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Issues brief

Deeble Institute for Health Policy Research

no: 43

date: 24/06/2021

title **Towards a sustainable funding model for telehealth in Australia**

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This paper was developed as part of a Jeff Cheverton Memorial Scholarship undertaken at the Deeble Institute for Health Policy Research, Australian Healthcare and Hospitals Association (AHHA).

The Jeff Cheverton Memorial Scholarship has been established by the Australian Healthcare and Hospitals Association (AHHA), together with Brisbane North Primary Health Network and North Western Melbourne Primary Health Network to honour the memory of Jeff Cheverton.

Acknowledgements

I would like to acknowledge Brisbane North PHN and North Western Melbourne PHN for supporting this scholarship. I would also like to thank the members of the Australian Healthcare and Hospitals Association (AHHA), the Deeble Institute for Health Policy Research, as well as the stakeholders for their invaluable insights and feedback on the draft. Thank you also to my supervisors and colleagues at the Centre for the Business and Economics of Health as well as the School of Economics, the University of Queensland for encouraging me to undertake this scholarship and complete this Issues Brief.

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Key messages

- Telehealth services in Australia should be supported and continued beyond the immediacy of the pandemic.
- To improve efficiency in the provision of telehealth services, the Australian Government Department of Health should trial add-on payments or bundled payment models that are less reliant on fee-for-service criteria.
- To reduce overutilisation of teleservices that provide low value for money, and achieve better health outcomes for patients, Government funding should be directed towards high value telehealth technologies which can be substituted for face-to-face services.
- The quality of telehealth services and performance should be monitored through data linkage and patient reported outcomes measures. An annual MBS telehealth item review should be performed to ensure ongoing suitability.
- To support the development of evidence-based policy and funding models, the telehealth program should be regularly evaluated by the Department of Health.
- The Australian Government should establish national telehealth standards and health workforce training guidelines to promote the use of high value technology and to ensure safe and high-quality delivery of care.

Executive summary

Telehealth services in Australia should be supported and continued beyond the immediacy of the pandemic.

The roll-out of the telehealth program during the COVID-19 pandemic has been a public health success, with limited evidence to suggest that telehealth services are harmful to population health and well-being. Nevertheless, its rapid implementation has resulted in a large government spending for new MBS items and ICT infrastructures.

Therefore, extending the telehealth program beyond the pandemic will require the consideration of fiscal sustainability on future budgets. Drawing on government and non-government research this Issues Brief identifies and investigates potential barriers to cost-effectiveness, efficiency and equity in existing telehealth policies. Where possible, Medicare data has been analysed to provide quantitative evidence of these issues in Australia.

Recommendations are made for refining telehealth policies in order to maintain health system sustainability and to achieve best outcomes for the whole population.

This includes consideration of:

- Improving and finetuning funding for telehealth;
- Monitoring and evaluating the impacts of telehealth services and rewarding those activities that result in better health outcomes;
- Establishing payments that reflect resource inputs and time commitment required;
- Establishing a primary care data set, linkable to other health data to support evidence based funding reforms; and
- Developing a set of national telehealth standards and suite of education programs.

1 Introduction

1.1 *Fiscal sustainability in health care*

In Australia, growth in health spending has generally remained higher than growth of the Gross Domestic Product (GDP); on average, 1.5% greater than GDP growth (2009-2013), falling to an average of 0.4% (2014-19) (Australian Institute for Health and Welfare, 2020b). This trend of growing health care costs will continue in the decade to 2030 in most OECD countries (OECD, 2019). Given that governments fund more than two-thirds of health expenditure in Australia (Australian Institute for Health and Welfare, 2020b), a focus on fiscal sustainability will be important to ensure current and future health care can be funded without incurring additional costs to the system (Boxall, 2011).

The rapid implementation of the telehealth program during the COVID-19 pandemic resulted in expenditure of more than \$2.4 billion paid for MBS telehealth items in the period March - September 2020 (Department of Health, 2020a). An additional \$130 million was allocated to extend telehealth services to March 2021 and to invest in ICT infrastructures supporting telehealth services (Department of Parliamentary Services, 2020). An extension of the program is now in place until December 2021. In the context of rising health costs, the extension of telehealth services beyond the pandemic must be considered as a factor which may impact fiscal sustainability in the health budget. Getting the right fit of telehealth services in an appropriate blend of services accessible to all will be important to ensuring that the telehealth services are integrated into the existing system in a cost-neutral manner.

1.2 *Value for money*

Although the Australian health system performs relatively more efficiently than health systems in many other OECD countries, health regulations and financial incentives are not performing as efficiently as they could be, resulting in wasteful spending, reduced access to care and sub-optimal quality and safety outcomes (Productivity Commission, 2015). The extension of telehealth beyond the pandemic should be premised on improving efficiency through achieving 'value for money', better health outcomes, higher quality services, improved access to services and reduced waste, for a given level of funding.

'Value for money' relates to the ability of the health system to improve the way existing resources are efficiently used to maintain the financial sustainability of the system (OECD, 2010). Increased 'value for money' can come from re-orienting funding towards high value services in the system (OECD, 2010). Shifting the focus of the telehealth funding model towards value and outcomes also enables the system to manage costs more effectively while promoting quality of care (AHHA, 2021).

1.3 *Value in health care*

Value in health care is defined as the health outcomes achieved per dollar spent (Porter, 2010). In a universal health care system like Australia, social value, or the price that governments are willing to pay for health care, are also considerations (Woolcock, 2019). The value of services should also be assessed on cost-effectiveness. (Sacristán, 2020). This is because an effective intervention is not necessarily efficient, and any decision on the value of an intervention needs to be linked to the concept of opportunity costs. The choice of a health intervention can also divert resources that could be used to finance other options. An intervention is efficient if the resources invested to achieve a

certain additional benefit cannot be used in another option that generates a greater benefit. When cost-effectiveness is used to assess value, low value services are:

- ineffective services that entail costs to the system;
- less effective but more expensive than their alternatives; and/or
- services with incremental or decremental cost-effectiveness that are not acceptable.

Definitions

- **Effectiveness:** The ability to achieve the desired outcomes for patients, clinicians and the community.
- **Efficiency:** The ability to deliver the right care at minimum cost (Australian Institute of Health Welfare, 2020b).
- **Cost-effectiveness:** The degree to which care is effective in relation to its cost.

1.4 Limited evidence on cost-effectiveness

A review of international studies has shown that telehealth can potentially reduce costs as a result of productivity gains and avoidable secondary care (Snoswell et al., 2020a). In Australia, it has been estimated that the use of telehealth could save over \$300 million a year through reductions in the time consumers spend in travel to consultations (Productivity Commission, 2017b). However, increased productivity, under the Australian fee-for-service model, may also increase costs to the system as providers are incentivised to increase service volumes, potentially at the expense of quality (Snoswell et al., 2020b).

In the United States, telehealth is used to reduce avoidable hospital admissions, particularly in emergency department visits, by redirecting patients to primary care providers, but there is no clear evidence that this results in savings for Government and patients (Langabeer et al., 2016). At the time of writing, there are no studies assessing the impact of telehealth services on hospitalisation rates in Australia.

Prior to the COVID-19 pandemic in 2020, telehealth payments in Australia were restricted, with telehealth services limited to people living in rural/remote areas and to specialist services. Therefore, it is difficult to extrapolate research evidence from this period to telehealth policies that cover a wider population and range of services. An up-to-date evaluation for telehealth services is required to support evidence-based funding reforms and policy development.

1.5 Safety and quality of telehealth services

Services delivered through telehealth may not be assured as safe and high quality for patients when there is a lack of guidelines, including quality and safety reporting systems (Guise et al., 2014).

A safe and high quality health system will provide the most appropriate and best value for money care to patients, contributing to the sustainability of the system, while keeping patients safe from preventable harm (Australian Institute of Health Welfare, 2020b). Improving safety and quality of care improves fiscal sustainability by reducing the costs of diagnostics error and adverse effects - which in 2015-2016 cost Australia more than \$270 million (Auraaen et al., 2018).

Guidelines for safe, high quality telehealth care should be developed collectively by professional colleges, in partnership with the Australian Commission on Safety and Quality in Health Care and the Australian Digital Health Agency and should include consideration of performance monitoring and reporting.

Enhanced data and information is critical for assessing the value and efficiency of telehealth services (Department of Health, 2020f). Telehealth services will require monitoring to ensure that they deliver safe and high-quality care and achieve value for money. Performance reporting and monitoring in Australia remains a challenge due to a lack of enhanced data and standardised outcomes measures (Department of Health, 2020f).

Existing data sources should be linked to support performance and quality monitoring and improve efficiency in the health system and patient reported outcomes should be developed to accurately measure and support future analysis of the value of telehealth.

What is safe and quality care? (Australia Commission on Safety and Quality in Healthcare, 2021).

Safety: Prevention of error and adverse effects associated with health care.

Quality: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

1.6 Fee-for-service model may promote inefficient delivery of care

In Australia, prior to COVID-19, there was limited implementation of telehealth policies, with telehealth services subsidised through the MBS strictly limited to eligible patients in rural or remote areas and residential aged care facilities (Gray, et al., 2012). Since the expansion of MBS items in March 2020, telehealth consultations have grown rapidly across different groups of providers, specifically in audio-only services (Australian Institute of Health Welfare, 2020a). Indeed, telephone consultations by general practices (GPs) increased by 34 percent (Snoswell et al., 2020a), suggesting that access to care improved as a consequence. However, if international experience is considered, this may also include some over-servicing. It is important to ensure that current payment models do not incentivise unnecessary care that is not aligned with patients' needs.

Other payment models, including capitation, global budget and activity-based funding have their strengths and weaknesses in improving quality and efficiency. For example:

- Fee-for-service models may incentivise providers to increase service volume, consequently increasing costs to the system.
- Capitation models are better at containing costs but can discourage providers from delivering optimal level of care.
- Global budgets can also contain costs, but may lead to patient selection, resulting in issues of inequity.
- Activity-based funding can improve efficiency, resulting in cost containment, cost-effective treatment and reduction in unnecessary care (Park et al., 2007).

Traditional payment models (OECD, 2016)

Fee-for-service: Retrospective activity-based payment with billing of individual services and patient contacts.

Capitation: Prospective lump-sum payment per enrolled patient covering a range of services.

Global budget: Prospective lump-sum payment covering a range of services independent of actual volume provided.

Activity-Based Funding: Activity-based payment per patient, with patients classified into groups based on diagnoses and resource use.

Across OECD countries, to reduce cost and improve efficiency, three major reforms have emerged (OECD, 2016):

- Blended payment methods.
- Adapting traditional payment models in efficient ways, and
- Implementing innovative non-fee-for-service payment methods, including add-on, bundled and population-based payments.

Innovative payment methods (OECD, 2016)

Add-on payments are made on top of existing payment methods, for example, for care coordination; or pay-for-performance (P4P), focused on improving quality of care.

Bundled payments are made for episodes of care or for chronic conditions, often relevant to a specific medical condition and treatment and grouped together for payment, with the aim of improving care quality and reducing costs.

Population based payment in which groups of health providers receive payments on the basis of the population covered, in order to provide most healthcare services for that population, with built-in quality and cost-containment requirements.

Blending different payment models to complement fee-for-services is supported by the Productivity Commission (Productivity Commission, 2017a) and the MBS Review Taskforce (Department of Health, 2020f). However, finding an effective mix takes time, requiring experimentation and trials.

To identify the optimal payment models for telehealth services, add-on and bundled payments that are less reliant on fee-for-service criteria need to be trialled by the Department of Health, incorporating external and independent evaluation in the Australian context. In the short term, MBS items for telehealth should be continued to ensure access to care for all Australians.

1.7 Unwarranted variation in telehealth services

Addressing unwarranted variation can contribute to more equitable and better value care (Australian Commission on Safety and Quality in Health Care, 2015). Unwarranted variation is defined as ‘variation that cannot be explained by the condition or the preference of the patient; it is variation that can only be explained by differences in health system performance’ (Australian Commission on Safety and Quality in Health Care, 2017).

1.7.1 The ‘digital divide’ population

Variations in telehealth utilisation by patients reflect challenges accessing quality telehealth services, such as videoconferencing, for those communities experiencing the ‘digital divide’ (Hardie, et al., 2021, Jayawardana et al., 2021, Scott et al., 2021, Snoswell et al., 2020a).

What is digital divide? (Yusuf, 2010)

‘Digital divide’ refers to the gap between individuals, households, businesses and geographic areas at different socio-economic levels with regard to both their opportunities to access information and communication technologies (ICTs) and to their use of the Internet for a wide variety of activities.

In 2021, a national survey of 448 Australian general practitioners showed that the uptake of video consultations is lower in those areas with higher proportions of people aged 65 and above, as well as in lower socioeconomic areas (Scott et al., 2021).

Indeed, 2.5 million Australians do not have access to Internet due to affordability and lack of digital literacy, with the majority being people aged 65 and above, people with disability or chronic conditions and people living in rural and remote areas (Australian Bureau of Statistics, 2020). Even among Internet users, 1 out of 4 Australians reported their Internet connection was too slow for video communication (Dane et al., 2013). A 2021 CHOICE survey of 1850 Australians reveals that reliability and speeds still remains one of the most common problems for internet users (Angove-Plumb, 2021).

Digital investment is required if every Australian is to have access to safe, high-quality telehealth services. Improving digital literacy is critical to maximising the benefits of telehealth.

1.7.2 Telephone versus video-consults

In Australia, there has been a higher uptake of telephone consultations relative to video consultations (Snoswell et al., 2021); and yet, while telephone consultations are useful in certain situations, for example history taking, triaging or referrals (Boggan et al., 2020), evidence suggests that video consultations can be as effective as providing in-person care (Hashiguchi, 2020). For example, when comparing telehealth modalities, video consultations provide significant improvements in diagnostic accuracy through their capacity for visual examinations and visual cues compared to telephone consultations (Agboola et al., 2016). In this regard, it has also been suggested that video consultations, used for follow-up care, are more effective at reducing hospital readmission rates (Rush et al., 2018).

However, it must also be acknowledged that consultation via video is more expensive and time-consuming to implement than consultation via the telephone (Rush et al., 2018); and more difficult to incorporate in existing business systems, especially for larger practices (Scott et al., 2021).

Therefore paying for video conferencing and telephone consultations at the same MBS fee level may influence providers to use more telephone services to reduce practice expenses. In fact, 90 percent of telehealth visits in Australia, where the MBS benefits for telephone and video conferencing are equal, are delivered through telephones (Snoswell et al., 2021).

The differences in uptake between telephone and video conferencing also likely to reflect variations in telehealth training and experience across the health system (Knott et al., 2020, Mozer et al., 2015, Scott, et al., 2021).

Videoconferencing training programs should be promoted and coordinated by medical education providers and professional colleges to encourage confidence in videoconferencing and to potentially

reduce telephone services utilisation. National clinical standards for telehealth services are required to support these training programs and to reduce variation across practices.

1.7.3 When convenience is a double-edged sword

Although telehealth enables more convenient access to care, its convenience may also drive more patients to seek care for conditions that they would have not sought care for if telehealth had not been available (Mehrotra et al., 2018). For example, instead of saving money by substitution, such as replacing face to face consults telehealth can lead to increased government spending in a publicly funded healthcare system such as that which we have in Australia (Mehrotra et al., 2018).

In Australia, the number of face-to-face consultations has reduced since the introduction of additional telehealth MBS items in 2020, however this reduction has been offset by an increase in the number of telehealth services being delivered (Australian Institute of Health Welfare, 2020c). It is difficult to determine whether this reflects telehealth's substitutability or the effects from government lockdown policies.

In the United States, common conditions such as colds or rashes have been shown to increase the number of short telehealth consultations, since most people do not seek face-to-face care for these (Licurse and Mehrotra, 2018). In Australia, Medicare statistics shows that more than 90 percent of the rise in telehealth services are short GP consultations (Appendix C). Compared to 2019, the volume of short consultations increased threefold in 2020 (Australian Institute of Health Welfare, 2020c). Such a large increase is suggestive of a rise in consultations that would have not required doctor care before the introduction of telehealth MBS items.

To prevent unnecessary care, the Australian Commission on Safety and Quality in health care has recommended improving patient health literacy, encouraging shared decision making and developing clinical guidelines (Australian Commission on Safety and Quality in Health Care, 2015). Ongoing government support for these strategies is required. Raising awareness for conditions that are more prone to overuse in telehealth should also be encouraged through health information platforms such as [Choosing Wisely](#) and [Healthdirect](#).

Programs that aim to improve health literacy and promote shared-decision making and use of evidence-based guidelines should be supported by governments to reduce inappropriate care and contain costs in the system.

1.8 Improving equity and expanding choice

1.8.1 Direct-to-consumer services

Telehealth-induced increased utilisation of the health system can result from the emergence of low value services such as direct-to-consumer (DTC) telehealth services or 'pop-up' telehealth services (Mehrotra et al., 2018).

Direct-to-consumer (DTC)

Direct-to-consumer telehealth services, unlike traditional telehealth services, does not require patient-provider relationship or coordination with the patient's primary medical doctor. On DTC websites or cell phone applications, patients select their clinical issues and submit online medical intake forms which are reviewed by a clinician. Patients may or may not be contacted by the clinician

for additional information. If deemed appropriate, a prescription signed by the clinician will be sent to a pharmacy or to the patient's home (Jain et al., 2019, Jain & Mehrotra, 2020).

In the United States, around 88% of the DTC telehealth visits for respiratory infections are considered new utilisation (Ashwood et al., 2017). In this case, savings substitution keeping people away from emergency department and doctor visits were outweighed by the increase in spending associated with new utilisation, resulting in a net average annual spending increase of US\$45 per telehealth user (Ashwood et al., 2017).

1.8.2 Regular practice restriction

Recognising the low value nature of DTC telehealth businesses, the Australian Government has imposed a "regular practice" restriction on Medicare Benefits Schedule (MBS) items to prevent this business model from becoming established in Australia. However, there is growing concern that this restriction may have adverse consequences on at-risk communities, such as people living in rural or remotes areas (Consumer Health Forum of Australia, 2020).

What is the regular practice restriction?

On 10 July 2020, the Minister of Health, Greg Hunt announced changes to the MBS telehealth items, introduced as a response to COVID-19. The changes included imposing a 'regular practice restriction' on telehealth services in an effort to promote continuity of care. This has meant that, from 20 July 2020, telehealth GP providers have been required to have an existing relationship with their patients in order to provide telehealth services and claim the MBS items (Department of Health, 2020b).

How is an existing relationship defined?

An existing relationship is defined as the patient having seen the same practitioner for a face-to-face service in the last 12 months or having seen other health professionals at the same practice for a face-to-face service during the same period. Other health professionals can include, for example, another GP, a practice nurse, or an Aboriginal and Torres Strait Islander health worker.

Exemptions included people receiving the GP service from an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service, infants (< 12 months old), people experiencing homelessness and people in impacted areas (for example, people under lockdown or quarantine) (RACGP, 2020a).

2 Reforming provider payment model to improve efficiency and reduce wasteful spending

2.1 Fee-for-service models may promote inefficient provision of care

Funding frameworks that direct how care service providers are paid is an important determinant of total health expenditure (Ke, X. et al., 2011; Park., et al, 2007); and in OECD countries, including Australia, fee-for-service funding models have been shown to incentivise providers to increase the volume of services delivered, at the expense of quality care (Park, M., et al., 2007). In Australia, a number of issues with the fee-for-service model have been identified (Department of Health, 2020e), but not addressed in the 2020 expansion and funding of telehealth services. These include:

- **Rewarding volume over value:** Providers are incentivised to provide unnecessary treatment and undertake low value care. For example, the COVID-19 telehealth funding schemes have resulted in doctors requesting multiple appointments rather than providing repeat prescriptions (Thomas et al., 2020).
- **Promoting siloed care:** Paying for individual services encourages providers to organise around functional specialties, promoting duplication of services and uncoordinated care. Although the Chronic Disease Management telehealth MBS items were introduced to promote continuity and coordination of care for chronic conditions, program uptake has remained fairly low (3.1% as of January 2021)(Appendix C), indicating low use of care team planning.
- **Perpetuating inefficiency:** MBS rebates do not adequately reflect advances in health care technology, with outdated services often more expensive than modern, safer technologies (Department of Health, 2020e). For example, in-home monitoring or telemonitoring - an established modality of telehealth where patients are monitored from a distance – resulted in lower rehospitalization rates and lower health expenditure for patients with chronic conditions, compared with usual care (Snowswell et al., 2020a). In spite of its success in a number of trials or small clinician-driven programs, lack of funding and infrastructure prevent telemonitoring to be established in Australia (Snowswell et al., 2020c).
- **Rewarding intervention over prevention:** Providers are often encouraged to treat illness, such as chronic conditions, rather than provide patients with education and prevention strategies (Cunningham, 2000). For example, the MBS subsidised health assessment has been shown to improve uptake of preventive health practices (Baillie, J. et al., 2019) and yet telehealth items for these services are limited (Department of Health, 2020c).

These issues are also examples of supplier induced demand, where providers have the opportunity to create demand for services that do not optimally align with patients' needs, potentially creating wasteful spending (Johnson, 2014).

Supplier-induced demand (Johnson, 2014).

Information asymmetry occurs when there is a mismatch in health knowledge between patients and providers. This often results in a situation where the provider can 'influence patient demand to suit their own interest'. Under an activity-based funding system, providers can be induced to provide care beyond the level that objective clinical judgment and patients' preferences would dictate.

To encourage efficient provision of care in the system and reduce wasteful spending, provider payment reforms that address unwanted incentives without compromising quality of care are needed (OECD, 2015).

Re-orienting the funding models towards value and outcomes will be critical to increasing fiscal sustainability and achieving better health outcomes for patients, without incurring excess costs to the system (Porter and Kaplan, 2016). Value includes the health outcomes for a patient, through the provision of effective, high quality and safe care that meets their needs (Marzorati and Pravettoni, 2017). Alternative payment models that are less reliant on fee-for-service should be implemented for telehealth services.

International evidence suggests that bundled payments can result in lower competition amongst providers (the Netherlands) (Vlaanderen et al., 2016) and lower fiscal sustainability (Italy) (Acerete et al., 2011). Therefore, consideration should also be given to potential unintended consequences when implementing payment reforms for telehealth.

2.2 Aligning expanded telehealth use policies with existing payment reform initiatives

For the last decade, Australia has been trialling various non-fee-for-service models in primary care settings, including the Practice Incentives Program eHealth incentive (ePIP), proposed voluntary patient enrolment and the Health Care Homes initiative (which ended in 2021). Although these models are/were expected to improve quality of care (Department of Health, 2020d, Service Australia, 2020), evidence regarding efficiency and cost-effectiveness is limited.

2.2.1 Practice Incentives Program eHealth incentive (ePIP)

The majority of ePIP funding is allocated to developing capacity in patient information exchange and promoting the use of electronic clinical resources (Service Australia, 2020). The ePIP has not been amended to encourage the adoption of telehealth for medical services.

ePIP: electronic Practice Incentives Program

ePIP is a financial incentive implemented under the Practice Incentives Program, a Pay-for-Performance model implemented since 1999 to promote continuous improvement in primary care (Wright, M., 2012). 33% of the Practice Incentives Program funding was paid to the eHealth incentive, reflecting both high uptake and relatively generous benefit from the program (Cashin, C., 2011). In 2018, more than 80% of all practices registered for PIP received payments for eHealth initiative (Department of Health, 2018a). Eligible practices can receive up to \$12,500 per quarter, to meet five requirements set by the Department of Health (Department of Health, 2016; Appendix B).

Despite high uptake, there is limited evidence to suggest that ePIP results in efficiency gains and cost savings. To ensure that the ePIP with telehealth as a specific inclusion works efficiently, enhanced data and performance reporting are critical for policy evaluation and management of service delivery at provider level. This will provide evidence as to whether the program is a cost-effective and sustainable payment model for telehealth services.

New requirements that promote efficient use of telehealth services should be included in the ePIP incentive. This should include a requirement that practices have systems in place to offer telehealth services for the purposes of care coordination and preventive health.

2.2.2 Voluntary patient enrolment

In the 2019-20 Budget, the Australian Government announced a Voluntary Patient Enrolment (VPE) initiative for patients aged 70 years and over, and Aboriginal and Torres Strait Islander people aged 50 years and over. This initiative is designed to provide financial incentives for GPs to provide consultations, referrals, test results, and scripts using telehealth. Participation in the program is voluntary for both patients and GPs (Department of Health, 2021a). The roll-out of this program was delayed as a consequence of COVID-19. In May 2020, the Government announced that the initiative is being revised and is expected to be finalised by late 2021 (Department of Health, 2021b).

The VPE program aims to improve care access and continuity (Department of Health, 2021a). However, poor initial program design suggests that VPE will have limited capacity to improve population health outcomes. For example, program eligibility is dependent on age, instead of health needs (Department of Health, 2021b). This means that while people in an older demographic with increased care needs will be able to take advantage of the full benefits of telehealth (Australian Institute of Health Welfare, 2018), younger people, adults or children who experience high health care needs will not. This includes younger people with disabilities and people with mental health conditions (Headspace, 2020).

Allowing patients to opt-out of the VPE program, instead of the voluntary enrolment can facilitate higher program uptake. Recent research has found that there are higher rates of organ donor and contributions to retirement savings plans when opt-out defaults are used instead of opt-in (McKenzie, 2013).

Embedding program evaluation from the onset will be critical for performance monitoring and making equitable improvements in health outcomes.

In the short term, MBS telehealth items should be made available to support continuity and access to care for the wider population. Simultaneously, trials of alternative payment models for telehealth will be required to ensure fiscal sustainability in the long term.

3 Improving access to telehealth services to reduce long term costs

3.1 Improving access to primary care will require relaxing the regular practice restriction

The regular practice rule is considered beneficial to patients as a consequence of the practice, or the GP, having knowledge of the patient's medical history. However, there are a range of circumstances where it is not possible for patients to have an existing relationship with a particular general practice and therefore no capacity for regular practice benefits to be realised. For example, this would impact patients who move homes or towns, people who do not have an established relationship with a general practice, people who seek second opinions, and people who want to change practices (Consumer Health Forum of Australia, 2020).

Telehealth is an effective modality for delivering care to vulnerable communities (Bradford et al., 2016). However, vulnerable communities, including those people living in rural or remote areas and people with poor health or disabilities, often have difficulties seeing their GP in person due to poor availability of appointments, out of pocket costs and limited access to specialised services (Glenister et al., 2021); and may not be able to access telehealth services under the proposed eligibilities of this rule.

In 2020, almost 3 out of 10 Australians reported not being able to obtain an in-person appointment with a preferred GP (Australian Bureau of Statistics, 2020). This number is even higher for people with poor health or long-term health conditions, and people in regional and remote areas (Australian Bureau of Statistics, 2020). There is also evidence that limited access to primary care in Australia increases emergency department visits, especially for people with mental health and chronic conditions (Vecchio and Rhode, 2017).

Given the importance of primary care in improving population health and lowering health expenditure (WHO, 2018), it will be important to relax the existing regular practice restriction so that vulnerable populations, in particular, have improved access to telehealth services.

3.2 Optimising My Health Record and voluntary enrolment

As electronic health records improve quality of care and continuity of care (Menachemi and Collum, 2011), the use of My Health Record (MHR) by patients and clinicians using telehealth should be strongly encouraged. Electronic health records have been shown to reduce unnecessary test duplication (Zlabek et al., 2011), improve medication safety (Australian Commission on Safety and Quality in Health Care, 2013, Roughead et al., 2016) and enhance access to care for consumers and providers (Smith et al., 2005).

Strong relationships between patients and care service providers has been shown to improve patient health outcomes (Lee et al., 2007) and reduce health expenditure for the most ill patients (De Maeseneer et al., 2003). This suggests that voluntary patient enrolment also has potential to improve fiscal sustainability in the health system. There is limited evidence on whether voluntary patient enrolment enhances patient outcomes and reduces costs in models of care which include telehealth.

4 Reducing unwarranted variation through MBS item review and infrastructure investment

4.1 Infrastructure investment to improve care access

Since March 2020, there has been an overall positive trend in the utilisation of telehealth in Australia (Australian Institute of Health Welfare, 2020c). However, studies have shown that uptake has varied across age groups, gender, state/territories and socio-economic groups (Hardie et al., 2021, Jayawardana et al., 2021, Snoswell et al., 2020a). These variations highlight previous concerns around issues of inequitable access to telehealth services, particularly in those groups who have limited or no access to modern communication technology (Barraket & Wilson, 2020).

It has been suggested that the low uptake of telehealth services during COVID-19 in older people and people with disabilities is a result of poor digital inclusion (Jayawardana et al., 2021); where limited access to the internet, affordability and digital literacy issues have created a barrier to accessing telehealth services for these high-need groups (Thomas et al., 2020). Around one in five older Australians and almost two in five people with disabilities do not use the internet (Australian Bureau of Statistics, 2020). In the United States, this technological divide has been directly linked to the poor adoption of video consults among these populations (Uscher-Pines et al., 2021a).

In Australia, variations in telehealth uptake are also reflected by the differences between and within states' digital infrastructure (Hardie et al., 2021, Jayawardana et al., 2021, Scott et al., 2021). MBS data shows that across states, Victoria has the highest uptake of video conferencing consultations, while Tasmania has the highest number of telephone consultations (Appendix C). This closely resembles digital capacity with Tasmania ranking lowest in Australia for access to the internet (Thomas et al., 2020).

Within states, telehealth consultations are concentrated in higher socioeconomic status areas, with a higher level of video consultations in these areas (Hardie et al., 2021). Although, data from New South Wales and Victoria reveals no significant difference in video and telephone consultations between urban and remote areas (Hardie et al., 2021). This the technological divide may be expanding in other states (Queensland and South Australia)(Thomas et al., 2020).

Equitable access

In Australia, health workforce capacity is unevenly distributed across the system (Phillips, 2019), affecting access to care, particularly for vulnerable population cohorts (Bickerdyke et al., 2007). While the expansion of telehealth at the onset of the COVID-19 pandemic was intended to help ease issues of access, a number of disparities for these cohorts still exist, for example, poorer access to the internet and/or inappropriate telehealth hardware (Barraket and Wilson, 2020). Issues of access have been highlighted in a survey of 800 Australian GPs which suggest a lower uptake of telehealth services in low socioeconomic areas compared to mid/high socioeconomic areas (Hardie et al., 2021).

Financial assistance and educational programs should be targeted to improving digital access and literacy to support disadvantaged communities making the most of telehealth's benefits; and improving digital infrastructure between and within the states is required to ensure equitable access to quality telehealth services in Australia.

4.2 Identifying high value services through MBS item review

Inadequacies associated with telephone consultations have been reported to include shorter consultation times, a fewer number of health concerns covered, and a lack of informal visual examinations or visual cues resulting in misdiagnosis (Campbell et al., 2014, McKinstry et al., 2010a, McKinstry et al., 2009, Rush et al., 2018).

The Australian Government has indicated videoconferencing as the preferred substitution for face-to-face consultations (Department of Health, 2020c)., and yet more than 90% of telehealth consultations are delivered via telephone (Snoswell et al., 2021).

The switch from telephone to video cannot be fostered through removing MBS items for telephone consultations, as this will limit access to care for the 2.5 million Australians who are not connected to the internet (Thomas et al., 2020). Instead, funding reforms are needed to promote the use of video conferencing while maintaining access to telephone services for communities with limited access to the internet.

Video consultations are perceived as being high cost by providers due to the difficulties associated with incorporating videoconferencing in existing business models, including implementing hardware across large practices and integration with appointment systems and practice workflow (Atherton et al., 2018, Mozer et al., 2015, Scott et al., 2021). Therefore, setting the same MBS fee for telephone and video-consults incentivises providers to choose telephone services. For example, in the United States, telephone consult reimbursement rates were increased to be equal with in-person and video visits, causing a surge in this modality, with one third of telehealth services subsequently being delivered by telephones (Jaklevic, 2020).

In Australia, while reducing MBS benefits for telephone consultations may reduce the overall costs associated with telehealth, if benefits become too low to cover the operational costs associated with telephone services, this will equally discourage providers from delivering telehealth services to patients with limited or no internet access (Uscher-Pines et al., 2021b).

A review of MBS telehealth items is required to identify settings where telephone consultations provide high value to patients, providers and Government. MBS telephone benefits should be adjusted to reflect service costs while allowing continuity of care for the 'digital divide population'. A 2010 study from the United Kingdom has previously recommended that telephone consultations may be more suited to follow-up and management of long-term conditions rather than for in-hours acute care (McKinstry et al., 2010b). Prioritising funding towards higher value services, such as video consults, will improve efficiency and benefit patients.

4.3 Training health workforce to be digitally ready

The low uptake of video consultations by providers has also been reported to be due, in part, to a lack of experience and training for videoconference services (Knott et al., 2020, Mozer et al., 2015, Scott et al., 2021). For example, an Australian study interviewing 448 GPs found a higher proportion of video consultations delivered by younger GPs (Scott et al., 2021), likely reflecting lifelong exposure to digital technologies and adaption to incorporating it in their lives.

Providers, such as specialists, who had access to MBS telehealth items before the pandemic also provided more video services during the pandemic compared to general practitioners, who are less established with telehealth service delivery (Scott et al., 2021). For example, in April 2020, at the start of the pandemic, specialists who had delivered care via video consultations since the introduction of the MBS items in 2011, delivered 20% of their non-in-person appointments via video, compared with only 2% delivered by GPs. This pattern has remained unchanged over the course of the pandemic (Appendix D).

Improving digital readiness within the health workforce requires the inclusion of telehealth in medical education and practical training programs. This should be coordinated by medical education providers and professional colleges.

To support these training programs and to reduce variation across practices, there is a need for national standards which outline the requirements for best practice delivery of telehealth care, optimising safety, quality, efficiency and value.

Alignment of occupational regulations relating to the provision of telehealth services is also required. Although national registration arrangements are in place for registered health professionals, there remain jurisdictional differences in scopes of practice for some Australian health professions due to state legislation, clinical context-specific guidelines, and employer or professional association-led credentialing (Leslie et al., 2021). For example, nurse practitioners can prescribe drugs in the ACT, but not in other states (Scanlon et al., 2016); and image based prescribing¹ is allowed for all drugs in ACT, but not in other states (Department of Health, 2020g).

¹ Image based prescriptions are faxed, or digital images of prescriptions, including prescriber signatures, are sent to pharmacy for dispensing of medication.

In the United States, variations across states' occupational regulations have resulted in unwanted variation in population health and access to care as well as to inefficiency in the health care system (Adams and Markowitz, 2018).

5 Improving safety and quality

5.1 *Monitoring performance and Patient Reported Outcome Measures*

Studies on the impact of telehealth services on patient safety and quality of care in Australia are limited (Bywood et al., 2013, Dillon & Loermans, 2003, Elliott et al., 2010). However, research reviews of international studies have shown that care delivered through telehealth meets safety and quality requirements as applied to face-to-face visits (Shaw et al., 2018; RACS, 2020). However, evaluation and performance monitoring of telehealth services in Australia will be critical to ensure safe and quality delivery of these services.

To monitor telehealth services, a performance and quality framework, including a national reporting tool, should be developed. At time of writing, an established digital health safety and quality standard is only available for mental health providers in Australia (Australia Commission on Safety and Quality in Healthcare, 2020).

Uptake of general practice telehealth services is monitored under the Digital Health indicators of the PHN Program Performance and Quality Framework (Department of Health, 2018b). It is measured as the rate of health care providers using smart forms, e-referral and or/telehealth. However, there is no separate measure for telephone versus video conferencing services. Given that there is a large gap between telephone and videoconferencing uptake in Australia, it is important to monitor these services separately. This will also support evaluation of the impact of training and education programs promoting videoconferencing in general practices.

In Australia, national quality indicators measuring health improvement from the use of digital health are still under development (Department of Health, 2018b). To support the rapid expansion of telehealth services and the development of alternative payment models, it is critical to develop a measure for patient outcomes as soon as possible.

National standardised patient reported outcome measures (PROMs), which capture patients' perception of their own health through questionnaires, should be used as a measure for health service improvement. The use of PROMs in the provision of patient-centred and value-based care and in improving quality, safety and efficiency in telehealth should be supported (Williams et al., 2016).

5.2 *Integrating data to enhance safety and quality*

In Australia, fragmentation of telehealth data between primary care and other health care settings limits the ability of service providers and governments to monitor and evaluate the impact of telehealth on long-term health outcomes, such as hospitalisation and aged care (Canaway et al., 2019). This is complicated by the fact that data on telehealth services is recorded as Medicare administrative data only and does not include services provided by hospital doctors to public patients or services under the Department of Veterans' Affairs National Treatment Account (Services

Australia, 2021). This creates an additional barrier for organisations, including Government, looking to evaluate the benefits or costs associated with telehealth services.

Due to variation between jurisdictions over time, the telehealth service data that is publicly available is not necessarily representative (Productivity Commission, 2020). This affects the ability to evaluate the impact of telehealth services at a local level. Data linkage should be supported to enhance safety and quality of telehealth services; and inform investment decisions facilitating equitable allocation of funding.

Routinely-linked health datasets can support development of a more rigorous evidence base on the clinical and cost effectiveness of health interventions (Productivity Commission, 2015), enabling identification of low value care and improving efficiency in the system. Improving the integration of hospital and other health service data at national level can enhance safety and quality. Linking administrative and survey data across the health system supports a richer understanding of how patients interact with services and their outcomes (Australian Institute for Health and Welfare, 2020a). This would contribute to the design of a quality indicator measuring long-term health outcomes for telehealth services, including its impacts on avoidable hospitalisation (Emery and Boyle, 2017). Evidence from these linked data could assist in fine-tuning MBS benefits to match the resource input requirements and the value achieved through different telehealth platforms.

Although there are existing linked datasets such as the Australian Longitudinal Study on Women's Health (Loxton et al., 2017) and 45 and Up Study (Banks et al., 2008), there is no national representative longitudinal linked dataset in Australia, making it even more difficult to evaluate a national program like telehealth.

Data development is required to allow primary care data to be linked with other state/territory data such as hospital, emergency, cancer, perinatal, births and deaths data; to capture information on medication errors and adverse events as a result of telehealth services; and to enable comparative study across different technologies.

6 Conclusions and recommendation

Since the introduction of telehealth items in April 2020, there has been a significant increase in the utilisation of telehealth services. This rapid rise in telehealth services could indicate both clinician and patient preference and acceptance of this delivery method. Given its benefit in reducing disparity in access to care, it is no doubt that telehealth services is becoming a valuable permanent component of the Australian healthcare system.

However, funding reforms are needed to ensure that telehealth services do not impact on the financial sustainability of the Australian health system. Blending the current fee-for-service model with bundled payments and add-on payments may slow health expenditure growth and improve efficiency through rewarding value over volume, and through promoting patient-centred care.

MBS restrictions limiting patients to a regular practice should be removed or further relaxed to maintain equitable access to care for all Australians. Review of telehealth MBS items should be conducted to identify low value and substitutable services, enabling the Government to redirect funding towards higher value services which can replace more costly face-to-face services. The

development of a telehealth primary care dataset, linkable with other parts of the health care system, is needed to ensure improved monitoring of the impact of telehealth policies on the whole system and to allow independent evaluation of such programs. Telehealth standards must be developed to support assurance of safety and quality, and these should be complemented by development of appropriate training for health professionals.

6.1 Recommendation 1: Blend payment methods for telehealth such as bundled payments and add-on payments to improve efficiency and reduce unnecessary costs

In order to contain expenditure and improve sustainability, the Australian Government Department of Health should trial payment models that are less reliant on fee-for-services to improve efficiency and contain costs, including:

- Providing financial incentives for training and adopting telehealth services through the eHealth Provider Incentive Program.
- Linking a population-wide Voluntary Patient Enrolment program, to telehealth MBS payments, with an option to opt-out to facilitate program uptakes.

6.2 Recommendation 2: Reviewing MBS telehealth items and re-directing funding towards high value services to reduce unwarranted variation

Review of existing MBS telehealth items is required to identify high value telehealth services. Funding should be redirected to these high value services in the form of MBS benefits adjustments, financial support for patients, health professional training and digital infrastructure.

To ensure equitable and continuous access to care and prevent the establishment of low value services the Australian Government Department of Health should:

- Relax the restriction for high-risk communities that have difficulties maintaining a relationship with a regular practice, such as people living in rural/remote areas, people with chronic health conditions or disabilities.
- Utilise Voluntary Patient Enrolment in telehealth services to promote patient choices and continuity of care.
- Promote the use of My Health Record in telehealth services to consumers and health professionals through training, education programs and financial incentives such as ePIP to ensure continuity of care.

6.3 Recommendation 3: Monitoring and evaluating the impacts of telehealth services on secondary care

The uptake of telehealth services nationally should be monitored under the PHN Program Performance and Quality Framework. However, the development of quality indicators that measure health improvement as a result of the use of telehealth services is required to enhance safe and quality delivery of these services, and to assess value. Performance measures that support the provision of patient-centred and value-based care such as Patient Reported Outcome Measures (PROMs), should be utilised.

6.4 Recommendation 4: Establish a primary care dataset, linkable to hospital and aged care data to support evidence-based funding reforms

The establishment of a primary care dataset that is linkable to other health data is needed to provide evidence to enhance safety and quality of telehealth services; and to inform investment decisions facilitating equitable allocation of funding. This will ensure proper monitoring of telehealth programs at a local level and support evaluation of the impact of telehealth on the health system.

6.5 Recommendation 5: Develop national telehealth standards to promote safe and high quality care

A national clinical practice standard for telehealth services should be established as a foundation for training, to ensure safe and high quality delivery of care and to improve the efficiency of the health system.

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Appendix A: COVID-19 telehealth policy changes, as of 19 March 2021

Date	Summary of policy changes
12 May	Regular practice requirements for a range of sexual, reproductive and mental health services were lifted in the 11 May 2021 Commonwealth Budget.
13 March 2020	COVID-19 telehealth MBS items commenced. Access to MBS items were available for GPs, mental health providers and medical specialists, where patients and GPs were required to self-isolate, or patients were considered vulnerable.
16 March 2020	Items were expanded to midwives and recognise a general practice for continuity of care (rather than an individual GP).
23 March 2020	All vulnerable GPs, and other vulnerable health professionals who are currently authorised to use telehealth item numbers, to use telehealth for all consultations with all their patients. This includes health care providers who are: <ul style="list-style-type: none"> • Aged at least 70 years old. • Indigenous and aged at least 50 years old. • Pregnant. • Parents of a child under 12 months. • Immune compromised. • Have a chronic medical condition that results in increased risk from coronavirus infection.
30 March 2020	Telehealth items were expanded for all patients, with or without COVID-19, to see to see any GP, medical specialist, mental health or allied health professional during the COVID-19 health emergency.
6 April 2020	Health providers could apply their usual billing practices to telehealth consultations, but the new services must be bulk-billed for concessional or vulnerable patients, or a child under 16 at the time the service is provided. New MBS items were introduced for telehealth and telephone services for consultant physicians, geriatricians and consultant psychiatrists.
20 April 2020	Specialists and allied health providers were no longer required to bulk-bill COVID-19 telehealth. New MBS telehealth items were introduced for a practice nurse or an Aboriginal and Torres Strait Islander health practitioner.
20 July 2020	Telehealth GP providers will be required to have an existing and continuous relationship with a patient in order to provide telehealth services. A relationship is defined as the patient having seen the same practitioner for a face-to-face service in the last 12 months, or having seen a doctor at the same practice for a face-to-face service during the same period. Exemptions includes: <ul style="list-style-type: none"> • People receiving the telehealth service from a GP at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service. • Infants (< 12 months).

	<ul style="list-style-type: none"> • People experiencing homelessness. • People in a COVID-19 impacted area.
1 October 2020	The temporary telehealth and phone consultations were extended until 31 March 2021. GPs were no longer required to bulk bill telehealth services for any patients.
	The temporary telehealth and phone consultations were extended until 31 March 2021. GPs were no longer required to bulk bill telehealth services for any patients.

Appendix B: Practice Incentives Program eHealth incentive requirements

Requirement 1: Integrating Healthcare Identifiers into Electronic Practice Records

The practice must:

- i. apply to Human Services to obtain a Healthcare Provider Identifier–Organisation (HPI–O) for the practice, and store the HPI–O in a compliant clinical software system,
- ii. ensure that each general practitioner within the practice has their Healthcare Provider Identifier–Individual (HPI–I) stored in a compliant clinical software system, and
- iii. use a compliant clinical software system to access, retrieve and store verified Individual Healthcare Identifiers (IHI) for presenting patients.

Requirement 2: Secure Messaging Capability

The practice must have a standards-compliant secure messaging capability to electronically transmit and receive clinical messages to and from other healthcare providers, use it where feasible, and have a written policy to encourage its use in place.

Requirement 3: Data Records and Clinical Coding

Practice must ensure that where clinically relevant, they are working towards recording the majority of diagnoses for active patients electronically, using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system. Practices must provide a written policy to this effect to all GPs within the practice.

Requirement 4: Electronic Transfer of Prescriptions

The practice must ensure that the majority of their prescriptions are sent electronically to a Prescription Exchange Service (PES).

Requirement 5: My Health Record system

The practice must:

- i. use compliant software for accessing the My Health Record system, and creating and posting shared health summaries and event summaries,
- ii. apply to participate in the My Health Record system upon obtaining a HPI–O, and
- iii. upload shared health summaries for a minimum of 0.5 per cent of the practice’s Standardised Whole Patient Equivalent (SWPE) count of patients per PIP payment quarter.

3 Appendix C: Medicare statistics used for calculations

Table 1. Numbers of GPs standard attendance, by mode of delivery length of services

Services	Video conferencing	Telephone	Total
GP attendance for an obvious problem	61,538	2,364,201	2,425,739
GP attendance less than 20 minutes	613,235	29,308,361	29,921,596
GP attendance at least 20 minutes	147,208	2,610,644	2,757,852
GP attendance at least 40 minutes	30,223	183,231	213,454
Total	852,204	34,466,437	35,318,641

Source: Medicare data, January 2020 – January 2021.

Table 2. Numbers of GPs services, by types of services

Services	Video conferencing	Telephone	Total
Standard attendance	852,204	34,466,437	35,318,641
Health Assessment for People of Aboriginal or Torres Strait Islander Descent	1,532	15,489	17,021
Chronic Disease Management	56,586	496,602	1,136,049
Autism, Pervasive Developmental Disorder and Disability Services	3	26	29
Pregnancy Support Counselling program	248	4,152	4,400

Eating Disorder Management	462	4,278	4,470
Mental Health Services	49,229	597,279	646,508
Urgent After Hours Attendance	4,102	34,629	38,731
Total	964,366	35,618,892	37,165,849

Source: Medicare data, January 2020 – January 2021.

Table 3. Telehealth uptake by states

Services	Via	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
General practitioners	Videoconference	286,252	339,414	136,616	36,798	76,241	17,298	11,032	7,384	911,035
	Telephone	10,724,778	12,746,691	6,142,248	2,397,634	2,322,377	748,678	363,568	123,871	35,569,845
Other medical practitioners	Videoconference	15,869	28,149	11,302	3,018	4,026	495	872	116	63,847
	Telephone	303,861	488,775	164,948	78,939	56,527	13,319	10,434	2,186	1,118,989
Allied health	Videoconference	25,317	48,767	13,040	2,411	3,348	994	1,223	153	95,253
	Telephone	61,861	166,734	77,246	28,075	18,551	6,358	1,624	547	360,996
Mental health	Videoconference	271,812	576,325	149,168	36,706	45,858	15,915	16,398	1,608	1,113,790
	Telephone	165,416	244,244	106,846	41,607	31,053	13,972	4,625	1,807	609,570
Specialist	Videoconference	280,116	520,429	116,275	32,270	39,907	9,292	11,862	1,368	1,011,519
	Telephone	1,246,088	1,790,313	496,486	254,458	197,962	75,214	36,241	6,532	4,103,294

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Obstetric Attendances	Videoconference	3,924	8,269	1,497	559	1,283	282	59	21	15,894
	Telephone	31,625	47,623	15,577	7,234	12,719	913	1,467	228	117,386
Participating Midwifery	Videoconference	677	1,979	979	159	225	54	7	4	4,084
	Telephone	911	2,069	1,919	2,571	4,652	415	30	20	12,587
Total		13,418,507	17,009,781	7,434,147	2,922,439	2,814,729	903,199	459,442	145,845	45,108,089

Source: Medicare data, January 2020 – January 2021

Table 4. Telehealth uptake, by types and providers

	General practitioners		Specialists	
	Telephone	Videoconference	Telephone	Videoconference
Mar-20	94.07%	5.93%	81.14%	18.86%
Apr-20	96.22%	3.78%	81.63%	18.37%
May-20	97.06%	2.94%	80.49%	19.51%
Jun-20	97.29%	2.71%	79.83%	20.17%
Jul-20	97.56%	2.44%	79.80%	20.20%
Aug-20	97.71%	2.29%	79.04%	20.96%

Source: AIHW data (Australian Institute of Health Welfare, 2020a).

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Suggested citation: Tran M and Haddock R. (2021). Deeble Issues Brief No. 43: Towards a sustainable funding model for telehealth in Australia. Australian Healthcare and Hospitals Association, Canberra, Australia.

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