



AACP

AUSTRALIAN ASSOCIATION
OF CONSULTANT PHYSICIANS

DISCUSSION PAPER

Telemedicine – What price?

Introduction

Telehealth or telemedicine or ehealth are essentially different names applied to the overall theme of delivering health and medical services remotely, and the infrastructure that supports the delivery of these services. They encompass two broad concepts.

The first is where the patient's records and associated medical documentation (such as test results) can be recorded, stored, transmitted and accessed electronically and from distant locations or by health care providers who are not physically present with the patient. Ultimately there will be a transportable record of which the patient may take charge.

The development of "ehealth" embodying the above, is proceeding around the world and in Australia that is stated has having "the potential to facilitate significant improvements in:

- continuity of care through multidisciplinary arrangements, particularly in chronic disease management;
- responding to acute illness;
- quality and safety through the use of electronic decision support;
- delivery of more uniform care across the country;
- collection of health status;
- customisation of health care delivery; and
- provision of greater access by individuals to information".

The second concept, and arguably the more important one for the AACP, relates to the practicalities of delivering medical care to patients of consultant physicians and paediatricians when the patient is not there. There is a need to recognise both the practical aspects of having relevant information available, but more importantly, there needs to be recognition of and value assigned to the contribution of the CPP in providing such services to a patient in a

remote¹ location. Currently, there is inadequate recognition in the Medicare Benefits Schedule of the participation of CPPs in the delivery of medical services in this manner. This is a problem that is not unique to Australia.

A related aspect that has received little attention to date is the manner in which changing medical technology is factored into the structure and determination of Medicare benefits. While successive Governments have acknowledged that there is a need for the Medicare Benefits Schedule (MBS) to be more responsive to changes in technology and, notwithstanding the establishment of the Medical Services Advisory Committee (MSAC) that was intended to provide timely advice on changing technology, technology continues to evolve much more rapidly than can be accommodated by the MBS.

The advent of remote medical services adds another complex dimension to this problem.

The Provision of Medical Care to “remotely-located” Patients: the provision of Patient Benefits

The problem that presents itself to those attempting to respond to the demands of the information revolution is that the system of medical benefits was constructed in 1970. The assumption was that all consultations would be face to face; and that all procedures would be undertaken at the same venue. In procedural work, the potential of the virtual operation has yet to be tapped, but it is one of the issues and one which the system of Medicare benefits has difficulty in comprehending, namely, the impact on the relativities with the advance of technology.

Telehealth stripped down to a basic level is being able to meaningfully conduct a medical service where the doctor and the patient are in contact but not face-to-face. Once you establish that the medium in which the two are connecting is legitimate and equivalent to face-to-face contact then there should be no problem in accommodating such a Medicare benefit. The problem has been in the adoption of the jargon, which suggests a different beast and the fact that the medium in which the contact is made is not equivalent to face-to-face. Therefore, it is this non-equivalence, which demands that there are restrictions placed on the patient accessibility to fees for Medicare benefit.

¹ “Remote” in the context is defined as not being present with the CPP in the consulting room.

The above is an argument about relative value – another way of stating the doctrine of equivalence. However, there will be situation where there is no alternative than recourse to non-face-to-face contact; and these situations need to be defined. Defining all possibilities is impossible – there is always the situation which nobody has thought about.

Hence, there is a need to write a generic item descriptor with the minimum of “weasel room” so that patients of CPP who are not able to attend the CPP in person – for whatever reason – are eligible for an appropriate Medicare benefit. At the same time, it is important that such Medicare benefits are not paid where services have not been provided in the manner envisaged – a possibility that the Government will scrutinise carefully.

The second element of the case that the AACP intends putting to the Federal Government is that expanded technical capability needs to be supported if the advantages of ehealth are to be realised.

All Medicare patient benefits contain a professional, a technical and a capital component. The professional component is that part of the benefit that relates to the professional service; the technical component relates to all other elements such as technical and support staff, office costs; the capital component relates to capital costs, principally for equipment.

The concern in relation to a growing ehealth capacity is whether the technical component is sufficient to provide for rapidly expanding requirements. It is not clear whether this is the case, and further discussion on requirements and existing capacity would be useful. In a recent US survey of almost 3,000 medical practitioners, two thirds cited cost and complexity as the key reason for not having digital records.

The question is also raised as to whether a small increase in the “technical component” of a Medicare benefit is sufficient or appropriate and whether some other mechanism should be explored to address expanding technology needs – that is, those solely relating to the management of and access to patients’ medical data, not for treatment.

Matters for Discussion

The AACP welcomes discussion of these issues prior to finalising its proposal to Government seeking recognition under the Medicare arrangements for e-medicine.

These issues are:

- (i) how can participation in consultations where the patient is not present with the CPP be defined in a manner that allows appropriate review by Medicare as required?
- (ii) what is the best mechanism for “measuring” such services: is time the only realistic measure?
- (iii) are there CPP sub-specialties that are likely to be significantly more affected by the full implementation of ehealth?
- (iv) is a significant enhancement of technological capacity required in order to deliver on the promises of ehealth? If yes, what is required and how should it be delivered?
- (v) what are the potential remote procedural technologies that need to be addressed?
- (vi) what experiences have you had in your own practice that can be usefully shared with the other CPPs?
- (vii) what do you see as major barriers to uptake of ehealth technology in your practice?

Thank you for your interest and contribution.

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President