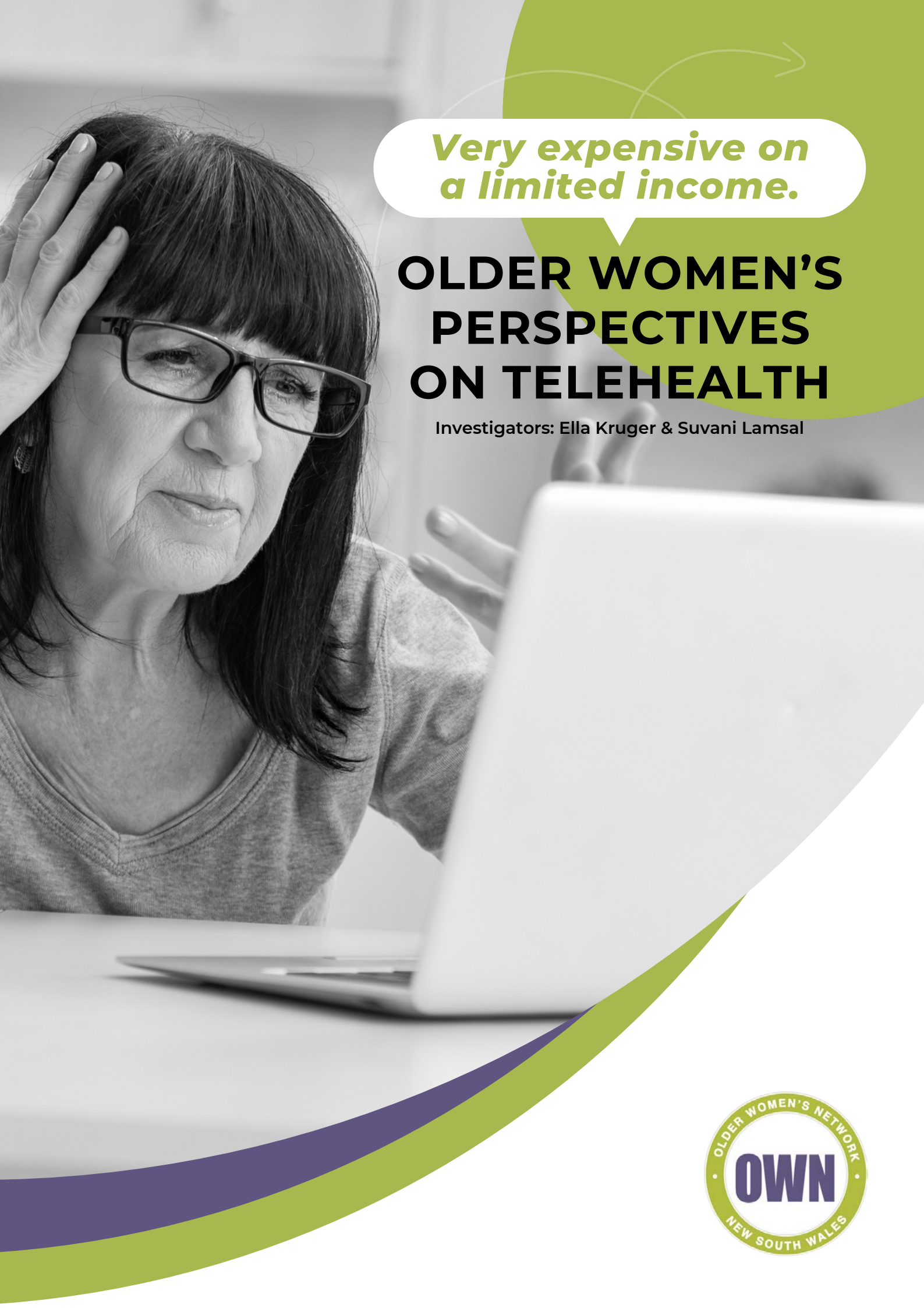

Very expensive on a limited income.

OLDER WOMEN'S PERSPECTIVES ON TELEHEALTH

Investigators: Ella Kruger & Suvani Lamsal

OLDER WOMEN'S NETWORK NEW SOUTH WALES
OWN

This is a publication by the Older Women's Network NSW.
This study was led by Yumi Lee, CEO, Older Women's Network NSW and Professor Dimity Pond.

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TELE
HEALTH

FOREWORD

I am pleased to introduce this report on older women's experience of telehealth as it highlights how much more we have to do to improve accessibility to healthcare for older people, especially older women.
The pandemic has impacted all our lives in so many ways, not least of which is the way healthcare is being delivered today. With lockdowns, we have had to innovate and use technology. However, as this study shows, the use of telehealth does have its limitations. It is important to be aware of these as we rush to seek answers to healthcare challenges in technology.

I would like to thank Professor Dimity Pond and Yumi Lee for leading this study, and Ella Kruger and Suvani Lamsal for their excellent investigation. Thanks are also due to Professor Pat Bazeley who has assisted with the study.

We hope that this report will add to the information which policy makers refer to in ensuring that older people, especially older women, are not forgotten in the design of healthcare policies.

Beverly Baker
National President
Older Women's Network

May 2023

BACKGROUND

Australians have the right of the highest attainable wellbeing and health (Attorney-General's Office, 2022). Fundamental to that right, is a healthcare system that is accessible in "safe physical reach" and "affordable for all" (Attorney-General's Office, 2022).

Safe physical reach to healthcare is especially important for Australians who live in rural and remote areas, with less healthcare facilities, and Australians with mobility concerns (AIHW 2022; Annaswamy et al 2020).

Similarly, affordable, quality healthcare is important for Australians who are marginalised socio-economically (AIHW 2022). Affordability is particularly crucial for groups including older people, women, First Nations people, and people from culturally and linguistically diverse (CALD) backgrounds.

THE ROLE OF TELEHEALTH

In Australia, telehealth is shown to promote healthcare access. Telehealth is the umbrella term for all healthcare services operated through landline telephone and digital communications, including telephone calls, video calls, email and remote monitoring (Dykgraaf, 2021). This report will focus on telephone and video calls.

Telehealth improves access by reducing the need for patients' travel (RACGP, 2017). Reduced commuting impacts people in rural Australia, people who need to regularly visit a practitioner, and people with limited resources to commute to access healthcare.

In Australia, the average commute to a healthcare service is 40 minutes (Productivity Commission, 2017). This is alongside poor public transport in rural areas, where travel can take hours, the high petrol costs required to drive to practitioners, and further challenges for people with mobility concerns (Barbieri & Jorm, 2019).

40 minutes is the Australian average commute to a healthcare service.

Older Australians are more likely to attend healthcare after hours.

For older Australians, a demographic most likely to visit healthcare regularly with both chronic and acute illness and more likely to attend healthcare after hours, accessibility is even more important (AIHW, 2021).

Research by the RACGP has shown that telehealth, for these reasons, increases healthcare attendance (Fisher et al, 2022). However, there are concerns about how older people access telehealth. Key amongst these are the fact that with telehealth, there is a lack of visual cues for patients who are deaf, not fluent in English, or do not have high health literacy and may require visual cues to assist understanding.

Further, telehealth requires patients to not only own but be confident with a digital device to contact their practitioner, unless they are using a telephone landline. Telehealth consultations via video calls are especially challenging, as they generally require more expensive devices and the cost of internet usage.

Affordability is a key contributor to the digital divide, disproportionately impacting older people and First Nations Australians (Australian Digital Inclusion Index 2022). Therefore, although telehealth is a crucial pillar for enabling the human right of accessible healthcare, it is necessary to consider a patient-oriented model, which builds on the tools and strengths of service users.

THE ROLE OF THE MEDICARE BENEFITS SCHEDULE

Medicare cover is another fundamental element of accessible telehealth. The Medicare Benefits Schedule rebate system is a universalised healthcare scheme that provides patients attending a general practitioner (GP) or specialist, at a cost either partially or fully covered by the federal government. Hospitals are funded by the State government with a contribution from the federal government (Services Australia, 2022).

Subsidised consultations, for example through Medicare, are essential for equitable healthcare access especially for Australians with lower incomes or living in poverty.
The fact that older Australians account for 16% of healthcare attendance, while comprising 30% of the population points to an underlying inequity of access to healthcare (AIHW 2021).

Older Australians, especially women, have disproportionately low incomes. Approximately 34% of single older women live in poverty (Older Women's Network 2020, 6). Therefore, the out-of-pocket cost of healthcare is prohibitive. Where appointments are bulk-billed (ie with no "gap" payment) under Medicare, the human right of accessible healthcare can be realised.

16%
of healthcare attendance are older Australians, while comprising 30% of the population.

34%
approximately, of single older women live in poverty.

Unfortunately, pressure on medical costs has meant that GPs and other services cannot necessarily “bulk bill” their patients, and increasingly a gap fee is being charged. Moreover, Medicare does not cover all healthcare services, including ambulance services, healthcare in some private facilities, and medical services which are deemed “not clinically necessary” (Commonwealth Ombudsman Private Health Insurance n.d.).

The clinical necessity of telehealth has rapidly changed in the past three years since the COVID-19 pandemic due to the need for patients with Covid to self-isolate. During the early part of the pandemic, telehealth consultations were mandatorily bulk billed, but this is no longer the case.

ORIGIN OF MEDICARE COVERED TELEHEALTH IN AUSTRALIA

In 2006, the first Medicare cover for telehealth was launched to empower accessible healthcare (Dykgraaf, 2021).

In 2006 the first medicare cover for telehealth was launched.

The first service was telephone and online mental health services for Aboriginal and Torres Strait Islander people, and people living in rural and remote Australia (Dykgraaf, 2021).

This aimed to address the boundaries of not culturally appropriate or not geographically nearby healthcare for these groups (Dykgraaf, 2021).

Due to the high uptake, the Federal government expanded Medicare cover to include telehealth for other services, including general practitioners (GPs), nurses and allied health (Dykgraaf, 2021). However, into the late 2010s, availability of bulk-billed telehealth was for only limited item numbers.

TELEHEALTH IN THE PANDEMIC - POLICY AND UPTAKE

In 2019, with the outbreak of the coronavirus, telehealth became a clinical necessity for the human right to accessible and safe healthcare. Telehealth was fundamental to Australia's healthcare as it reduced the high risks of transmission when commuting to healthcare practitioners.

In March 2020, then Minister for Health and Aged Care, Greg Hunt announced the expansion of Medicare cover for both GPs and specialists' telehealth consultations (Hunt & Kidd 2020). The expansion included approximately 300 new telehealth items, available to the whole population (Dykgraaf, S. H. et al. 2021; Hunt & Kidd 2020).

Further, GPs were permitted to practice telehealth at an expanded 80:20 ratio, meaning practitioners could provide 80 bulk-billed telehealth services on 20 or more days per twelve months (Department of Health and Aged Care 2022). Essentially, this allowed practitioners to provide more telehealth services to those who needed them.

↑ **73%** increase in telehealth use in Australia in 2020

These measures were embraced by practitioners and patients alike. Taylor et al found that 2020 saw a 73% increase in telehealth use in Australia (Taylor et al, 2021). In the first month of increased telehealth items since COVID-19, there were more than 4.3 million telehealth consultations (Hunt 2020). Moreover, an expanded 94,144 practitioners offered telehealth services.

The most common group accessing healthcare in Australia was women aged 65 to 74, who comprised 38% of telehealth attendance (Australian Bureau of Statistics, 2021). Telehealth was also used regularly by people with long-term health conditions, and those living in inner-regional areas (Australian Bureau of Statistics, 2021). The RACGP also cite many telehealth consults since Covid have been for mental health services (Tsirtsakis, 2022).

Since the expansion of telehealth, phone calls have been the preferred mode, making up 88% of Medicare telehealth numbers (Centre for Online Health, 2022). Video calls are the second most common platform, however substantially lower at 12% (Centre for Online Health, 2022).

38% of telehealth attendance were women aged 65 to 74.

The phone call has been the preferred mode.

The initial expansion of Medicare telehealth cover was planned for six months, until September 2020. However, as COVID-19 continued to present high health risks, it was extended until December 2021, with an additional 40 specialist services (Department of Health and Aged Care, 2021). Subsequent Medicare cover of telehealth was updated in similar six-month instalments in response to the danger posed by COVID-19. As mentioned above, there is no ongoing requirement for telehealth items to be "bulk billed" and a private additional charge may be made.

In December 2021, the Department of Health, then under Greg Hunt, announced spending to establish telehealth as a "permanent" feature of Australian healthcare (2021). However, on January 1 2022, the Department of Health announced a substantial reduction in Medicare rebates for telehealth, on the premise that higher rates of vaccination reduced telehealth's role.

The announcement saw 128 of the newly instated telehealth items removed and 17 amended (Department of Health, 2022). Similarly, the 80:20 ratio for telehealth to face-to-face GP consultations was replaced with a 30:20 mandatory ratio meaning practitioners could only bill a reduced 30 telehealth consultations on 20 or more days per twelve months (Department of Health, 2022).

The reduction of telehealth availability was critiqued by practitioners and service users alike. Isautier et al demonstrate that "telehealth has the potential to reduce inequality" and the RACGP stated that telehealth resources are crucial for promoting flexible and affordable care for all patients, especially those with less mobility and financial resources (Isautier et al, 2020; RACGP, 2017).

With the emergence of the highly transmissible Omicron strain, the reduction in telehealth item numbers was suspended on January 16 (Department of Health and Aged Care, 2022). However, this was again on a temporary basis until 30 June and 1 July 2022 (Department of Health, 2022).

Reduced telehealth cover impacts safe access to healthcare with a high risk of COVID-19, and affects people with already limited access to healthcare facilities.

CURRENT POLICY AND USER EXPERIENCE

Since the June and July 2022 updates to telehealth Medicare cover, 117 GP and 51 specialist telehealth item numbers remain (Department of Health and Aged Care, 2022). This drastically reduced telehealth cover severely restricts the accessibility to healthcare by those unable to pay for services. Items such as mental health care plans and chronic disease management plans can only be billed if they are delivered by video, and not by telephone. Moreover, the patient has to have seen the GP within the last 12 months, unless the consultation is Covid related.

> ***Removing these Medicare rebates is particularly detrimental for older patients, Aboriginal and Torres Strait Islander people, those with disability, and for some people living outside major cities, including rural areas.***
>
> **Bruce Willet**
> **Chair of the Queensland RACGP**

Reduced telehealth cover impacts safe access to healthcare and increases the risk of contracting COVID-19, especially for those whose immune systems are compromised. It affects people with already limited access to healthcare facilities. The RACGP has strongly criticized the policy. The Chair of the Queensland RACGP, Bruce Willet, highlighted how the most vulnerable in the community will be impacted, stating, “removing these Medicare rebates is particularly detrimental for older patients, Aboriginal and Torres Strait Islander people, those with disability, and for some people living outside major cities, including rural areas” (Martin 2022).

Natural disasters, such as flooding are another scenario where at least a telephone consult (even with a distant doctor) would be possible and advantageous in instances where there may not be a doctor available in person. The reduced telehealth cover negatively impacts these vulnerable groups of people who need to deal with the trauma of rebuilding their lives.

Patients with complex medical conditions, long commutes to practitioners and lower immunity have expressed similar distress in light of the policy change, describing the move as a “devastating” loss to their only safe means of healthcare access (Shepard, 2022).

Moreover, of the remaining telehealth items, 119 are for video conferencing, with only 49 item numbers for telephone consultations (Department of Health and Aged Care, 2022).

This division of cover does not reflect patients' telehealth use, which, over the course of the pandemic, has shown a high preference for telephone consultation over video conference (RACGP, 2022). This policy disproportionately impacts Australians already socio-economically excluded from the healthcare system through their lack of devices and inability to afford the cost of connectivity.

Practitioner research shows this will primarily impact older women and Aboriginal and Torres Strait Islander people, who are excluded from access to healthcare opportunities due to patriarchy, ageism and colonialism (Martin, 2022). Less financial resources mean that these groups are not equally able to access healthcare without Medicare rebates, and are not able to purchase the technology and internet connection necessary for video conferencing consults.

These changes do not reflect the patient’s resources, experience of telehealth over the past two years, and needs. Further, it is discriminatory to vulnerable groups.

This inequitable distribution of healthcare is described by Hart's Inverse Care Law, whereby the availability of quality medical care varies inversely among the populations who most need it (Hart 1971). This is shown to be exacerbated without robust public medical cover.

Since July 2022, some cover has been reinstated by the new government, such as allowances for GPs to conduct telehealth appointments at an 80:20 ratio with face-to-face appointments, and longer consultations via telehealth (Woodley 2022; Tsitsakis 2022).

However, these measures have only been extended until October 2022, despite the RACGP calling for these to be permanent fixtures of telehealth for accessible healthcare (Tsirtsakis 2022).

For both practitioners and patients, healthcare workers have described the impact of reduced and inconsistent telehealth Medicare as "simply not financially viable", and ultimately, "unethical" (Shepard 2022).

DIGITAL SPREAD

In the last four years, the number of Australians using the internet has increased significantly. We are now one of the most prominent users in the world, third only to the USA and Sweden.

In the USA and Australia, studies have shown that there are obvious inequalities in the availability of internet access depending on a variety of factors such as education, income, and age. In the USA, race and ethnicity also influence access to the internet.

Although geographical location in Australia does not directly determine the availability of internet access, there are still rural and regional regions with a digital divide.

The cost of Internet access in rural and regional Australia is higher than in metropolitan areas.

The number of people in Australia who can use computers at home has increased significantly, however, the number of people in the country who can access the internet has not (Curtin, 2001). The fact that the cost of internet access in rural and regional Australia is higher than in metropolitan areas definitely impacts accessibility (Curtin, 2001).

There are fewer people with high income and tertiary education in regional and rural areas compared metropolitan areas. This also reflects the digital divide as it influences the number of people who can access the internet (Curtin, 2001).

Although the digital divide is decreasing following the COVID-19 pandemic with more people working from home, groups like the older population are still struggling to keep up (Ewing, 2016). It was found that 80% of people older than 65 find it difficult to keep up with technology changes (Ewing, 2016).

80%
of people older than 65 find it difficult to keep up with tech changes.

DEMOGRAPHICS

16%
of healthcare attendance are older Australians, while comprising 30% of the population.

34%
of older Australians are not living in a metropolitan centre.

Older women have substantially less superannuation than men.

67%
of older Australians cite the pension as their main source of income, with 78% of Australians over 85 relying mainly on the pension.

6 out of 10
Australians surveyed by the ANU are concerned that the current single-aged pension of $944.30 per fortnight is not enough to get by.

30%
of women do not have an income stream compared with 7% of men who retire without a personal income.

37%
of older people, were born overseas, predominantly in Europe and South-East Asia, and many speak a second language at home.

People over 60 make up 16% of the Australian population, and 30% of healthcare consultations (AIHW, 2021). Among older people, 37% were born overseas, predominantly in Europe and South-East Asia, and many speak a second language at home (AIHW, 2021). However, there remain marked gaps in the data with older people who are First Nations or from a CALD background (AIHW, 2021). Older Australians also are more likely to live in rural or regional areas, with 34% not living in a metropolitan centre (AIHW, 2021).

Older people's socioeconomic status is mostly determined by the aged pension or other government support. Many people retire due to illness or lack of available work, with 67% of older Australians and 78% of Australians over 85 citing the pension as their main source of income (AIHW, 2021). However, with the current single-aged pension at $944.30 per fortnight, six out of ten Australians surveyed by the Australian National University are concerned this is not enough to get by (Biddle, Breunig & Marasinghe, 2021).

As people get older, they are less likely to have private health insurance because they have less finances. However, their need to attend healthcare facilities increase. Further, there is a strong correlation between lower socioeconomic status and a higher need for healthcare, especially for potentially avoidable causes (Hart, 1971). Research has confirmed that the key barrier to healthcare access is cost.

Cost barriers to healthcare are even more prohibitive for older women, who are more likely to retire than men without a personal income and greater need for government support (Australian Bureau of Statistics, 2019). Compared with the 7% of men who retire without a personal income, 30% of women do not have an income stream (Australian Bureau of Statistics, 2019). This means often, older women have to rely on male partners or children; or if they live alone, have an even lower income and higher risk of poverty.

Due to cumulative gendered working inequalities, older women have substantially less superannuation than men (Australian Bureau of Statistics, 2019). Often, older women do not have enough money from government subsidies alone to live a "comfortable lifestyle" (Office for Women 2006; Older Women's Network, 2020). For this reason, older women have a bigger need for strong government policy to provide financial assistance, including the Medicare Benefit Scheme.

OUR RATIONALE

This policy paper investigates how older women in Australia have used telehealth in the past year (2021-2022) under the expanded Medicare cover to demonstrate the importance of, and challenges for, older women accessing these services.

Research on the impact of the expanded telehealth cover has begun to emerge in the past two years, clearly suggesting a positive reception of telehealth, favouring the continuation of the service (Matthew, Lee, Ianno & Benson, 2021). However, there is a gap in the literature regarding older people's experience, especially older women's experience and that of older people from culturally and linguistically diverse backgrounds.

As mentioned above, older women are both more likely to be in need of healthcare and have less resources to access it easily and safely. Older women's needs should be included in future telehealth and Medicare policy. In this study, we have attempted to address this gap of understanding the needs of older women for access to telehealth through a survey of 400 older women, 12% from a CALD background.

This paper offers insight and feedback from these women to assist in the creation of a more patient-centred Medicare telehealth policy, which focuses on the rights, health and resources of older women, who have been discriminated against in the recent telehealth reductions.

Telehealth services need to be accessible, affordable and responsive to the needs of the diverse population - including for older people.

METHODOLOGY

An eighteen question survey was distributed through the Older Women's Network (OWN) NSW mailing list, to gather data about older women's use and experience of telehealth in the past year. The aim was to understand the impact of the reduced Medicare for telehealth services in June and July 2022 and promote older women's perspective on this policy change.

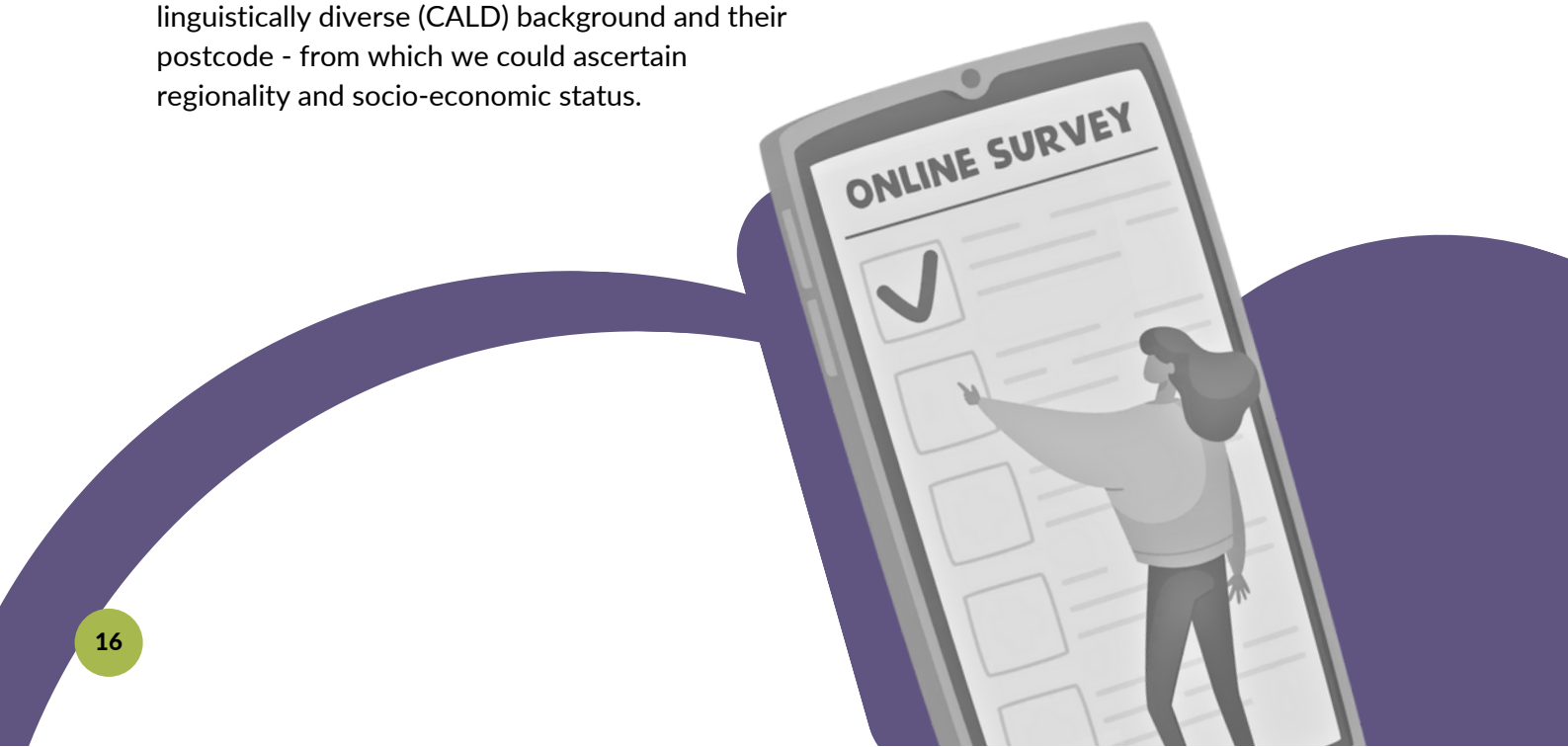
The survey was developed by OWN NSW, in collaboration with Professor Dimity Pond from Western Sydney University. The survey aimed to capture older women's use of telehealth covered by Medicare, and the importance of these services for older women's safe and equitable healthcare access. The survey also seeks to understand which groups are most affected by the reduced Medicare cover for telehealth, especially groups with less access to mainstream healthcare due to cultural, geographical and financial needs.

The survey aimed to capture older women's use of telehealth covered by Medicare, and the importance of these services for older women's safe and equitable healthcare access.

To develop the survey, we reviewed the pre-existing literature on telehealth in Australia. We reviewed literature about telehealth and its reception before the pandemic, the impact of the pandemic on telehealth policy and its subsequent reception. We also reviewed the literature on older women's financial status.

We specifically investigated the demographics of older women, such as the diversity of culture, access to digital devices, financial inequality and age distribution in Australia. The literature review aimed to inform the background of our survey, the gaps in the literature the survey sought to fill, and the apparent inequities our survey aimed to highlight among older women.

Eighteen survey questions were subsequently developed to meet the study's aims. The first questions gathered information about the demographics of the respondents, including their age, whether they are Aboriginal or Torres Strait Islander, whether they are from a culturally and linguistically diverse (CALD) background and their postcode - from which we could ascertain regionality and socio-economic status.



These questions were included because the literature shows that different groups have different resources to access healthcare, and can be discriminated against in the healthcare system. These factors are important to enable us to analyse the socio-economic inequities which correlate with healthcare inequities.

The next questions surveyed whether older women had used telehealth in the past year and what they understood to be the main benefits and challenges of accessing these services. The questions were also divided between telephone and video telehealth, as the literature shows these are the two primary modes of telehealth. We wanted to ascertain the frequency of the use of these modalities as there is a discrepancy in funding with more video call telehealth receiving continued Medicare cover compared to telephone telehealth calls.

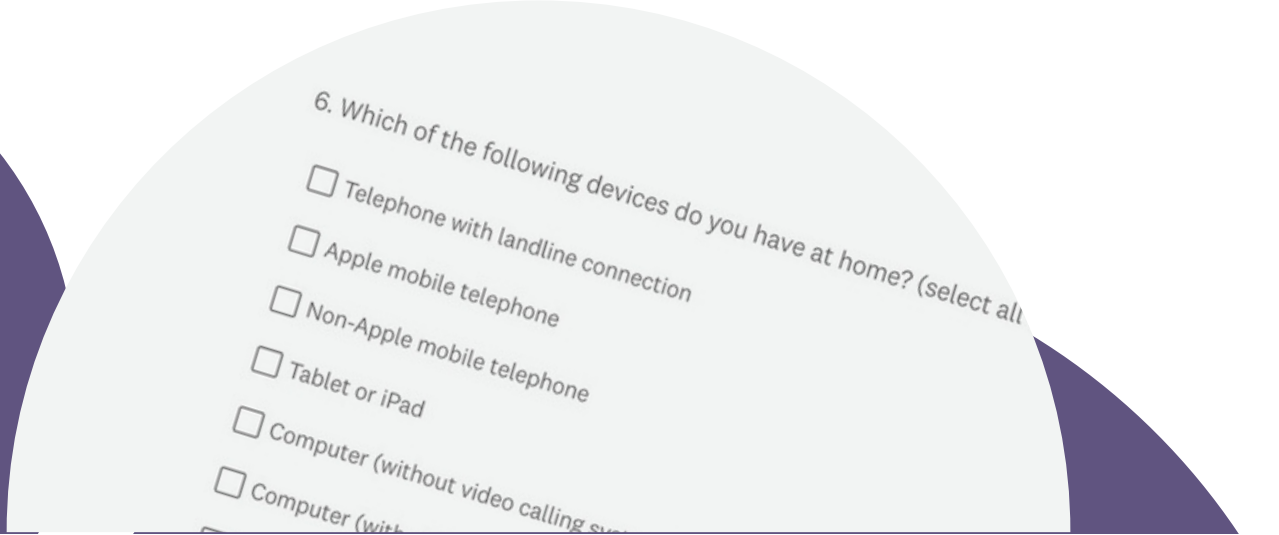
These questions would provide us with information as to whether the mode of telehealth impacted older women's equitable and safe healthcare access.

The survey was distributed to the OWN NSW's 4,000 person mailing list. The survey was distributed via email, with a link to complete the survey online on the online survey platform Survey Monkey.

Twenty surveys were also followed up in person, using a paper version of the Survey Monkey form. These were conducted at the OWN Bankstown Wellness Centre, to ensure the research also included responses from individuals who are less confident with online forms and email. The OWN Bankstown Wellness Centre also has more older women from CALD backgrounds, whose perspectives are important for inclusion.

All respondents were informed by a written message before the survey about their rights and confidentiality when completing the survey, and what their responses would be used for. All respondents were also offered email addresses of OWN staff to contact with any questions and concerns.

The results from Survey Monkey were automatically downloaded by the software into a spreadsheet, to which we manually added the paper responses. To analyse the data, we aggregated the data in ten-year age brackets, socio-economic status based on the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD), and regionality based on postcode classification from the Australian Government Department of Agriculture, Fisheries and Forestry website. Qualitative responses were analysed to find main themes in each question. We also collaborated with research consultant Professor Patricia Bazeley to analyse the raw data sets.



RESULTS

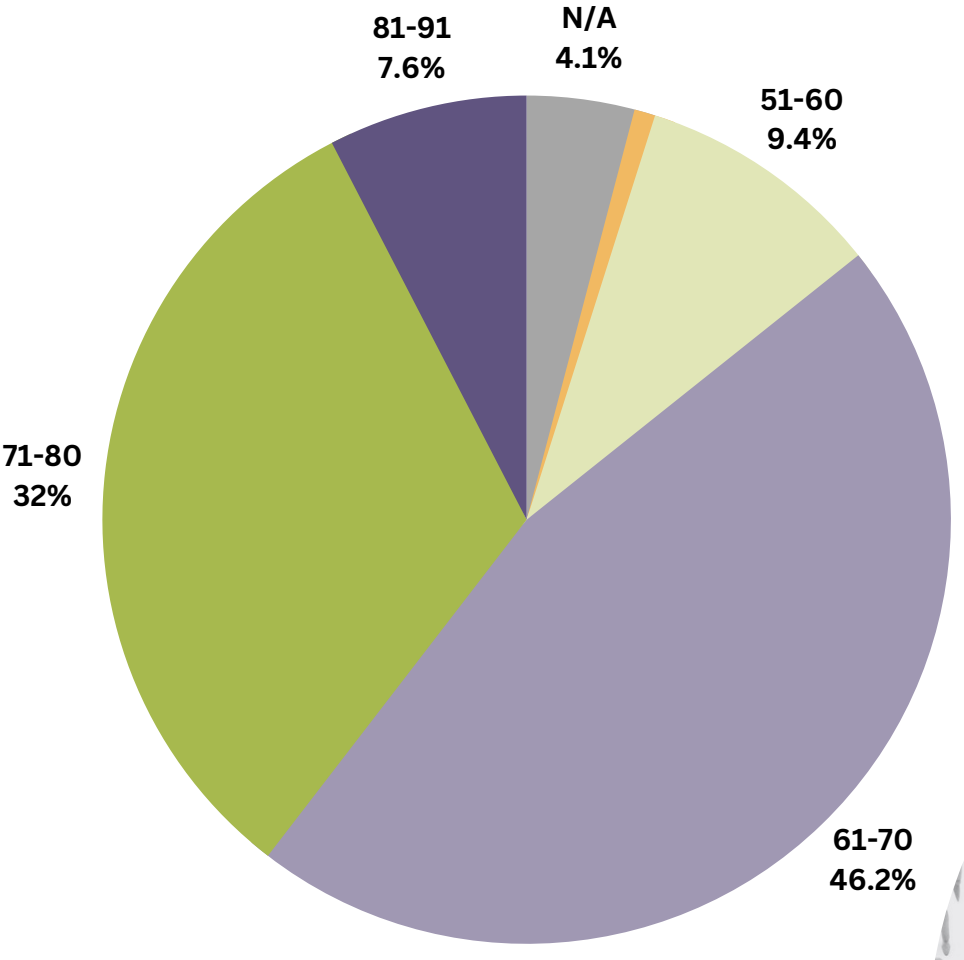
RESPONDENTS

In total, of the 4,000 people contacted, 400 people participated in our survey. This is a 10% response rate. However, 6 (1.5%) of the responses were from males and as this group was too small to reliably gather data from, their responses were eliminated from the analysis. Of the remaining 394 responses, 376 surveys were completed on Survey Monkey and 18 were completed in person. The following graphs detail the demographic groups of the respondents.

98.2% of respondents described their gender as female.

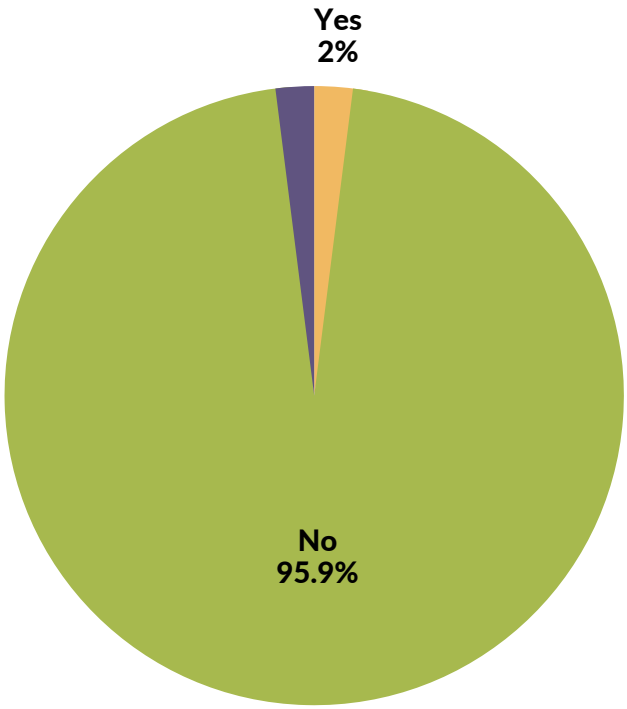
Q. WHAT IS YOUR AGE?

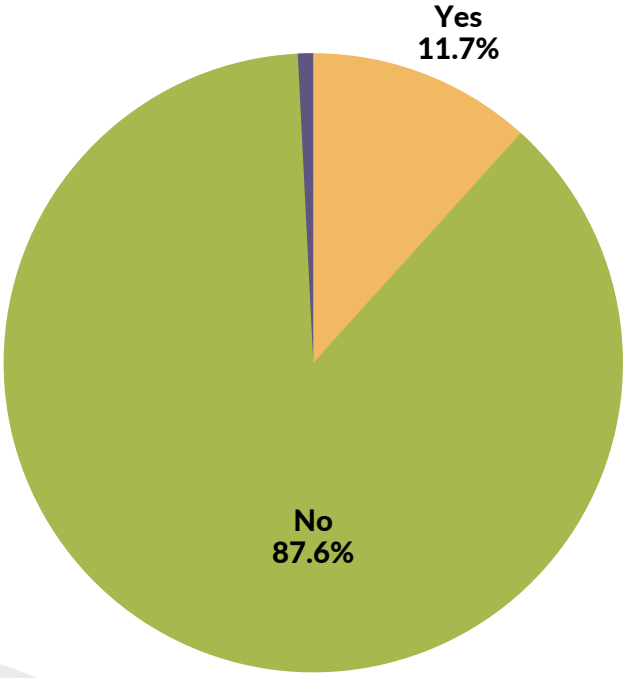
Of the survey respondents, the age range was 46 to 91. The most common age bracket was 61 to 70, comprising 46.2% of the survey data. The smallest age group was 40 to 50, only comprising 0.8% of the data, and 3 responses. Overall, the median respondent age was 69 and the mean was 69.3, with a standard deviation of 7.5.



Q. ARE YOU ABORIGINAL OR TORRES STRAIT ISLANDER?

In the study, 2% of the respondents are Aboriginal or Torres Strait Islander. This is less than the 3.2% of the number of Aboriginal and Torres Strait Islander people in the total Australian population (Australian Bureau of Statistics, 2022). A further 2% of respondents selected “prefer not to say” to this question.





Q. ARE YOU FROM A CALD (CULTURALLY & LINGUISTICALLY DIVERSE) BACKGROUND?

Of the participants, 11.7% were from a CALD background. This is a significant portion of the respondents; however, it is also lower than the overall percentage of older people in Australia from a CALD background. In Australia, 37% of older people are from a CALD background and many speak a language other than English at home (AIHW, 2022).

Q. WHAT IS THE POSTCODE WHERE YOU MOSTLY LIVE?

The respondent's primary residence was divided into rural and metropolitan areas based on the postcode classification from the Australian Government Department of Agriculture, Fisheries and Forestry website.

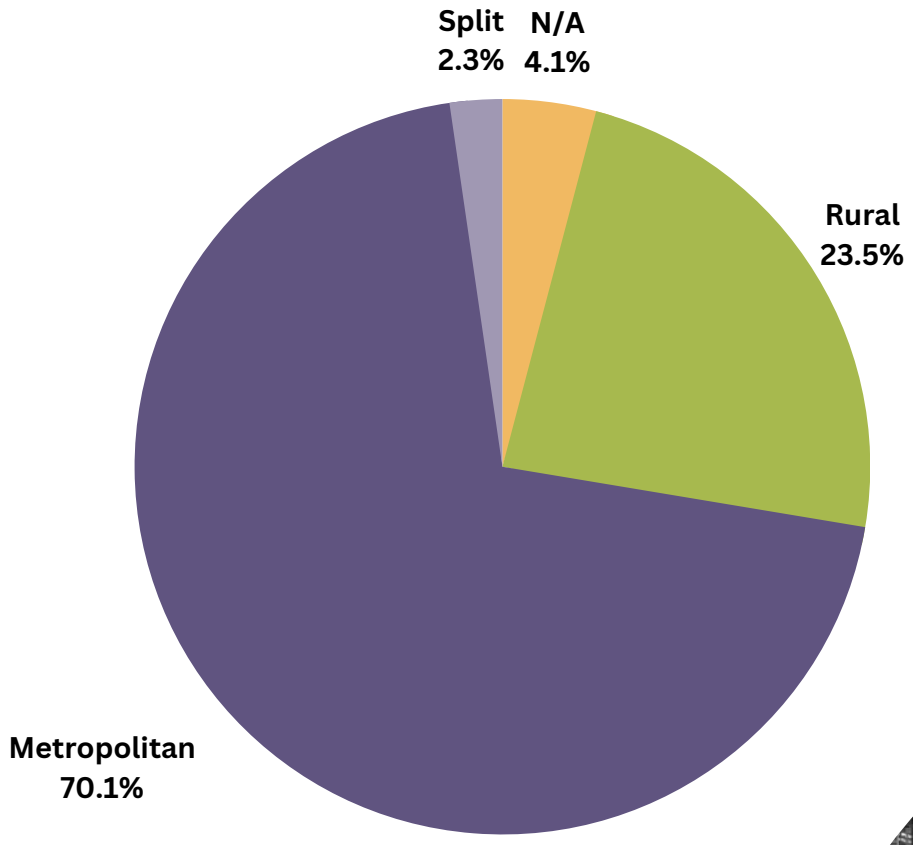
Based on this scale, 70% of the survey respondents were from a metropolitan area, with 68% of those in the greater Sydney region. 23% were from a rural or regional area. 2.3% were from an area split across both metropolitan and regional categorisation and 4.1% did not provide a postcode.

Ninety-one point six percent of the people who responded live in NSW, and 2.5% live in interstate Australia. The remainder did not respond.

The respondent's primary residence was also used to determine a difference in an individual's socio-economic status, using the Australian Bureau of Statistics Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) mapping.

The IRSAD scale accounts for "access to material and social resources, and ability to participate in society", from 1, limited access and greater disadvantage, to 5, high access and socio-economic advantage (Australian Bureau of Statistics, 2018).

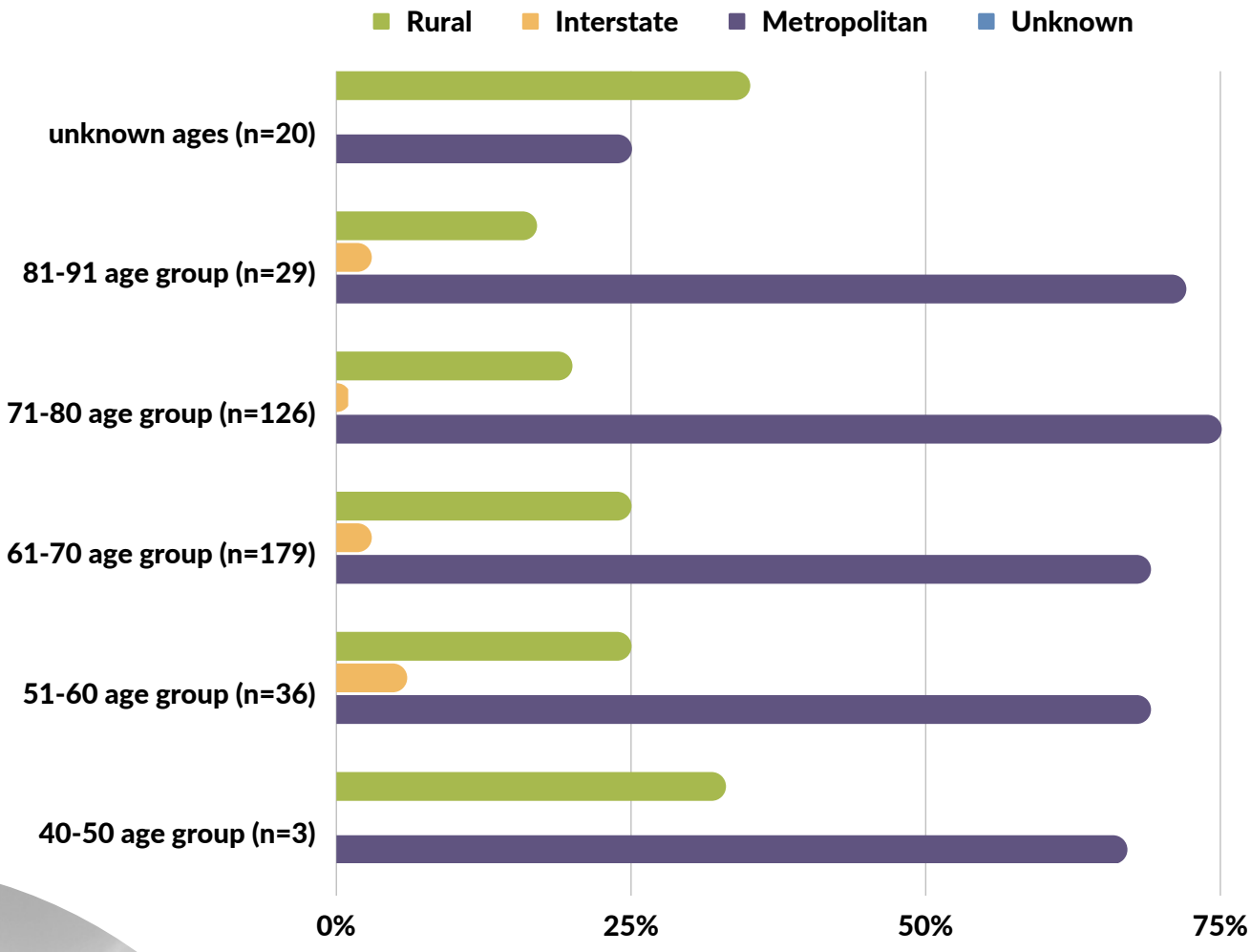
The average IRSAD area of the survey respondents was 3.8, meaning most survey respondents lived in more advantaged areas.



QUANTITATIVE DATA ON TELEHEALTH DISAGGREGATED BY TEN YEAR AGE BRACKETS

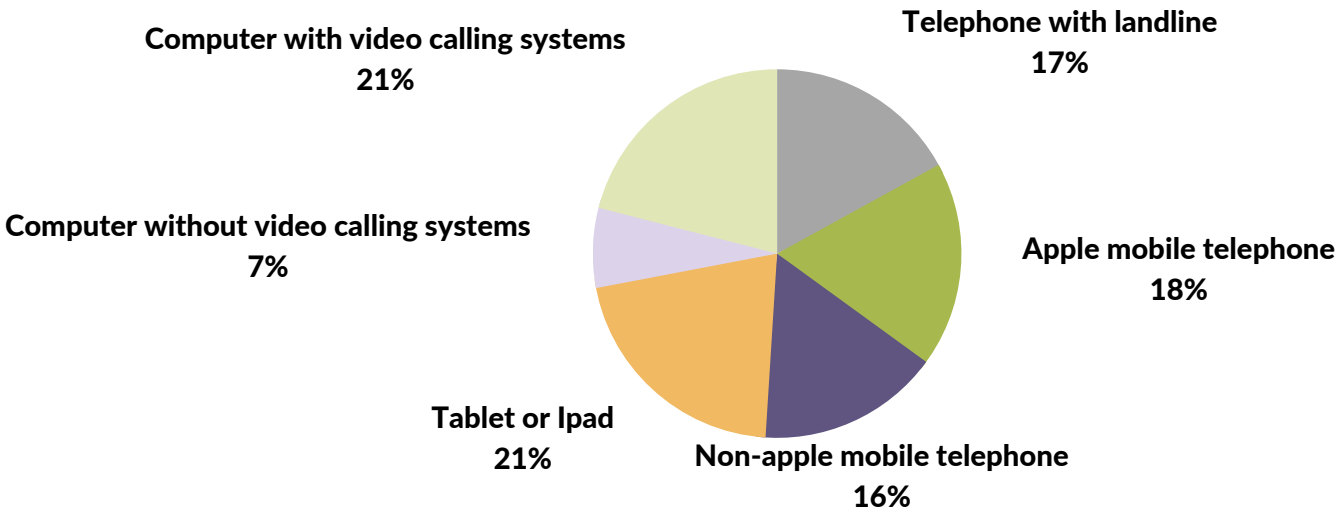
Older women use healthcare more often than younger women (Deeks et al, 2009). Older women also have less financial resources than younger women (Wilkins, 2017). Therefore, clearly understanding how age impacts telehealth use can guide more patient-centred Medicare policies.

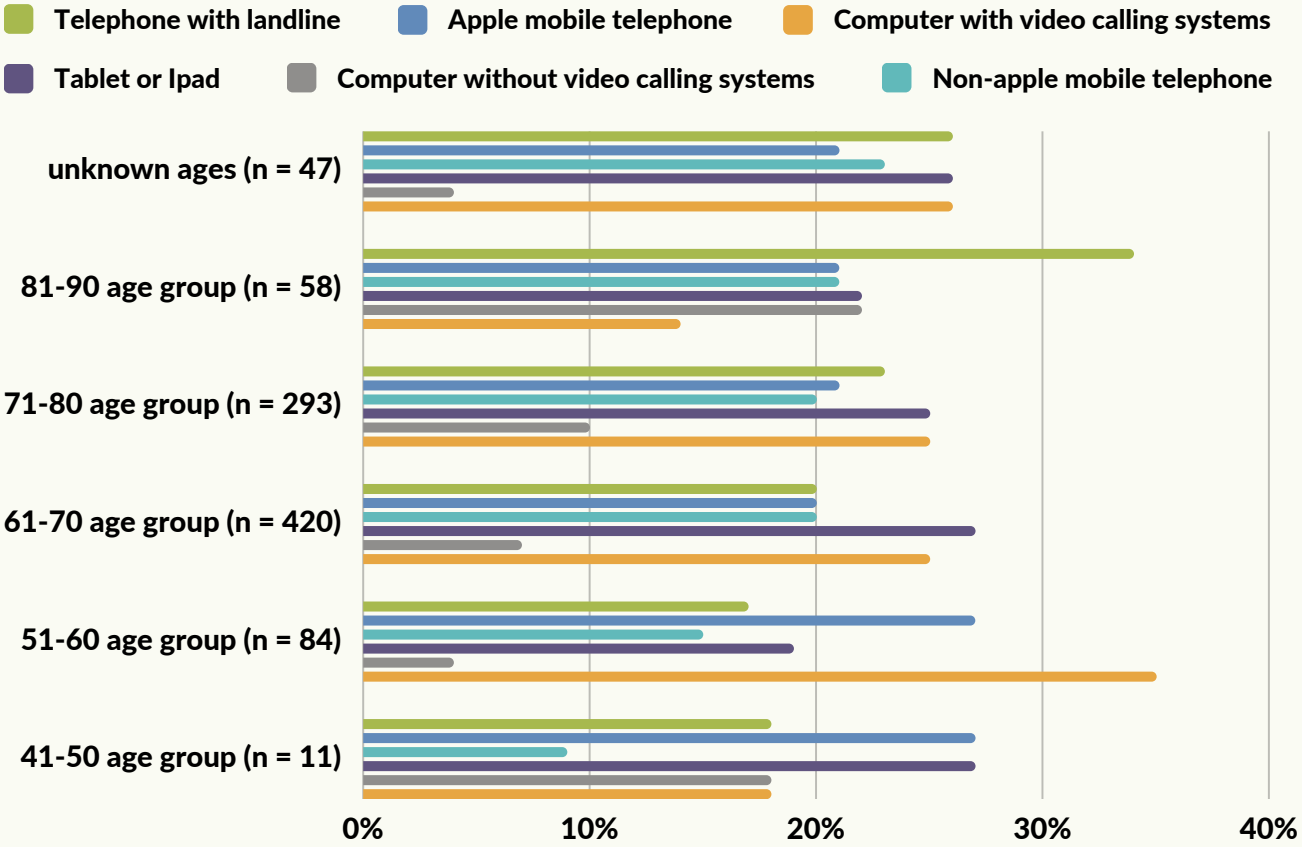
The graph below shows the number of people in different age groups living in rural, metropolitan, or split (half rural, half metropolitan) areas. Throughout all age groups, the number of respondents in metropolitan areas is higher than that of respondents living in regional areas.



Q. WHICH OF THE FOLLOWING DEVICES DO YOU HAVE AT HOME?

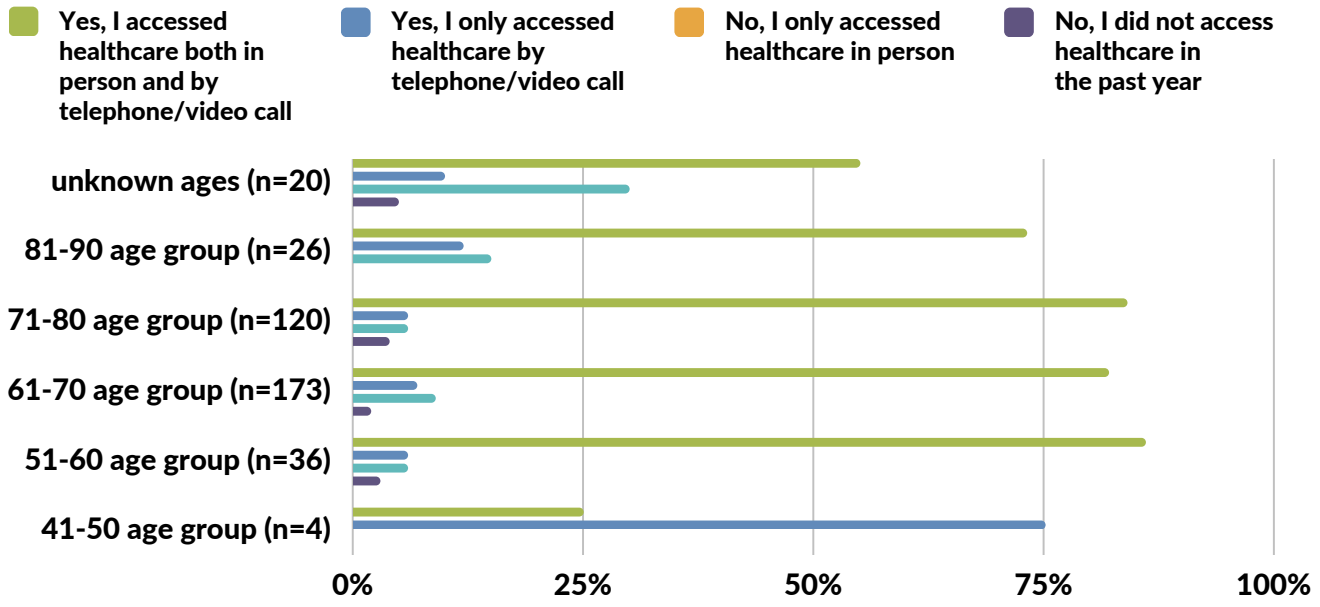
The graphs below show the overall increased use of computers with video calling systems and tablets or iPad, compared to other devices. The use of tablets or iPads is especially high among the age groups of 61-70 and 71-80. The use of computers with video calling systems decreased in the 81-90 age group. This can impact access to video consults for this age group. The use of Apple mobile phones is high among younger age group brackets (40-60), but its usage decreases for older or unknown age groups.





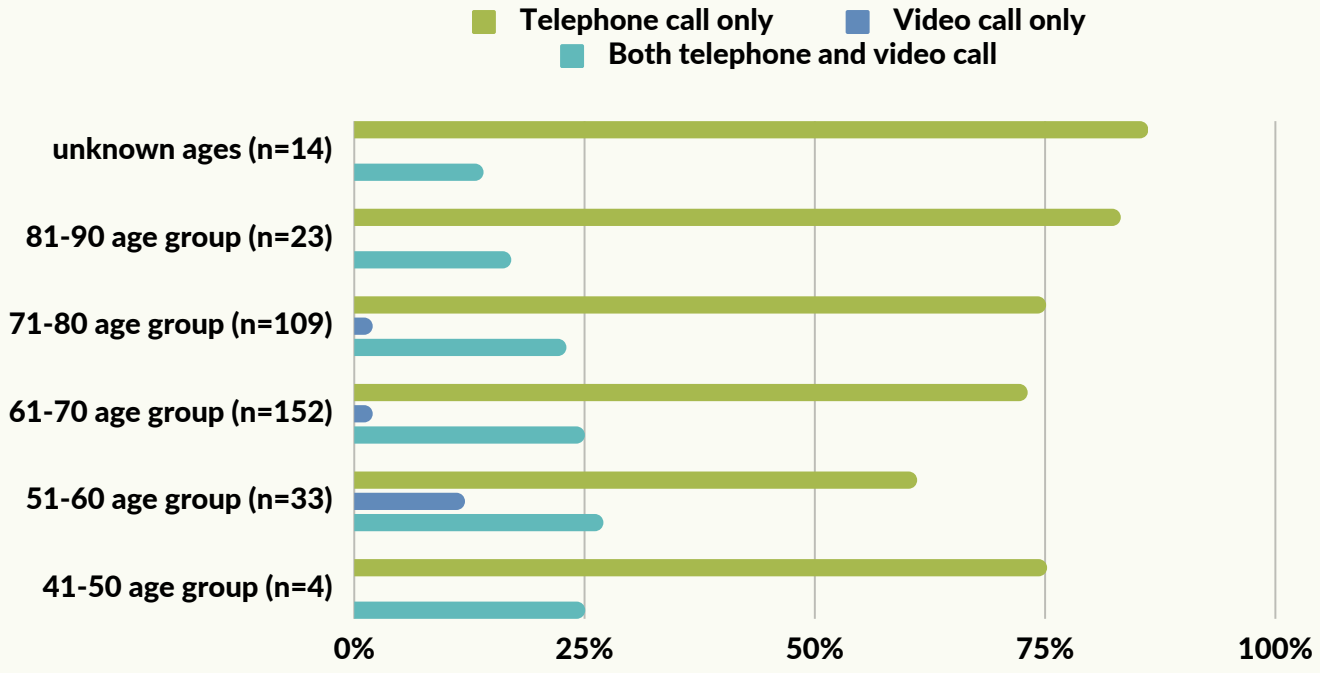
Q. IN THE PAST YEAR, DID YOU ACCESS A HEALTHCARE CONSULTATION BY TELEPHONE OR VIDEO CALL?

The graph below shows that only the youngest group reported greatest healthcare access by telephone/video call. All other groups used both face-to-face and telehealth as their greatest form of access, The older groups showed a greater proportion of access only in person. It also shows how, overall, only a small percentage of respondents had not accessed healthcare in the past year.



Q. WHICH PLATFORM DID YOU USE?

The graph below shows how most respondents access telehealth through the telephone instead of video calling.

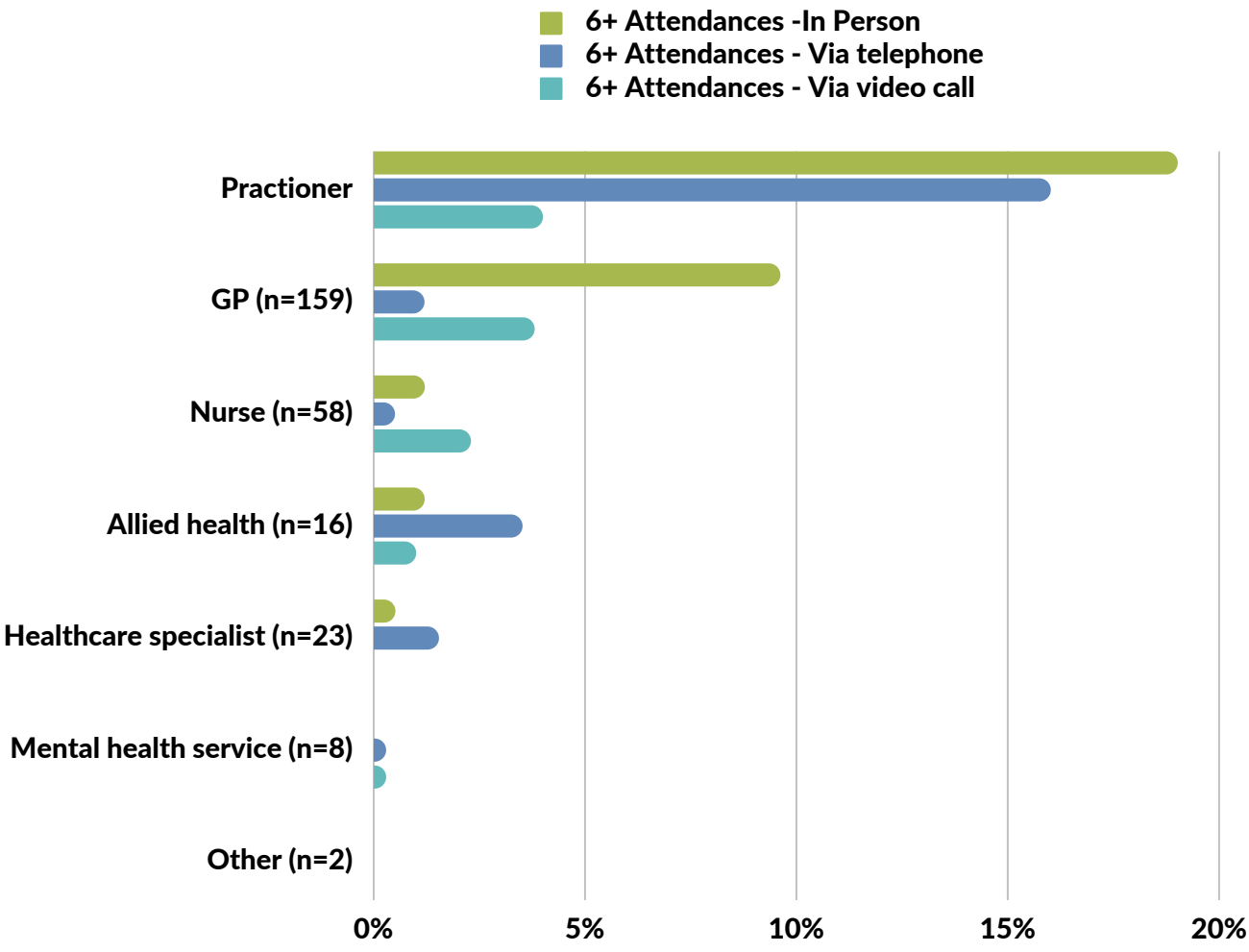


Q. IN THE PAST YEAR, APPROXIMATELY HOW MANY TIMES DID YOU SEE A HEALTHCARE PROFESSIONAL IN THE FOLLOWING SETTINGS?

This question offered responses of 0-5 attendance and 6+ attendances.

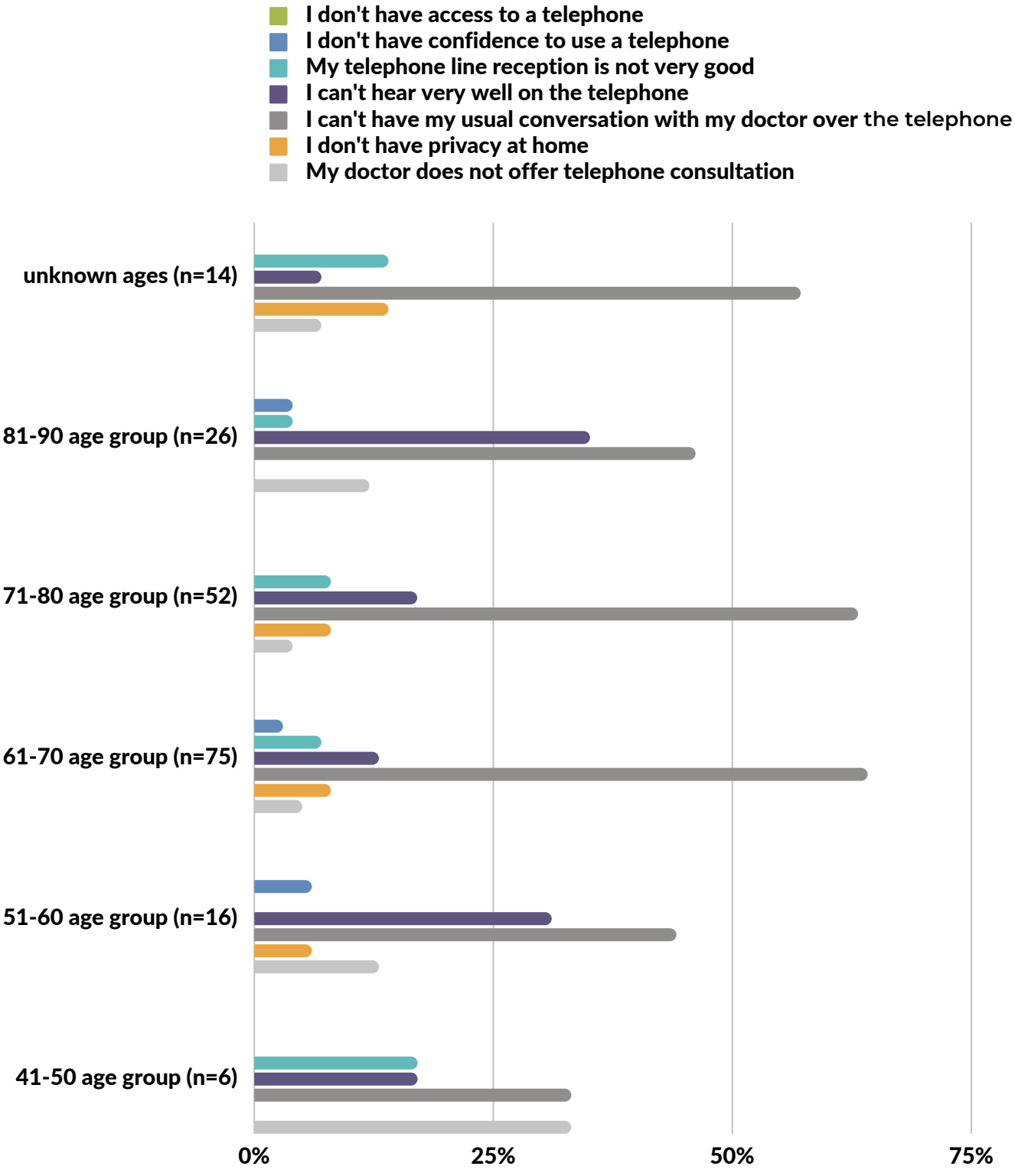
For the 6+ responses, GPs and nurses were the services which the participants were most likely to attend in person. However, the services which the respondents were most likely to attend 6+ times via telephone call included mental health services and healthcare specialists. Overall, excluding nursing, all services were more likely to be attended 6+ times via some form of telehealth, be that phone or video, than face-to-face between 2021 and 2022.

For technical reasons, the data from the 0-5 responses was unreliable and for the purpose of analysis, we are focusing on the 6+ responses only.



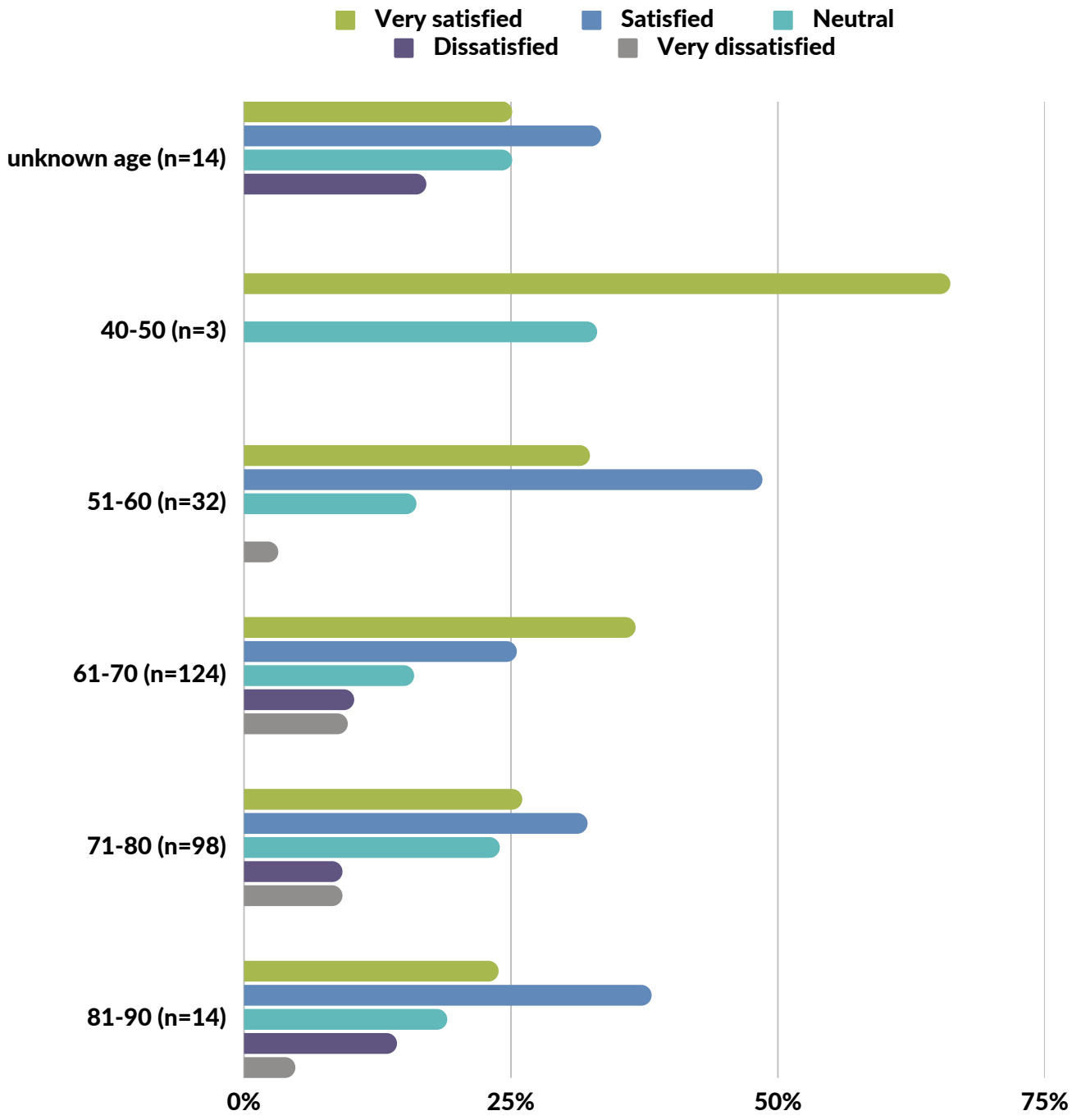
Q. WHAT ARE YOUR PRIMARY CONCERNS ABOUT TELEHEALTH HEALTH CONSULTATIONS?

The most common concern regarding telehealth was that the respondents felt they could not have their usual conversations with their doctor over the telephone. Concerns relating to hearing is also reported in older age groups.



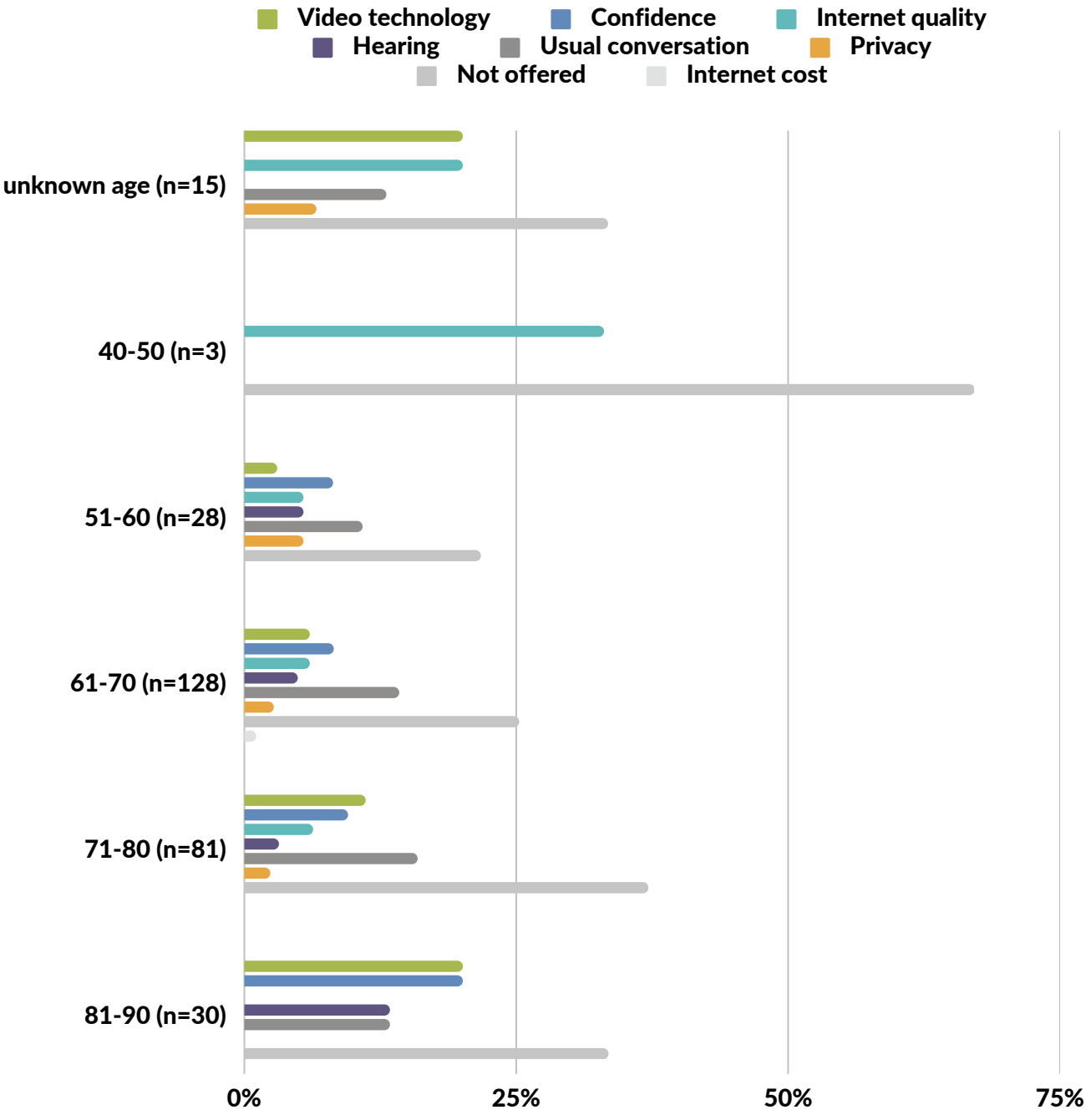
Q. HOW SATISFIED ARE YOU WITH TELEPHONE CONSULTATIONS WITH YOUR DOCTOR?

The responses to this question show that across the age groups, the majority of participants were satisfied or very satisfied with telephone telehealth consultations. However, our data clearly shows satisfaction decreasing with age. Where 81% of the participants aged 51-60 had a positive response, only 57% and 58% of participants aged 71-80 and 81-90 respectively, had very satisfying or satisfying experiences of telephone telehealth.



Q. WHAT ARE YOUR PRIMARY CONCERNS WITH VIDEO CALL CONSULTATIONS?

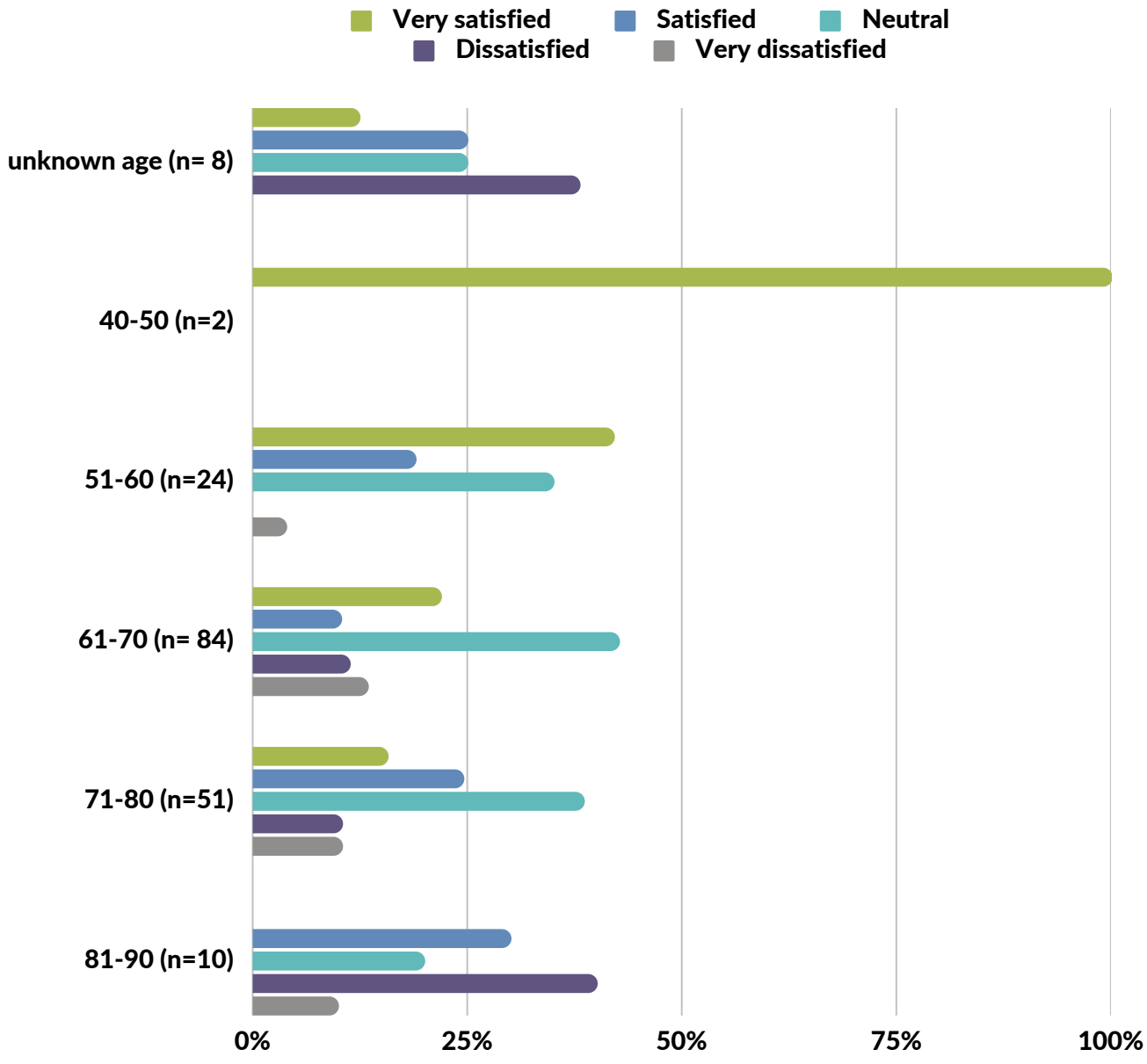
This graph shows that as women age, affordability of video technology and confidence in using it becomes increasingly prohibitive to accessible healthcare. It also shows that across the ages, a high number of respondents reported that their "doctor does not offer" video consultations. As a service advertised as a "permanent feature" of telehealth, either these services are not being offered by older women's healthcare providers, or without sufficient awareness of their availability. Finally, hearing on video calls becomes a much greater challenge to people aged 81-90. This was raised to a similar degree for telephone consultations for people aged 81-90.



Q. HOW SATISFIED ARE YOU WITH VIDEO CALL CONSULTATIONS WITH YOUR DOCTOR?

In this research, for participants aged between 51-90, video consultations had a much lower satisfaction rate than telephone consultations. For participants aged 51-90, the average satisfaction with telephone consultations was 64% compared to video consultations with only 40% reporting that they were satisfied. This trend is reflected in the literature, which shows older people are more likely to use telephone over video call appointments (Chen et al, 2022).

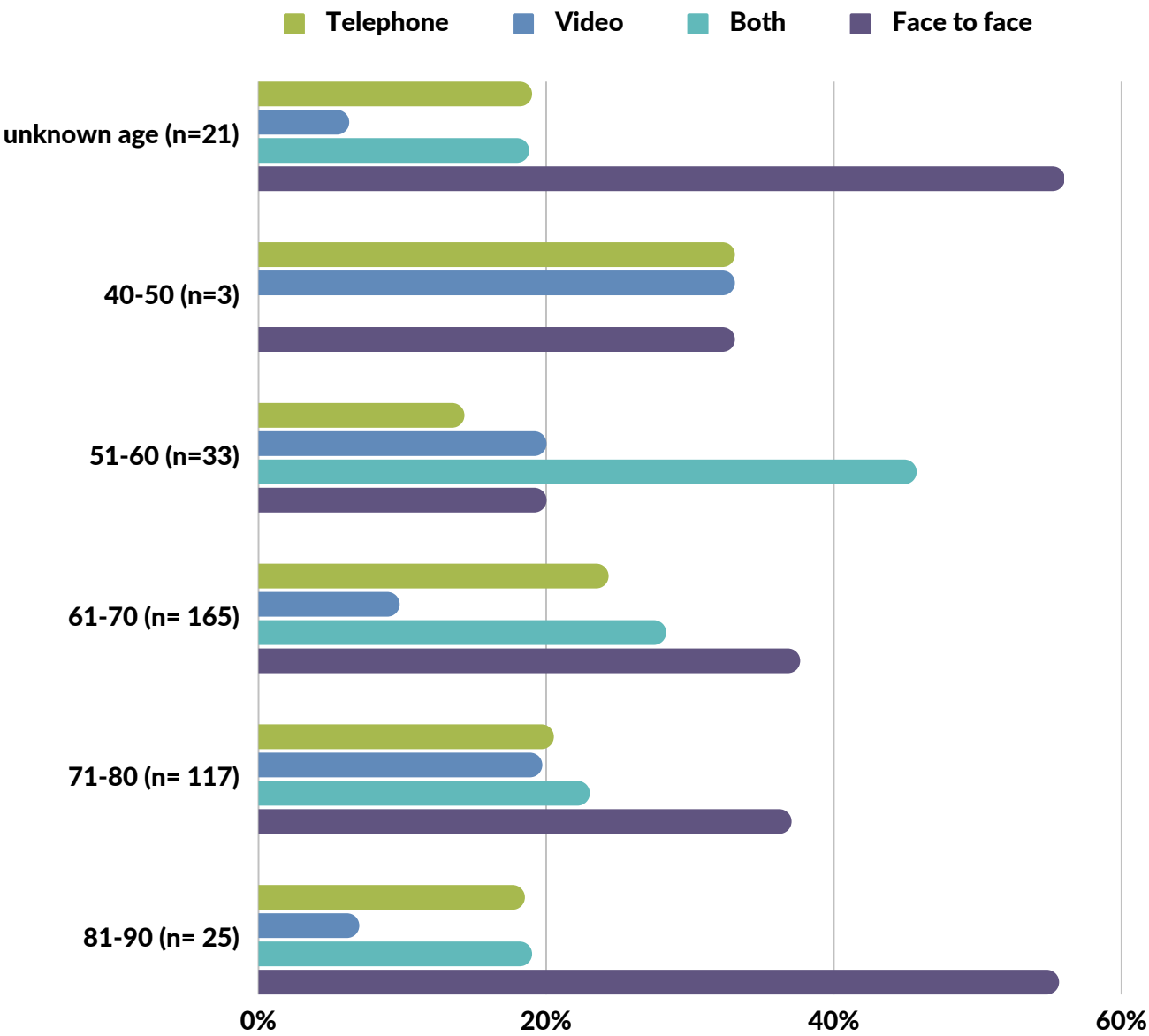
Further, when broken down by 10 year intervals, older participants had even higher video call dissatisfaction than the younger groups. Where the participants aged 61-70 had a 24% dissatisfaction rate, participants aged 81-90 had double with a 50% dissatisfaction with video healthcare. However, it is important to note that within telehealth in Australia, video calls account for a much smaller portion of consultations (Tsirtsakis, 2022).



Q. IF BOTH OPTIONS OF TELEPHONE AND VIDEO CALLING ARE AVAILABLE TO YOU, WHICH WOULD YOU PREFER TO USE?

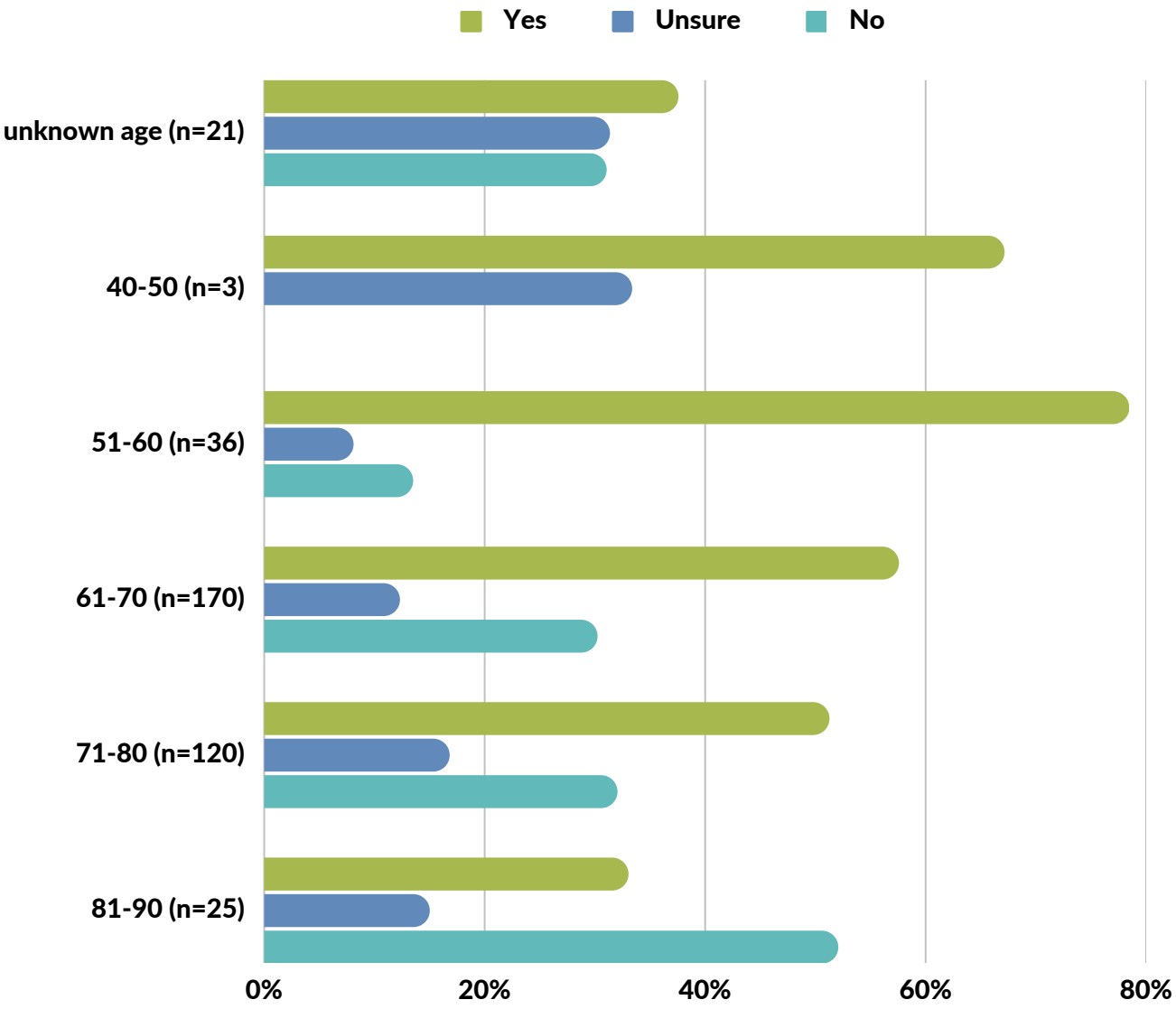
In this study, combining the percentage of respondents who selected telephone, video and both options for telehealth and face-to-face, the preference for some sort of telehealth availability was strong. Face-to-face or mixed was also strongly preferred. The preference for face-to-face consultations was highest in the 81-91 age group.

This study shows that telephone consultation is more popular than video across the age groups. It found no statistical difference in preferences for healthcare consultation based on whether participants were from a metropolitan or regional area.



Q. IF THERE WERE NOT PANDEMIC RISK FACTORS, WOULD YOU USE TELEHEALTH?

Similar to the findings for Q15, a majority of respondents were in favour of using telehealth even without pandemic risk factors. However, this research found that preferences for the continuation of telehealth were age-related. People in the 81-91 age group were less interested in continuing telehealth without pandemic risk factors. As there is a presiding interest in the other age groups for telehealth, there remains a need for the government to find ways of supporting older women to engage with telehealth.

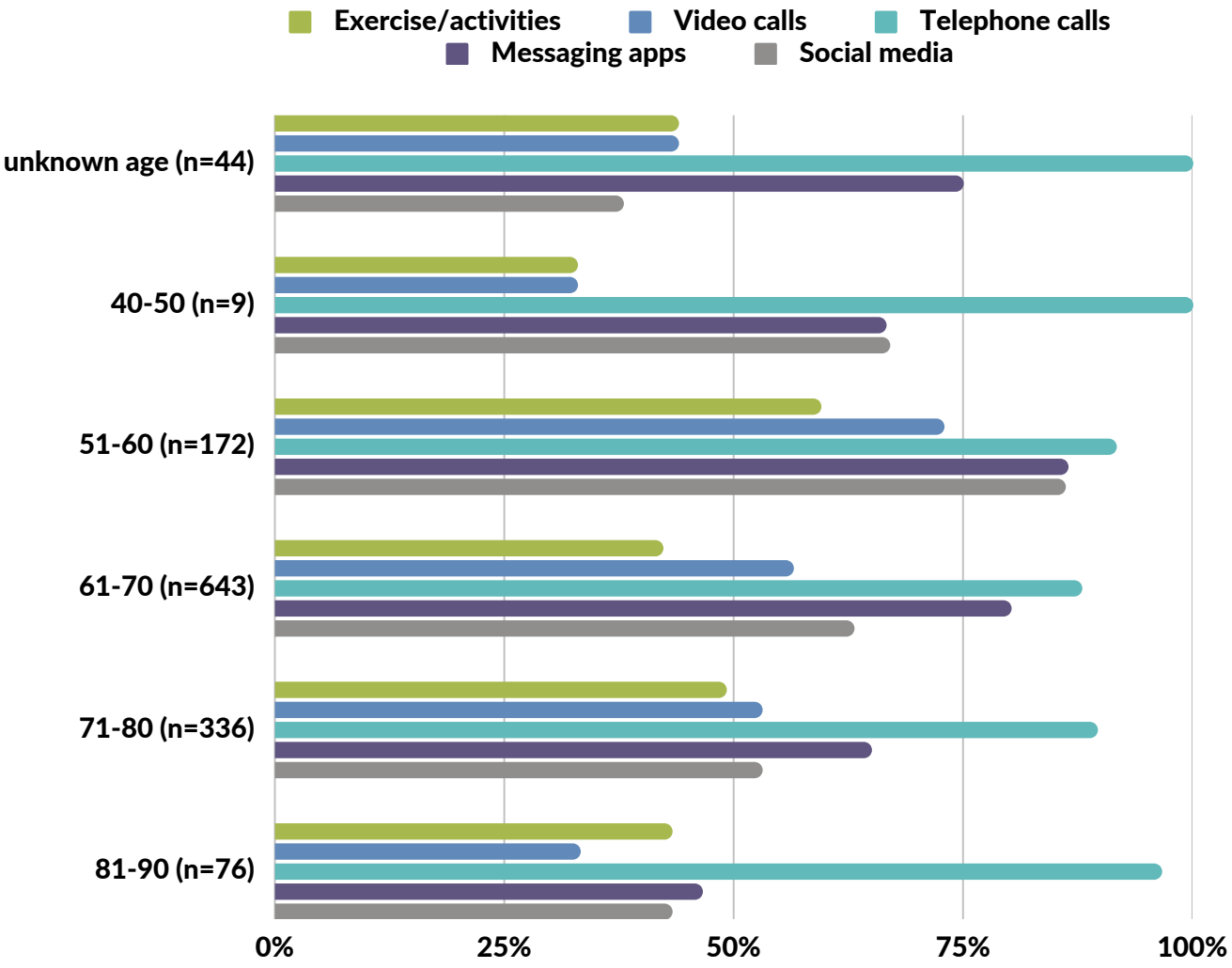


Q. DO YOU DO ANY OF THE FOLLOWING?

These findings about how older women use digital communication recreationally demonstrate that different age brackets use vastly different platforms. For older women aged 51-60, 73% used video calling with friends or relatives. However, this usage declines with age, to 56% of women aged 61-70, 51% of women aged 71-80, and down significantly to 33% of older women in the 81-91 age group who use video calls with friends and relatives. This demonstrates that effective telehealth policy which is accessible to all older women has to be designed with their capability and capacity in mind.

For respondents across the age groups, the most popular device used was telephone calls with friends and relatives. This is consistent with other data collected in Australia which shows that older people are less likely to use devices connected to the internet than younger people (Australian Digital Inclusion Index, 2022; Australian Communications and Media Authority, 2022).

As noted, lower usage is most commonly related to costs of devices or related equipment or internet charges (Australian Digital Inclusion Index, 2022). This study confirms that the telephone remains the preferred medium for the respondents.




Please let's keep the telephone healthcare going as it is a boon to us oldies and those with limited mobilty.

QUALITATIVE RESPONSES

To analyse the qualitative responses, the replies were categorised into dominant themes and coded to investigate which concerns and goals were prioritised by the older women who responded to the survey.

Q. IF YOU USE TELEHEALTH, WHAT ARE THE PRIMARY BENEFITS OF HEALTHCARE VIA TELEPHONE/VIDEO CALL?

A key theme in the qualitative responses was the importance of accessible healthcare. More than half of the respondents spoke about either the benefit of convenience, avoiding travel or improved healthcare access. Accessibility is a cornerstone of the human right to healthcare (Attorney-General's Office, 2022). Themes of accessibility influenced the experience of the older women surveyed, including the importance of geographic access, especially for those with limited public transport or who live in rural areas, and the value of accessibility of appointments for repeat scripts or referrals.

Responses included:

I live in a rural area with poor public transport. Petrol is extremely expensive. I have a chronic illness (autoimmune) and am often too sick to get to the doctor.

I feel safer doing it from home. Much easier due to chronic pain and anxiety.

I can talk to my doctor and she sent my new script to my mobile phone and then I went to pharmacy to obtain script - very efficient.

I don't think I could manage my complex health conditions without phone consults.

I do not have a car and there is limited public transport to my psychologist's rooms so my telehealth appointments are great.

I have complex mental health problems and when unwell I become isolated, unable to cope with leaving the house.

Another key theme was the importance of not being exposed to disease. This has been especially relevant for older people, and people with long term health conditions throughout the COVID-19 pandemic. For example:

Can access GP when not safe to go to surgery because if Covid or too sick to travel to GP surgery.

Q. WHAT ARE YOUR PRIMARY CONCERNS ABOUT TELEPHONE HEALTH CONSULTATIONS?

For this question, excluding comments of “no concern”, 42% of respondents added additional written responses about their primary concerns about telephone healthcare.

The most common concern raised was poor healthcare because there was no physical check up. This was raised in more than half of the “Other” written comments for this question. Often, the comments spoke to the difficulties of not being able to have their symptoms properly checked over the phone, or having symptoms missed.

Comments included:

For difficult issues, doctor can't see me clearly or really tell how I am e.g. dementia, dizziness and falls.

Having only telehealth calls means that the GP can't physically examine me. You are less likely to mention other "less important" issues, and focus only on getting a new script etc. My blood pressure is being taken less often. I didn't get a skin infection checked as soon as I should because I wasn't in their office. Even my specialist cardio did apts x 2 this year over the phone. Seeing the cardio and having BP and heart listened to is reassuring. So you miss out on that. When my GP suddenly went on leave for a month, it was hard to get a Dr on phone to do script - they wanted to have seen you in the past year, was really hopeless and stressful.

The second most prevalent theme was issues with communication, with respondents having issues with health literacy, or ability to clearly communicate over the phone. This was notable for people who experience deafness.

I wear a hearing aid for right ear, left is dead completely, I find phone difficult.

I need to lip read.

Finally, some respondents raised concerns about their experience of less attentive, personal healthcare over the telephone.

Part of the healing is in the personal exchange and as a solo older person who lives on her own and has no family, personal contact is essential for my mental health and stability.

Q. WHAT ARE YOUR PRIMARY CONCERNS ABOUT VIDEO CALL HEALTH CONSULTATIONS?

For this question, a quarter of respondents added a written comment. The key themes in these qualitative responses were no physical symptom checks, administrative and technology issues, and an expressed preference for face-to-face consultations.

In the comments section, a lack of quality physical examination was the highest concern with video call consultations. Although fewer respondents raised this than for telephone calls, however it was still the most common concern raised in the "Other" section.

There was also a much greater concern for administration and technological issues with video health instead of telephone health.

Comments included:

Several times the systems the different Drs (hospitals and specialists) use are clumsy or do not work correctly. This is stressful.

The usual time wasted on technical aspects.

I feel strangely self conscious!

My friend has no internet connection but only landline. Vision impaired.

Currently I have no access to anything having lost everything in the flood.

DISCUSSION

Age is a key variable in technology ownership and confidence across Australia. The Australian Communications and Media Authority (ACMA) found that 63% of people aged 18-54 have four plus devices, compared with 46% of Australians 55+ (2022).

46%
of Australians aged over 55 have more than 4 devices

Digital device access, and by extension digital confidence, is primarily determined by people's financial resources (Australian Digital Inclusion Index, 2022). The trend in this data, and wider literature, of older women's lower device ownership, is a direct result of this group's financial exclusion and higher likelihood of poverty among other issues. Further, where low device ownership is caused by poverty, it also exacerbates it (Australian Digital Inclusion Index, 2022).

This risk is heightened as a result of the telehealth Medicare cover for items such as care plans and mental health care plans. These are now only available on certain devices, which means that older women who cannot afford video-calling devices will pay a higher telehealth fee.

Older women from age 46 to 91 took part in this study with the most common age group being 61-70, and the least common was 40-50, with only 3 respondents. We know that the prevalence of many health conditions is higher in the older population (65+ years), leading to older people being more likely to visit healthcare professionals than younger people (AIHW, 2014). This means that the insights provided by the older women in the study provide important insights when discussing telehealth services.

Only 2% of the respondents were Aboriginal and Torres Strait Islander and 11.7% were from CALD backgrounds. Indigenous voices are important in the design of healthcare policy, and it is a limitation of this study that there were not more First Nations' perspectives. In a healthcare system which is still informed by colonial ideology, we need to support the primacy of First Nations run healthcare facilities (Creative Spirits, 2022). Similarly, it is important to highlight CALD experiences in healthcare policy, as the right to accessible healthcare must consider cultural safety and different levels of English health literacy. It is important to consider how all these variables are impacted by telehealth.

Seventy percent of the respondents were from metropolitan areas, while the others were from regional or rural areas. Perhaps due to the smaller number of respondents from regional and rural areas, there were no significant differences between these groups and urban residents in relation to access to telehealth.

Understanding the regional and socio-economic spread of the survey participants is important, as higher healthcare accessibility and quality is linked to living in a metropolitan area and having greater wealth (AIHW, 2021). Therefore, telehealth potentially has a different impact on people living in rural and regional Australia. However, as stated previously, in these survey responses, there were no significant differences between the responses based on the variables of rurality and socio-economic status. This may be due to limited response numbers from these groups and may not reflect the general population.

It is likely that if all portions of the population were represented proportionally in this survey, the results could demonstrate even poorer responses to telehealth availability and lower preference for video than shown here especially in light of more expensive internet charges and poor coverage in certain rural and regional areas.

Research has shown that most older Australians are less likely to have an internet connection, with women having consistently fewer devices than men (ACMA, 2022). Tablet or iPad, as well as computers with video calling technology, were the most common devices used overall in our study, especially among the 61-80 age groups. We found that women from CALD backgrounds were more likely to have non-Apple mobile phones than Apple mobile phones. This question was asked because GPs noted that video calling technology can fail when patients have different phone models. This could create further complications in relation to accessing telehealth services.

European research noted most older people require assistance while using technology but do not want to depend on others (Raja, et al., 2021). A separate study showed that when older people asked for assistance, others quickly completed the job for them instead of guiding them, hence limiting their ability to learn to use a new device (Vaportzis, Clausen & Gow, 2017). Therefore, while an individual may own various devices, that does not ensure their confidence in using the device, as well as their ability to use it without assistance from others.

We found that there was consistent access to healthcare consultations through telephone or video, as well as in person in the age cohorts we studied. Between accessing healthcare consultation through telephone or video, respondents have used telephone services a lot more than video calling services.

As this survey was taken during the COVID-19 pandemic, an increase in mental health telehealth consultations was noticed, further underscoring the benefits of such telehealth consultations. However, it should be noted that mental health care plans, required to access a Medicare rebate for mental health consultations require a video call to be made. It cannot be done over a telephone telehealth consultation.

It is observed that for telephone consults, most respondents were more satisfied or very satisfied than dissatisfied or very dissatisfied. This is also found in a study in America on demographic differences between telephone and video healthcare consultation referencing. Older people were a key group who were more likely to prefer the telephone (Chen et al., 2020). Nonetheless, despite overall satisfaction, such satisfaction with telehealth is seen to decline slightly among older age groups in our study.

Higher healthcare accessibility & quality is linked to living in a metropolitan area & having greater wealth.

This data reflects the trends in Australian research into telehealth since the beginning of the pandemic. In the early instalments of Medicare-covered telehealth in 2020, the University of Sydney surveyed Australians about their telehealth experience and satisfaction with the service.

Majority of respondents found the service equal to or better than face-to-face consultations.

Their research similarly found that the majority of respondents found the service equal to or better than face-to-face consultations (Isauiter et al, 2020). Their research found that older women were the most likely demographic to use telehealth services, however, they did not disaggregate the impact of these demographics on satisfaction. Further, the Global Centre for Modern Ageing surveyed specifically older people in Australia, and found 85% of their respondents were equally, if not more, satisfied with telehealth consultations (2020).

Concerns regarding hearing are common among 50-90 age groups.

The most common concerns in relation to telephone services include not being able to have their usual conversation with the doctor over the telephone. It is also noticed that concerns regarding hearing are common among 50-90 age groups. Such concerns were also seen by Gordon, et al., (2020), where patients felt they could not speak up over the telephone and effectively communicate with their healthcare provider. As noted by one respondent: “I’m not feeling like I’m part of the conversation”.

Most respondents are dissatisfied or neutral rather than satisfied or very satisfied with video consultations. This also reflects providers' wariness of video consultations with privacy concerns being paramount. “Providers were apprehensive about being recorded during video consultations and recordings being posted on websites, and felt that this was likely to influence their decision about the type of health advice they provided” (Clay-Williams, 2017). The research noted that respondents also described that they “felt exposed” and “uneasy” about the possibility of the video service being used inappropriately. This directly parallels the results from our survey as the most common concern throughout all ages was that the respondents felt they could not have their usual conversations with their doctor.

Accessibility to video telehealth was more prominent for older participants (61-70; 71-80) who have less access to video calling technology. The June and July changes to Medicare retain more video consultation items, and reduced cover for telephone telehealth. It needs to be acknowledged that these age brackets use healthcare more regularly and are less likely to be in regular paid employment. Hence, this is the group that will primarily need Medicare-covered healthcare more and will not be able to access telehealth rebates if it is only offered for video consults.

Overall, the use of telephone telehealth is more popular and preferred than video calling services. Despite this, it is yet unknown how telehealth will affect the utilisation of various other services. Systematic reviews are needed to determine what influences the extent to which telehealth interventions replace or supplement in-person visits (Shigekawa, et al., 2018). On the other hand, telehealth was found to be generally successful for mental health, rehabilitation, and other studied conditions (Shigekawa, et al., 2018). In addition to this, our survey also found that most respondents are in favour of using telehealth even without pandemic risk factors.

LIMITATIONS OF THIS STUDY

This study has some limitations, one of which is the inability to access prior literature on older women's use of telehealth. As a result, there were not many relevant papers on which we could base our study or make comparisons.

Additionally, the participants in the study all came from OWN's mailing list. The study was also mostly done online, with only some in person, therefore, it can be said that more people with online literacy were involved. This may indicate that they are disproportionately from privileged socioeconomic categories, which does not accurately represent the whole population. The insignificant SES results serve as additional evidence for this. The study was also lacking Indigenous perspectives, with only 2% of respondents being Aboriginal and Torres Strait Islander, further not reflecting the whole population.

The study was also limited by an incomplete question design for question nine, whereby respondents who had not attended healthcare services in the last year could not be distinguished from those who had attended them up to five times. This is addressed in more detail in the results.

My belief is that telephone consults and video consults are only to be used due to distance issues or health mobility issues. It is preferable to have a personal relationship with the medical practitioner. Telephone & video calls do not always translate information exact, including for Physio & OT etc.

RECOMMENDATIONS

EXPAND MEDICARE TELEHEALTH

The 30/20 regulation, which was implemented on July 1st, would require any GP who provided more than 30 daily telephone consultations on 20 or more days over the course of a 12-month period to be reported to the Professional Services Review (PSR). The 30/20 regulation is meant to promote high-quality care while limiting telephone-based business models that could affect the viability of comprehensive practices.

With most older women more likely to use healthcare than younger women (Deeks et al., 2009), our survey has found that older women are in favour of using telephone telehealth even without pandemic risk factors.

Although our survey may not reflect the entire population, what is notable is that those who use telephone consultations often recognise the benefits. Some of the common benefits of telehealth described in our study include reduced travel concerns, particularly in rural areas (petrol, limited public transportation, and limited nearby resources), reduced concerns about limited mobility (both physically and mentally), safety from COVID-19 (in waiting rooms, on transportation), efficiency for repeat visits (check-ups with chronic illnesses, repeat scripts), and more readily available appointments.

As various benefits of telehealth became evident, particularly among groups such as older women, who are more vulnerable and have fewer financial resources than younger women (Wilkins, 2017), we recommend expanding Medicare telephone telehealth and reconsidering the 30:20 ratio.

EXPAND PHONE CONSULTATIONS SPECIFICALLY

According to our survey, most respondents prefer telephone consultations to video calling services. Clay-Williams et al. (2017) reflects some of the reasons why telephone is favoured, as some potential barriers to video-calling telehealth services were highlighted as privacy issues, professional risks, low acceptance of video services, and so on.

Most respondents were more satisfied or very satisfied than dissatisfied or very dissatisfied with telephone consultations in our survey. However, this is not true for video-calling services. This shows a clear preference for telephone among the respondents.

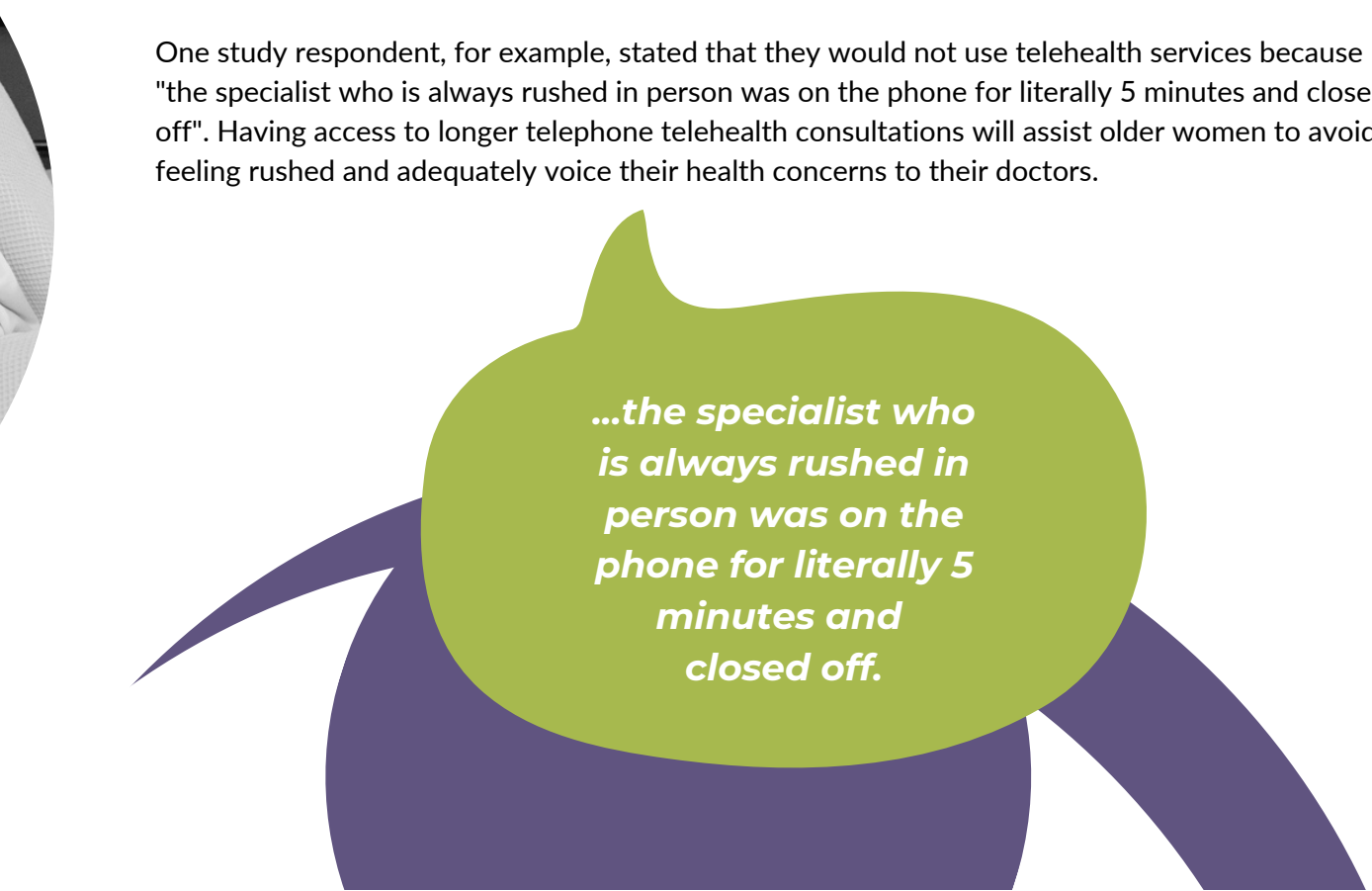
Our survey also shows that respondents from CALD backgrounds are more likely to own a ‘non-Apple’ mobile phone. This has implications for video calling technology as some devices do not 'speak' to each other. If the patient's and doctor's devices are incompatible, it can make access to telehealth services difficult and complicated.

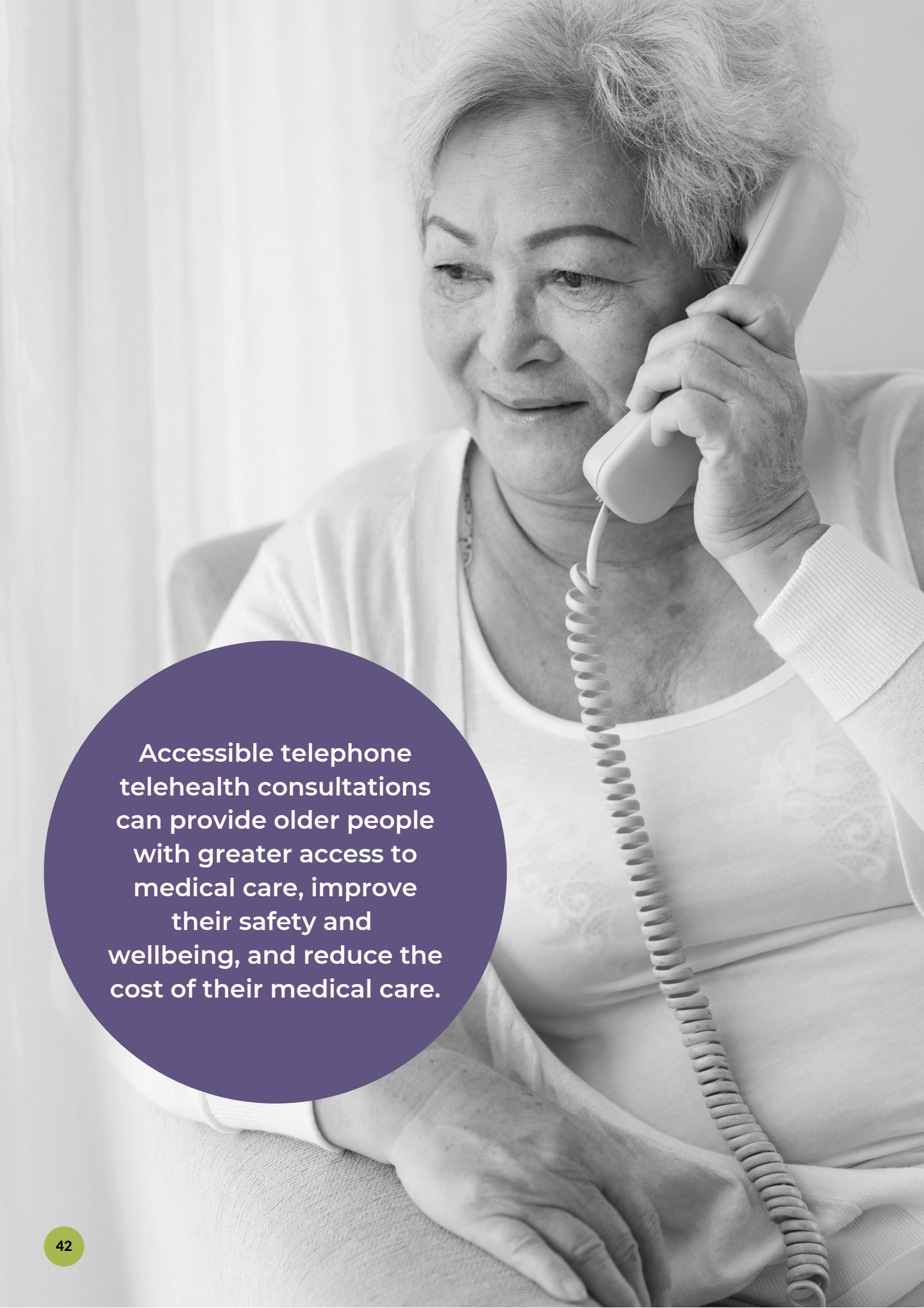
Telephone services can be provided via mobile phones as well as landlines, making telehealth via telephone a benefit for everyone, even vulnerable groups such as individuals from CALD backgrounds. We recommend extending more phone consultations to the Medicare benefits scheme specifically because this makes healthcare consultations accessible to more people, and it is prefered by most older women we surveyed.

“REINSTATE” LONG CONSULTATIONS VIA TELEHEALTH

Since October 31, 2022, Medicare rebates for phone consultations lasting more than 20 minutes are available for patients, but only for those seeking advice on the prescription of COVID-19 oral antiviral treatments (Attwooll, 2022). The ineffectiveness of short telehealth services was identified in our study through participants' comments; hence, we recommend the extension of long telehealth consultations for medical care for antiviral treatments as well as other healthcare services beyond October 2023.

One study respondent, for example, stated that they would not use telehealth services because "the specialist who is always rushed in person was on the phone for literally 5 minutes and closed off". Having access to longer telephone telehealth consultations will assist older women to avoid feeling rushed and adequately voice their health concerns to their doctors.





Accessible telephone telehealth consultations can provide older people with greater access to medical care, improve their safety and wellbeing, and reduce the cost of their medical care.

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ABOUT THE OLDER WOMEN'S NETWORK NSW

The Older Women's Network (OWN) NSW is a non-profit organisation based in New South Wales, Australia, that was founded in 1985 by a group of women who wanted to challenge the stereotypes and discrimination faced by older women.

The mission of OWN NSW is to promote and protect the rights, dignity, and wellbeing of older women. The organisation works towards achieving this goal through a range of activities, including lobbying for policy changes, running workshops and events, and providing support services to members.

It also conducts studies on issues which impact older women and works in partnership with other like-minded organisations to further the objectives of the organisation.

Current areas of advocacy include affordable housing for older women and ending violence against older women.

More information on the work of OWN can be found on its website at www.ownnsw.org.au or by writing to us at info@ownnsw.org.au

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