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APPLIED ECONOMIC & SOCIAL RESEARCH

COPING WITH COVID-19: RETHINKING AUSTRALIA

Taking the Pulse of the Nation 2020

9. The Future of Healthcare After COVID-19

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9 THE FUTURE OF HEALTHCARE AFTER COVID-19

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COVID-19 has caused a significant disruption in the use of healthcare, changing the way healthcare is delivered. Innovative models of delivery supported by changes to funding models while reducing waste are key lessons going forward.

How the fall in the use of healthcare during the pandemic has changed how care is delivered.

Australia's health sector is the largest part of the economy at 10 percent of GDP (Australian Institute of Health and Welfare 2020). In early 2020 when Australia recorded the first cases of COVID-19, a priority was to 'protect' the health sector, so it had the capacity to treat a potentially large number of COVID-19 cases. As a result, many non-urgent elective surgeries or routine care (e.g. dental exams) were suspended or delayed. This caused a large fall in utilisation of healthcare, especially hospitals, that has since re-bounded as the backlog is being cleared. In addition, people have been avoiding visiting healthcare providers because of fear of contracting the virus, or from facing new financial hardship and being unable to afford out-of-pocket costs. This has led to continuing falls in the membership of private health insurance and the downgrading of insurance cover (Zhang, Liu and Scott 2020).

The changes in demand and patterns of use during COVID-19 presented significant challenges for healthcare providers who had to rapidly adapt by introducing new models of care and ways of working while being concerned about their own safety. This included sharp increases in the use of telehealth consultations supported by new Medicare funding in March, funding for electronic prescribing, and closer integration between public and private hospitals to ensure sufficient capacity. As we emerge from the pandemic, what have we learned and what are the priorities going forward?

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What we have learned during COVID-19

By the end of the first wave (June), around 14 percent of Australians reported that they did not seek healthcare when they needed. This trend has continued increasing despite many states and territories having no new cases of community transmission. By October, 20 percent of respondents reported avoiding healthcare when needed (Figure 9.1).

Younger people, especially men, are more likely to avoid needed healthcare. Among men, 28 percent of those aged 18-44 and 12 percent of those aged 65+ avoided needed care in October; among women, 21 percent of those aged 18-44 and 11 percent of those aged 65+ did so. This pattern continued from June to October.

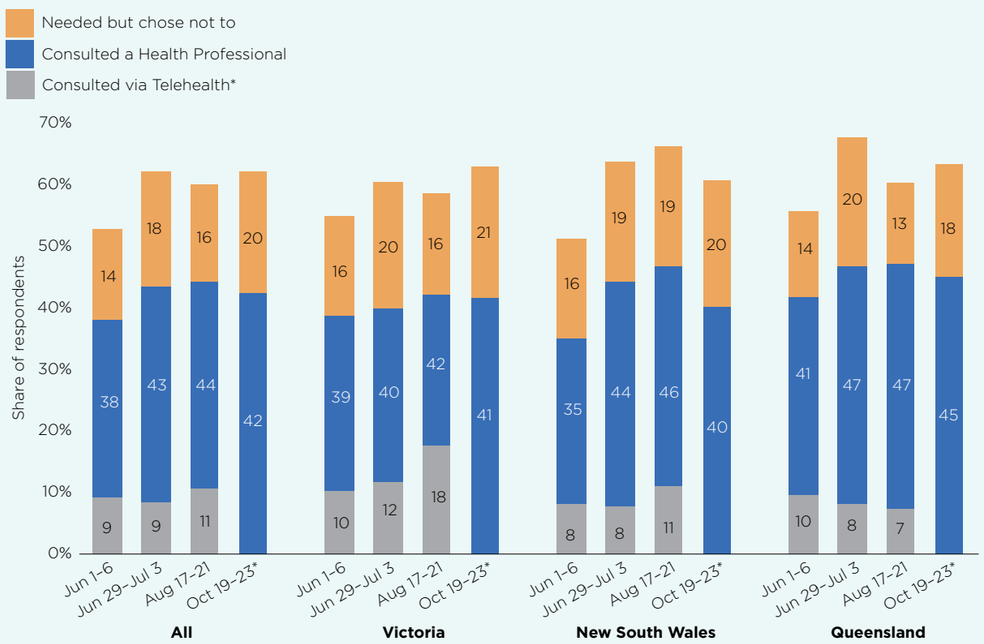
People with financial stress are three times more likely to avoid needed healthcare: 37 percent among those financially stressed, 14 percent among those making ends meet, and 13 percent among those financially comfortable in October. The disparity persisted from June to October.

People with high mental distress were seven times (53.1 percent compared with 8.1 percent) more likely than those with low mental distress to avoid consulting a health professional when needed (Figure 9.2). This disparity worsens over time. In October, 53.1 percent of those with high mental distress avoided seeking healthcare when they needed to. The longer the disparity persists, the more serious the downstream consequences for individuals and for the healthcare system.

The use of telehealth has increased since June 2020. Victoria, in particular, saw a notable increase in the use of telehealth in August when it faced a second surge of COVID-19 cases and imposed strict lockdown policies (Figure 9.1).

At the national level, use of telehealth increased sharply in the second quarter for both GP and specialist services as face to face consultations plummeted. Telehealth accounted for 34 percent of all GP consultations, 33 percent of mental health consultations provided by GPs, and 27 percent of all specialist attendances (Australian Government - Services Australia 2020). Only three percent of telehealth GP consultations were via video with the rest by phone, while 16 percent of telehealth specialist consultations were via video. Use of telephone may be appropriate for some consultations, but not for others.

Figure 9.1 Changes in Healthcare Utilisation Over Time, by State



Source. *Taking the Pulse of the Nation* survey (Melbourne Institute), waves 9, 13, 17, and 21. Sample sizes are 1,200 in each wave. The sample is stratified by gender, age and location to be representative of the Australian population.

Notes for Figure 9.1 The vertical axis indicates the proportions (%) based on weighted responses. *'Consulted via telehealth' was not asked in Oct 19-23.

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Financial barriers are one reason why people avoid needed care. Job loss and falling wages because of COVID-19 coupled with ever-increasing out of pocket costs is a key issue. Bulk-billing incentives should be targeted at the most vulnerable groups, or at those living in the most disadvantaged suburbs, including those with mental health problems and families suffering financial hardship. Patients need to be able to access better information on out of pocket costs and quality of care. Price transparency is still in its infancy, but doctors should be mandated to publicly post their fees and likely out of pocket costs to consumers.

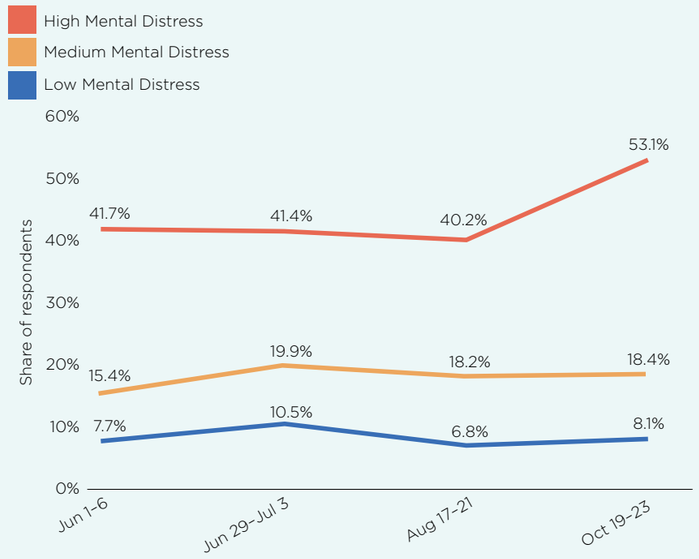
Though telehealth has helped meet the needs for patients during the pandemic, its potential beyond the pandemic has been widely recognised, in addition to other digital technologies (e.g. digital monitoring, electronic prescribing) to support healthcare at home rather than in hospitals. In other countries telehealth has been used and shown to be effective in palliative care, urgent care, behavioural health, after-hours hospital medicine, and emergency room triage (Calton et al. 2020, Hollander and Carr 2020). A key issue, however, is that almost all telehealth services in Australia were provided via phone instead of video, especially for GP consultations. Though using a telephone may be appropriate for some types of care (e.g. follow up and discussion of test results), video is preferable for others where physical examination and non-verbal communication play a key role in diagnosis.

The recent announcement to fund Telehealth permanently is a welcome policy, but funding going forward needs to recognise the potential higher value of video consultations compared to telephone through differential Medicare rebates; now telephone and video consultations attract the same rebate.

During the pandemic, both patients and providers have been forced to re-think what healthcare is necessary and what is not. Others have shown low-value care is common and that there is substantial 'waste' in the system (Badgery-Parker et al. 2019). Governments and private health insurers together need to re-think funding models to support only necessary, high value healthcare, delivered in the right settings including out of hospital where appropriate. Current funding models re-enforce the status quo and encourage high volumes of care that does not always improve patient's health and may cause harm. Taxpayer funding that is used to subsidise care in both the public and private sectors should be removed for low-value care.

Governments and private health insurers together need to re-think funding models to support only necessary, high value healthcare

Figure 9.2 Percent of People With Mental Distress Who Avoided Needed Healthcare



Source. *Taking the Pulse of the Nation* survey (Melbourne Institute), waves 9, 13, 17, and 21. Sample sizes are 1,200 in each wave. The sample is stratified by gender, age and location to be representative of the Australian population.

Notes for Figure 9.2 The vertical axis indicates the proportions (%) based on weighted responses. We categorised mental distress to high, medium and low levels by using answers to the question "during the past week about how often did you feel depressed or anxious?" in the survey. We define those responded with "most" to "all" the time as high mental distress, those responded with "some" of the time as medium mental distress, and those responded with "a little" or "none" of the time as low mental distress.

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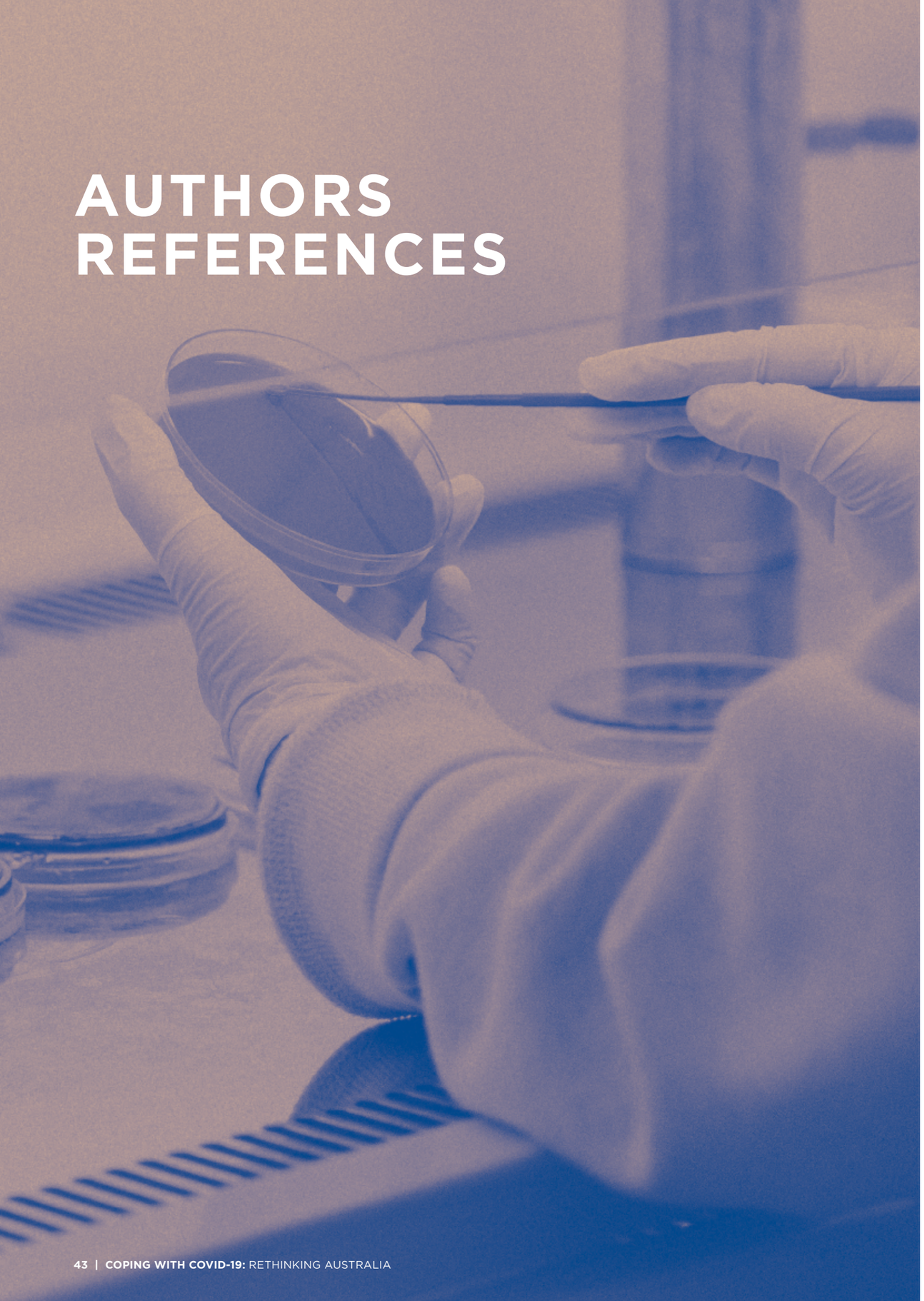

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To draw comparisons with Australian's economic and social outcomes before COVID-19, this report also uses other survey data collected in the years before the pandemic. This report uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and is funded by the Australian Government Department of Social Services (DSS) and is managed by the Melbourne Institute: Applied Economic & Social Research (Melbourne Institute). The findings and views reported in this report, however, are those of the authors and should not be attributed to either DSS or the Melbourne Institute.

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The *Taking the Pulse of the Nation* survey was created for the purpose of being able to track the economic and social wellbeing of Australians and to provide measures of attitudes and willingness to take on risk given the coronavirus pandemic. These data have been used to provide timely insights that track behaviour and inform policy.

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