 14). *The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic | Effective Health Care Program*. Effectivehealthcare.ahrq.gov; Department of Health and Human Services. https://effectivehealthcare.ahrq.gov/products/telehealth-expansion/white-paper

Almathami, H. K., Win, K. T., & Vlahu-Gjorgievska, E. (2019). Barriers and facilitators that influence telemedicine real-time online consultation at patients' home: A Systematic Literature Review. (Preprint). *Journal of Medical Internet Research*, *22*(2). https://doi.org/10.2196/16407

Armfield, N. R., Edirippulige, S. K., Bradford, N., & Smith, A. C. (2014). Telemedicine - is the cart being put before the horse? *Medical Journal of Australia*, *200*(9). https://www.mja.com.au/journal/2014/200/9/telemedicine-cart-being-put-horse#Box

Australian Bureau of Statistics. (2020, July 13). *Household Impacts of COVID-19 Survey, 24-29 June 2020*. Abs.gov.au; Australian Bureau of Statistics. https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/24-29-june-2020

Australian Digital Health Agency. (2019). *Statistics and Insights - December 2019*. https://www.digitalhealth.gov.au/sites/default/files/2021-06/myhealthrecord_stats_dec2019.pdf

Australian Institute of Health and Welfare. (2018). Healthy Communities Patients' out-of-pocket spending on Medicare services, 2016-17. In *AIHW*. https://www.aihw.gov.au/getmedia/f6dfa5f0-1249-4b1e-974a-047795d08223/aihw-mhc-hpf-35-patients-out-of-pocket-spending-Aug-2018.pdf.aspx?inline=true

Australian National Audit Office. (2020). *Auditor-General Report No.17 2020–21: Managing Health Provider Compliance, Department of Health,* Commonwealth of Australia, ISSN 2203–0352 (Online).

Bradford, N., Liam Caffery, & Smith, A. (2016). Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability. *Rrh.org.au*, *16*(4). https://doi.org/10.22605/RRH3808

Burton, T. (2021, June 7). *Pandemic catapults medical care into the future*. Australian Financial Review. https://www.afr.com/policy/health-and-education/pandemic-catapults-medical-care-into-the-future-20210601-p57x1v

Cancer Australia (2021, September). The impact of COVID-19 on cancer-related medical services and procedures in Australia in 2020: Examination of MBS claims data for 2020, nationally and by jurisdiction, Cancer Australia, Surry Hills, NSW.

Centre for Online Health. (2022, May 25). *Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia*. Coh.centre.uq.edu.au; University of Queensland. https://coh.centre.uq.edu.au/telehealth-and-coronavirus-medicare-benefits-schedule-mbs-activity-australia

Dalzell, S., & Macmillan, J. (2020, March 10). *How the Government plans to spend $2.4 billion protecting Australians against coronavirus - ABC News*. Www.abc.net.au; Australian Broadcasting Corporation. https://www.abc.net.au/news/2020-03-11/how-government-plans-to-spend-billions-protecting-coronavirus/12044192

De Guzman, K. R., Caffery, L. J., Smith, A. C., & Snoswell, C. L. (2021). Specialist consultation activity and costs in Australia: Before and after the introduction of COVID-19 telehealth funding. *Journal of Telemedicine and Telecare*, *27*(10), 609–614. https://doi.org/10.1177/1357633x211042433

De Guzman, K. R., Snoswell, C. L., & Smith, A. C. (2022). The impact of telehealth policy changes on general practitioner consultation activity in Australia: a time-series analysis. *Australian Health Review: A Publication of the Australian Hospital Association*. https://doi.org/10.1071/AH22058

Department of Health. (2019, July 4). *New Medicare data shows bulk billing at record levels*. Department of Health; Australian Government. https://www.health.gov.au/news/new-medicare-data-shows-bulk-billing-at-record-levels

Department of Health. (2022). ASKMBS ADVISORY MBS COVID-19 telehealth "existing relationship" requirement-clarification of exemptions. In *health.gov.au*. Australian Government.

https://www.health.gov.au/sites/default/files/documents/2022/06/askmbs-advisory-existing-relationship-clarification-askmbs-advisory---existing-relationship-clarification.pdf

Department of Health and Aged Care. (2020, July 10). *Continuous care with telehealth stage seven*. Department of Health and Aged Care; Australian Government. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/continuous-care-with-telehealth-stage-seven

Desborough, J., Hall Dykgraaf, S., Toca, L., Davis, S., Roberts, L., Kelaher, C., & Kidd, M. (2020). Australia's national COVID -19 primary care response. *Medical Journal of Australia*, *213*(3), 104. https://doi.org/10.5694/mja2.50693

Dickinson, H. (2019, March 27). *What is the Medicare rebate freeze and what does it mean for you?* UNSW Newsroom; University of New South Wales. https://newsroom.unsw.edu.au/news/general/what-medicare-rebate-freeze-and-what-does-it-mean-you

Flodgren, G., Rachas, A., Farmer, A. J., Inzitari, M., & Shepperd, S. (2015). Interactive telemedicine: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews*, *2015*(9). https://doi.org/10.1002/14651858.cd002098.pub2

Hunt, G. (2020, April 20). *Australians embrace telehealth to save lives during COVID-19*. Greghunt.com.au. https://www.greghunt.com.au/australians-embrace-telehealth-to-save-lives-during-covid-19/Media Release

McCauley, D. (2019, December 21). *Australians shun My Health Record with only 9 per cent ever logging in*. The Sydney Morning Herald. https://www.smh.com.au/politics/federal/australians-shun-my-health-record-with-only-9-per-cent-ever-logging-in-20191220-p53lz0.html

Medicare Benefits Schedule Review Taskforce. (2020, December 8). *Medicare Benefits Schedule Review Taskforce final report*. Department of Health; Australian Government. https://www.health.gov.au/resources/publications/medicare-benefits-schedule-review-taskforce-final-report

Mendelson, D. (1999, August 1). *Devaluation of a Constitutional Guarantee: The History of Section 51(xxiiiA) of the Commonwealth Constitution[1999] MelbULawRw 14; (1999) 23(2) Melbourne University Law Review 308*. Www5.Austlii.edu.au; University of Melbourne. http://www5.austlii.edu.au/au/journals/MelbULawRw/1999/14.html

Orlando, J. F., Beard, M., & Kumar, S. (2019). Systematic review of patient and caregivers' satisfaction with telehealth videoconferencing as a mode of service delivery in managing patients' health. *PLOS ONE*, *14*(8), e0221848. https://doi.org/10.1371/journal.pone.0221848

Phillips, J., Grove, A., & Cook, L. (2019). *Health – Parliament of Australia*. Aph.gov.au; Parliament of Australia. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201920/Health

Professional Services Review. (2020). *Professional Services Review Annual Report 2019–2020*. Commonwealth of Australia.

Royal Australian College of General Practitioners. (2021, September). *Health of the Nation 2021*. Racgp.org.au; Royal Australian College of General Practitioners. https://www.racgp.org.au/getmedia/c6fc787b-9c6e-43a5-a1d9-46847a151615/ID-949-HOTN-21-summary-v4-WEB.pdf.aspx

Royal Australian College of General Practitioners. (2022, July 28). *COVID-19 telehealth MBS items*. Racgp.org.au; RACGP. https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20resources/Changes-to-telehealth-FAQ.pdf

Ryan, P. (2020, February 11). *NBN "near completion and on budget", but figures show $2b loss in six months*. ABC News. https://www.abc.net.au/news/2020-02-11/nbn-on-track-and-on-budget-says-ceo-stephen-rue/11953694

Smith, A., Snoswell, C., & Caffery, L. (2020a, June 22). *Telehealth in lockdown meant 7 million fewer chances to transmit the coronavirus*. Theconversation.com; The Conversation. https://theconversation.com/telehealth-in-lockdown-meant-7-million-fewer-chances-to-transmit-the-coronavirus-141041

Smith, A., Snoswell, C., & Caffery, L. (2020b, June 22). *Telehealth in lockdown meant 7 million fewer chances to transmit the coronavirus*. Theconversation.com; The Conversation. https://theconversation.com/telehealth-in-lockdown-meant-7-million-fewer-chances-to-transmit-the-coronavirus-141041

Snoswell, C. L., Caffery, L. J., Haydon, H. M., Thomas, E. E., & Smith, A. C. (2020). Telehealth uptake in general practice as a result of the coronavirus (COVID-19) pandemic. *Australian Health Review*, *44*(5). https://doi.org/10.1071/ah20183

Snoswell, C. L., Caffery, L. J., Thomas, M. L., Haydon, H. M., Thomas, E., & Smith, A. C. (2022, August 24). *Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia*. Coh.centre.uq.edu.au; Centre for Online Health. https://coh.centre.uq.edu.au/telehealth-and-coronavirus-medicare-benefits-schedule-mbs-activity-australia

Snoswell, C., Mehrotra, A., Thomas, E., Smith, K-lynn., Haydon, H., Caffery, L., & Smith, A. (2020, March 5). *Making the most of telehealth in COVID-19 responses, and beyond* (M. Sweet, Ed.). Croakey; Crikey. https://www.croakey.org/making-the-most-of-telehealth-in-covid-19-responses-and-beyond/

St Clair, M., & Murtagh, D. (2019). Barriers to Telehealth Uptake in Rural, Regional, Remote Australia: What Can Be Done to Expand Telehealth Access in Remote Areas? *Studies in Health Technology and Informatics*, *266*, 174–182. https://doi.org/10.3233/SHTI190791

Taylor, A., Caffery, L. J., Gesesew, H. A., King, A., Bassal, A., Ford, K., Kealey, J., Maeder, A., McGuirk, M., Parkes, D., & Ward, P. R. (2021). How Australian Health Care Services Adapted to Telehealth During the COVID-19 Pandemic: A Survey of Telehealth Professionals. *Frontiers in Public Health*, *9*. https://doi.org/10.3389/fpubh.2021.648009

Thomas, E. E., Taylor, M. L., Ward, E. C., Hwang, R., Cook, R., Ross, J.-A., Webb, C., Harris, M., Hartley, C., Carswell, P., Burns, C. L., & Caffery, L. J. (2022). Beyond forced telehealth adoption: A framework to sustain telehealth among allied health services. *Journal of Telemedicine and Telecare*, 1357633X2210744. https://doi.org/10.1177/1357633x221074499

Thompson, G. (2019, April 23). *Australia was promised superfast broadband with the NBN — this is what we got instead*. ABC News. https://www.abc.net.au/news/2019-04-23/what-happened-to-superfast-nbn/11037620?nw=0&r=HtmlFragment

Tsirtsakis, A. (2020, May 14). *"We don't want to be bulk-billing clinics."* NewsGP; Royal Australian College of General Practitioners. https://www1.racgp.org.au/newsgp/professional/we-don-t-want-to-be-bulk-billing-clinics

Wade, V. A., Eliott, J. A., & Hiller, J. E. (2014). Clinician Acceptance is the Key Factor for Sustainable Telehealth Services. *Qualitative Health Research*, *24*(5), 682–694. https://doi.org/10.1177/1049732314528809

White, J., Byles, J., & Walley, T. (2022). The qualitative experience of telehealth access and clinical encounters in Australian healthcare during COVID-19: implications for policy. *Health Research Policy and Systems*, *20*(1). https://doi.org/10.1186/s12961-021-00812-z

Woodley, M. (2021a). *newsGP - Should bulk-billing rates be used as a measure of healthcare success?* NewsGP. https://www1.racgp.org.au/newsgp/professional/should-bulk-billing-rates-be-used-as-a-measure-of

Woodley, M. (2021b, June 21). *newsGP - Should bulk-billing rates be used as a measure of healthcare success?* NewsGP. https://www1.racgp.org.au/newsgp/professional/should-bulk-billing-rates-be-used-as-a-measure-of

Australia &
New Zealand
School Of
Government

ANZSOG