

Telehealth uptake in general practice as a result of the coronavirus (COVID-19) pandemic

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Abstract. In March 2020, the Australian Government added new temporary telehealth services to the Medicare Benefits Schedule (MBS) to reduce the risk of patient–patient and patient–clinician transmission of the 2019 coronavirus (COVID-19). Here, the MBS statistics for general practitioner activity and the associated costs are described; a small increase in both activity and costs for the new MBS telehealth items were observed. The opportunities for future research and policy implications are also discussed.

Additional keywords: primary care, telephone consultations, video consultations.

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Introduction

In an effort to reduce patient–patient and patient–clinician transmission of the 2019 coronavirus (COVID-19) during the current global pandemic, the Australian Government introduced additional funding to enable all citizens access to general practice and other healthcare services.^{1,2} Prior to the pandemic, telehealth services subsidised through the Medicare Benefits Schedule (MBS) were strictly limited to patients living outside of major cities and predominantly only for specialist video consultations. However, during the pandemic, 281 new temporary MBS item numbers were added to the schedule for video-conference or telephone consultations between patients and general practitioners (GPs), specialists, allied health and nurse practitioners. Simultaneously, access to this funding was significantly enhanced, by removing geographical and patient-risk factors from the original eligibility criteria.³ The new item numbers were released at five different time points between March and May 2020, with the first available items claimed from 13 March 2020.

Telehealth, the delivery of health care from a distance, enables patients to access routine clinical care (e.g. ongoing management for chronic disease) during infectious disease outbreaks.^{1,4} For decades, telehealth has been widely acknowledged as a valuable method of improving access to healthcare services, which would

normally be difficult to access – perhaps due to location (rural and remote) or other barriers (such as frailty, lack of transport or other physical or mental health conditions).^{5,6} Our conventional health-care system is mainly dependent on consultations done in person, thus creating potential inequality for those unable to physically attend. Prior to COVID-19, GP telehealth services in Australia occurred in three contexts: in accordance with existing MBS item numbers; through hospital outpatient departments; or as part of commercial services where patients paid the full cost for their consultations. The temporary MBS item numbers introduced for the pandemic provided a mechanism for GPs to provide more MBS-funded consultations.

Methods

We analysed MBS-subsidised GP consultations for this study. Telehealth activity and financial data since the introduction of temporary telehealth item numbers were obtained from the publicly available MBS data sources.⁷ At the time of writing, telehealth activity data were available for March, April and May 2020. We also compared activity data over a full 12-month period, from March 2019 to allow a month-to-month comparison of overall (in-person and telehealth) GP activity. The 40 item numbers included in the analysis are for standard GP attendances,

healthcare assessments for people of Aboriginal or Torres Strait Islander descent, chronic disease management, disability services, pregnancy support, eating disorder management and urgent after-hours attendances.³ Item numbers for GP consultations for mental health services were excluded as they are provided by GPs with extra training.

Results

The average number of GP-related MBS services (excluding specific mental health services) claimed from March 2019 to February 2020 was ~11.1 million consults per month. From March 2020 to May 2020, the average number of services was ~12 million consults per month, representing an increase of ~9%. Table 1 summarises the activity and related costs of MBS-subsidised GP activity, and Fig. 1 provides a graphical presentation demonstrating the overall trend for both activity and cost.

Discussion

Preliminary results show an exponential increase in the number of MBS services being provided in Australia since March 2020, coinciding with the declaration of the global pandemic, the introduction of new MBS-funding opportunities and relaxed funding rules for telehealth. Analysis over an extended time frame will help substantiate precise reasons for this marked increase in telehealth activity – and its relationship to factors such as: the physical distancing regulations; the health risks associated with the pandemic; changes to infrastructure (such as internet access and general practice software); and the direct investment our government has made in telehealth services.

The increased uptake in telehealth is often driven by policy changes in other countries.⁸ The key drivers of this increased activity (e.g. funding reforms, increased clinician willingness, fear of viral transmission) remain unclear. Once the immediate health threat of the pandemic shows signs of resolve, the implementation of different telehealth policies and funding reforms in Australia and around the world will provide an interesting natural experiment.

Since the introduction of new telehealth MBS items in Australia, there has been a significant increase in volume of telephone consultations involving GPs (from 0% to 34% of all consultations), with little change to the volume of consultations done by videoconference (from 0% to 1% of all consultations). This rapid increase in telehealth services overall indicates both clinician and patient interest and acceptance of this modality in clinical practice.

Telehealth literature has demonstrated patient and clinician satisfaction with telehealth services.^{9,10} However, given the rapid change in Australian services and the predominant use of telephone use, further research is required to determine the extent to which patients prefer telehealth over conventional in-person services. Additionally, further research is needed to compare clinical outcomes and telehealth quality measures – and how these compare with in-person appointments. Although telehealth is not designed to remove the need for an in-person appointment, these observed changes in service delivery are highlighting circumstances where patients do not need to be physically present for a consultation. This process has prompted clinicians to rethink the way they provide services and should influence the development of revised models of care.^{11–13}

Table 1. General practice activity and cost of services provided as part of the Medicare Benefits Schedule (MBS) from March 2019 to May 2020

Costs are shown in Australian dollars. M, millions; K, thousands

		2019												2020				
		Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
Activity	In-person	11.1M	10.6M	13.6M	11.0M	11.8M	11.9M	10.8M	11.4M	10.9M	9.4M	10.1M	10.8M	11M	8.3M	8.2M		
	Pre-existing videoconference	0	0	0	0	0	0	0	0	22	20	57	42	173	558	737		
	COVID-19 videoconference	0	0	0	0	0	0	0	0	0	0	0	0	61K	0.2M	0.1M		
	COVID-19 telephone items	0	0	0	0	0	0	0	0	0	0	0	0	1M	4.4M	4.2M		
Costs	Total activity per month	11.1M	10.6M	13.6M	11.0M	11.8M	11.9M	10.8M	11.4M	10.9M	9.4M	10.1M	10.8M	12.0M	12.9M	12.5M		
	In-person	\$552M	\$510M	\$637M	\$526M	\$580M	\$589M	\$538M	\$572M	\$546M	\$466M	\$505M	\$545M	\$533M	\$370M	\$399M		
	Pre-existing videoconference	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1K	\$1K	\$3K	\$2K	\$8K	\$30K	\$40K		
	COVID-19 videoconference	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$9M	\$6M		
	COVID-19 telephone items	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$41M	\$197M	\$187M		
	Total cost per month	\$552M	\$510M	\$637M	\$526M	\$580M	\$589M	\$538M	\$572M	\$546M	\$466M	\$505M	\$545M	\$577M	\$576M	\$592M		

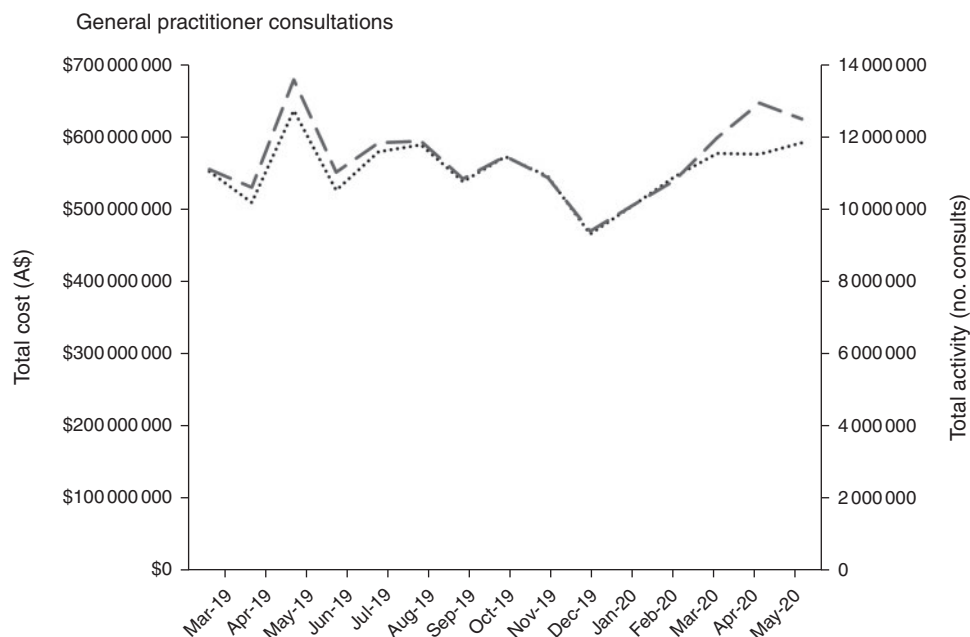


Fig. 1. Overall general practice activity (dashed line) and cost of services (dotted line) reimbursed by the Medicare Benefits Schedule (MBS) from March 2019 to May 2020.

The recently introduced COVID-19 MBS item numbers for videoconference and telephone consultations are currently reimbursed at the same value as the equivalent in-person consultation codes. Consequently, the increase in service activity since the pandemic has resulted in an increase in costs to the MBS; however, the increase remains proportional to the activity increase. In an effort to address the sustainability of existing GP practices, the Australian government has announced that the COVID-19 MBS item numbers will be restricted for use with a patient's regular GP or medical practice.^{3,14} This policy change will likely see newly established telehealth providers ceasing services or needing to introduce a full fee-for-service model.¹⁵ Similarly, telehealth providers established before COVID-19, who for the first time have been offering MBS-subsidised services, will need to revert to their original full-fee paying model.

In regards to other policy implications, next steps may involve adjustments to the MBS items used for telephone consultations versus in-person consultations. Remuneration needs to take into consideration the consultation type, clinical purpose, time required and effort. Although we believe parity is important for video consultation services and in-person consultations, a reduced payment for telephone consultations would align with what other countries such as the United States of America (USA) have implemented, where many providers reimburse synchronous telephone consults at a lower rate than standard in-person or videoconference services.¹⁶ However, a change in the value of reimbursement for telephone consultations should also be made in conjunction with the removal of bulk-billing restrictions, allowing general practice service providers the choice to charge a gap fee payment, thus ensuring the financial viability of a GP service.

The increased MBS subsidisation of telehealth and increased uptake of telehealth as a result of COVID-19 demands further

examination of evidence-based policy. The comparative increase in telephone versus videoconference services raises questions regarding actual clinical outcomes associated with all delivery methods. How do they compare? Such research is needed to quantify any differences and to provide justification for any changes in funding-related policy. Other factors influencing policy decisions need to recognise the high levels of satisfaction associated with the use of telehealth; efficiency gains reported in service planning and delivery; and the willingness of patients to potentially contribute to the costs of telehealth services. It is also important not to create any new barriers for vulnerable patients who might find it difficult to access health services due to physical location, age, cultural factors, health conditions or affordability.

Competing interests

The authors declare no competing interests.

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