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EDITORIAL

Remote clinics: a panacea during the pandemic or a promoter of health inequality?

Remote clinics have shown many benefits including patient safety, but if we look closer, does this move exclude certain groups of patients from accessing healthcare and promote health inequality?

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Until recently, the majority of new outpatient appointments were undertaken in person (face to face). The COVID-19 pandemic changed this almost overnight. In the space of a few weeks the speculative NHS plan to move to tele-based communication with patients was implemented by necessity, at pace. Remote consultation via telephone, email or video was rapidly introduced to replace face-to-face consultation, with imaging replacing examination. This allowed high numbers of consultations to continue despite restricted movement and circumvented the risk of transmission by decreasing footfall in one of the riskier places during the pandemic – hospitals.

Now we are in the second wave of the pandemic in the UK, the threat of COVID-19 remains and many are wondering which changes implemented during the first wave should be retained and which should return to the pre-pandemic 'normal'. Many outpatient departments are using telephone consultations and, following their success, are proposing a move to online video consultations.

The benefits of remote clinics

From a healthcare provider perspective, remote clinics have been proven to be extremely beneficial. There is less risk of cross infection, fewer resources are required and time is saved for both patient and healthcare provider. Barts NHS Trust (2016) saw the 'did not attend' rate for the diabetic clinic fall by two thirds and consultations were on average 6 minutes quicker. The use of remote clinics has shown benefits for patients as well. Patient feedback has usually been positive owing to the convenience, efficiency and reduced time off work. There is significantly decreased travel time, especially in rural areas, with less travel costs and no hospital parking charges (Hilty et al, 2007).

What are the downsides?

Moving to tele-based communication systems looks like an attractive option, but it is important to pause and consider the potential disadvantages. There are patients who will benefit and patients who will not. So, who is potentially most at risk of being left behind by this sudden move away from face-to-face consultations? Interestingly, it may be the very patients who have the greatest need for healthcare.

Barriers to access

This concern is supported by a report on digital inclusion in Wales which found that people with long-term conditions are less likely to have access to the internet. This group accounts for 50% of GP appointments, 64% of outpatient appointments and 70% of total health and care expenditure (Welsh Assembly, 2018).

Many patients simply cannot access an online service. Internet access, even on smartphones, remains inaccessible to significant segments of the population who cannot afford such services (Doctors of the World, 2020), do not live in areas with good access (Welsh Assembly, 2017), or do not have the necessary skills to use the technology. The UK Consumer Digital Index (2020) estimated that 3.6 million people do not use the internet at all in the UK and 9 million struggle to access online services themselves and therefore

require assistance to use the internet or use the devices required to do this. Age is the leading characteristic of low digital engagement, with 77% of over 70-year olds having very low levels of digital engagement (UK Consumer Digital Index, 2020). Therefore, a move to video consultations will be difficult for this group of patients.

Low income patients are already almost twice as likely to report poor health than those in the top 20% of earners. Unsurprisingly, the additional cost of broadband or mobile data is a further barrier to them accessing healthcare. This accessibility issue is especially true of patients in the most at-risk sections of society, who include:

- Refugees
- People seeking asylum, including unaccompanied asylum-seeking children
- Undocumented migrants, including survivors of trafficking
- People in and recently released from immigration detention
- People experiencing homelessness
- Gypsy, Roma and Traveller communities
- Sex workers
- People recently released from prison (Doctors of the World, 2020).

Added together these groups represent over half a million people in England who need healthcare support.

We must also consider patients who will struggle to access online healthcare even if it is available. The Good Things Foundation (Yates, 2020) estimated that 10 million people in the UK do not have the basic digital skills they need to thrive in today's world. Furthermore, lower literacy and numeracy skills often cause people to struggle with evaluating and trusting online health information, so they often rely on verbal communication about their health (Diviani et al, 2015).

Some patients are not able to afford the cost of making calls and are therefore reliant on being phoned themselves. Furthermore, long waiting times on the phone can lead to calls being dropped. This is exacerbated when waiting for an interpreter and has been found to be a challenge for patients who are refugees (Doctors of the World, 2020).

Consultations may be lost as a result of power issues on phones, the slow speed of patients' devices, signal strength, Wi-Fi speeds and bandwidth. About 5% of the population of Wales simply do not have any access to broadband as there is not adequate coverage (Welsh Assembly, 2017). All of these are added complexities that can disrupt a consultation with a patient.

Social deprivation is inversely correlated to use of NHS Direct, a well-established telemedicine service. When ethnicity is considered in addition to deprivation, it has been observed that Indian and Chinese populations demonstrate lower than expected uptake of the service (Cook et al, 2014). A move to increase the use of telemedicine services could risk further affecting minority ethnic groups.

Communication issues

Telephone and video clinics are inaccessible to patients who require assistance with communication. This includes patients whose hearing is impaired or those whose English language skills are low, putting these groups at potential risk of being isolated from the health care they require.

There are also more subtle challenges that make access to healthcare more difficult with this move. There is the risk that important clinical information such as increasing frailty or deterioration in a patient's condition could go unnoticed over a telephone call or poor-quality video link.

Privacy

Privacy may also be an issue. Public embarrassment and privacy matters have been identified as a reason for non-engagement with telemedicine. Privacy is denied when we consider patients who live with multiple members of their family, usually patients of low socioeconomic status, refugees or minority ethnic groups. Where can these patients go to be told devastating news or talk about sensitive personal issues if they live with other family members of varying ages in an overcrowded space, especially if they are calling on a landline? Some patients may not have access to the internet at home and may require

Key points

- Remote clinics can increase staff and patient safety, reduce do not attend rates and increase efficiency.
- Some patients simply do not have access to the internet or suitable devices, and other patients may not have the necessary skills to use the internet or devices.
- Remote clinics are not an option for those who require assistance with communication.
- Privacy is at risk when communicating with people using telemedicine.

free or paid internet to access health services, for example having to use an internet cafe. Would a move to virtual clinics force these patients to discuss their health in public and deny them the right to privacy and confidentiality?

Conclusions

A move to remote clinics clearly has benefited many patients and staff, but a total move to remote consultations should be carefully considered as this may disenfranchise a group of patients that should be prioritised. Trusts will need a mix of outpatient department models, which should include both telephone or video, as well as face-to-face consultations. Solutions to ensure privacy could be sited in community centres, libraries or GPs surgeries to ensure consultations can be made in bookable sound-proofed booths, provided especially for this purpose. It will also be important to set up social teaching programmes for digital engagement, made readily available to the most challenged groups. Moving forward, patients' perspectives must be considered to ensure the most vulnerable are not denied their right to health care as a result of the way it is provided. Being aware of potential barriers to digitalisation should allow clinicians and managers to tailor healthcare outpatient services to suit all individuals.

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