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HEALTHCARE & PHARMACEUTICALS **ALERT**

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Telemedicine: Band-aid or long-term solution?

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Telemedicine: Band-aid or long-term solution?

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COVID-19 highlighted the necessity of having a viable telemedicine regime as a 'safety net' to ensure continued access to healthcare services whilst maximising social distancing. We now have an opportunity to better understand the challenges and exploit the benefits of telemedicine services.

To do more with less, beyond the pandemic, innovative developments in technology can increase access to care (where appropriate) and lower systemic costs, particularly for vulnerable groups and those in underserviced rural areas, where face-to-face care is not a viable or efficient option.

What is telemedicine?

Terms such as telehealth services, digital health and e-health are often used synonymously with telemedicine. Examples include specialists exchanging a patient's medical history via messaging apps, telephonic or video consultations between patients and healthcare workers and remote monitoring of patients.

Telehealth is defined by the World Health Organisation (WHO) as the remote delivery of healthcare services by all healthcare professionals, where distance is a defining factor, using information and communication technology (ICT) for the exchange of information for the diagnosis and treatment of diseases and injuries, research and evaluation, and for the continuing education of health professionals.

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Regulation of telemedicine in South Africa

COVID-19 necessitated a relaxation of the rules governing telemedicine. As an infection-control solution, telemedicine helps reduce health care workers' contact with patients, whilst enabling vulnerable groups to receive certain healthcare services during self-isolation. Telemedicine in South Africa is regulated in terms of, amongst others, the *General Ethical Guidelines for Good Practices in Telemedicine*, issued by the Health Professions Council of South Africa (HPCSA) in 2014 (2014 Guidelines).

The HPCSA is a statutory body overseeing the education, training, and registration of health professionals, aiming to among other things, ensure that practitioners maintain professional and ethical standards. Understandably, there is a need to regulate healthcare practitioners' conduct, especially when dealing with patients remotely. Having certain checks and balances in place is desirable to ensure that the process is not abused to the detriment of patients, for example, through over-servicing. Rules can help maintain standards and ensure that the quality and safety of patient care is not unnecessarily compromised.

Under the HPCSA's initial paradigm all telemedicine services should involve a healthcare provider where there is an actual face-to-face consultation and physical examination of the patient in a clinical setting by a 'consulting practitioner', who will communicate the information to the 'servicing practitioner' to provide the necessary assistance.

Accordingly, the 2014 Guidelines barred first-time consultations between a patient and healthcare worker and meant that only telemedicine consultations facilitated by

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one healthcare practitioner with another healthcare practitioner (on behalf of the patient) were allowed, with limited exceptions if there was already an existing relationship between the healthcare worker and the patient.

When the national lockdown commenced, and only for the limited duration of the COVID-19 pandemic, the HPCSA minimally relaxed its stance by issuing guidance which replaced the reference to *"telemedicine"* with *"telehealth"*, which definition now included telepsychology, telepsychiatry, and telerehabilitation, amongst others. The requirement for an already established practitioner-patient relationship remained, except for telepsychology and telepsychiatry. Critics referred to a lack of clarity in respect of the length of time and other requirements needed to *"establish a relationship"* between the patient and the physician. Despite the hard lockdown having commenced, the HPCSA specifically advised against telephone and/or virtual consultations for new patients (HPCSA Guidance Note 26 March 2020).

This limited relaxation met resistance from the medical fraternity, nudging the HPCSA to issue further amendments in order to allow first-time consultations between clinicians and patients without an established relationship, provided such consultations are in the clinical best interest of patients. (HPCSA Notice 3 April 2020)

When announcing the aforesaid relaxations, the HPCSA cautioned that the revised provisions on the use of telehealth are only applicable during the COVID-19 pandemic and indicated it would make further announcements on the continued use of this guidance after the pandemic subsides. This presents an opportunity for expanding the responsible use of telehealth services.

One can expect businesses and practitioners which have invested in technology to support telehealth during the pandemic will likely resist a complete reversal of the relaxations.

Benefits

Telemedicine is frequently judged against the counterfactual of face-to-face care, where it may fall short. In South Africa, however, the lived experience of the counterfactual is often no or less care due to access constraints. Telemedicine can enable healthcare workers, particularly scarce specialists, to reach patients in remote and rural locations which they would not normally be able to access. Pre-pandemic, the National Department of Health, in its e-health strategy (2012 – 2016) recognised the potential of telemedicine *"as a tool that could bridge the gap between rural health and specialist services."*

An additional important benefit is the role telemedicine can play in upskilling health care workers, by using technology as a training tool; a huge gain in South Africa where we face a healthcare human resources crisis and an inequitable geographic spread of available specialists, amidst a high burden of disease.

There is also the potential to lower costs and improve patient outcomes, particularly in under-resourced areas.

Telemedicine: Band-aid or long-term solution?*...continued*

Implementing the lessons learnt requires the HPCSA's stewardship in reimagining the expansion of telemedicine regulation in a manner that responsibly manages patient risks without foregoing the potential benefits.

Challenges

Telemedicine is not without its risks and challenges.

Most obviously of concern are inaccurate clinical diagnoses in a virtual world, for example, if patients are unable to correctly describe their symptoms, particularly where there are language barriers, and there is no physical examination. These challenges are less prevalent for certain specialities, such as mental health consultations.

Another considerable obstacle is the ownership and transfer of patient data, in the light of the absence of an implemented system for a single electronic interoperable health record. For example, the 2014 Guidelines require informed consent for the use of telemedicine technologies to be obtained in writing from the patient and a witness, that a duplicate of this consent form be kept as part of the patient record and a copy be shared with the patient. This has been criticised as being impractical, especially, if the patient is in a remote location, is illiterate, or incapacitated and urgent advice is required. However, hanging in the balance are the rights of patients to informed consent and privacy, as well as the requirement for POPI compliance.

Reimbursement models are an important factor in healthcare worker uptake of telemedicine solutions. It is understood that telemedicine consultations are broadly still reimbursed at lower rates than face-to-face consultations. A delicate balance must still be found between reimbursing healthcare workers fairly for time spent in delivering high quality telemedicine services versus losing potential cost efficiencies.

Regarding telemedicine across country borders, the 2014 Guidelines provide that practitioners serving South African patients must be registered with the equivalent regulatory bodies in their original countries, as well as with the HPCSA. This limits the potential for South Africa to obtain exposure to international expertise, particularly for rural communities. However, in a subsequent media statement dated 9 March 2020, the HPCSA makes temporary allowance for healthcare practitioners registered outside of South Africa to practice cross-border telemedicine as long as they are registered with an equivalent professional body in the country in which they are based. It is hoped that this amendment can remain post COVID-19, for appropriate use, so that South Africa can continue to leverage opportunities from international health human resources.

From a pragmatic perspective, South Africa's electricity load shedding epidemic and the high costs of data may present connectivity challenges. However, this does not mean that telemedicine in and of itself is a dead-end, but rather that eradicating total inequality in healthcare delivery will be unlikely.

Converting the band aid into a long-term solution

Implementing the lessons learnt requires the HPCSA's stewardship in reimagining the expansion of telemedicine regulation in a manner that responsibly manages patient risks without foregoing the potential benefits. Stakeholder involvement and buy-in through the participation of patients, healthcare professionals and providers, funders, technology providers, and the Department of Health, will be critical.

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BBBEE STATUS: LEVEL TWO CONTRIBUTOR
Our BBBEE verification is one of several components of our transformation strategy and we continue to seek ways of improving it in a meaningful manner.

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