

Remote care - good for some, but not for all?

The COVID-19 pandemic fuelled an unprecedented expansion in remote health service delivery globally and employers and governments encouraged people to stay at home in an effort to reduce the spread of the virus. In many countries, including the United Kingdom (UK), primary and secondary health care shifted rapidly to 'remote by default', with a substantial increase in the use of virtual care such as home monitoring and home based treatment, supported by telephone and online methods to interact with patients and care service users.

Remote care has long been advocated, not least by companies that market digital technologies. The promise is convenience and choice: features that many people enjoy in other areas of everyday life, with many government, financial and consumer services moving to digital first, or digital only modalities.

As we move from the pandemic, remote care delivery in the UK is becoming a 'new normal': the number of telephone appointments in general practice rose from 3.5 million in 2019 to 11.4 million in March 2021.¹ Remote home monitoring or virtual (COVID) wards proliferated during the pandemic, despite a rapid systematic review in 2021 being unable to reach substantive conclusions regarding efficiency, safety or the identification of early deterioration for patients with COVID-19.² In the USA, remote patient monitoring increased more than fourfold during the pandemic³ and the UK has set the ambitious aim to have introduced 40–50 'virtual ward beds' per 100,000 population by December 2023.⁴ There is also growing research interest in other forms of remote care such as telephone and online triage⁵⁻⁶ and video consulting.⁶⁻⁸

Unequal access and uneven work

In their essay published in the Journal of Health Services Research and Policy, Williams et al. consider the implications of remote primary care consultations for policy and care delivery across low-, middle- and high-income countries.⁷ As part of a thoughtful process incorporating a literature review and gathering experiential learning from an expert panel, they explored the challenges and opportunities of remote consulting for patients and clinicians. While conceding that the shift to remote consulting in the pandemic "appears to have changed the way some people select and prefer to access care" (p4) they conclude that remote consultations are not suitable for all conditions or every patient.

A key challenge is digital access and digital literacy. Digital technologies facilitate access to care for some, but others, including those with language, cognitive, and hearing difficulties may not enjoy these benefits. People who cannot afford, do not have access to, or simply prefer not to use digital devices may be disadvantaged by the shift to remote care. Digital access is a social determinant of health: a third of the world's population do not own a mobile phone, and 50% have no internet access.

Alongside concerns about inequality there is a growing recognition that digital technologies may not substitute for human labour, but instead shift work. Salisbury et al. projected that online, telephone, or video consultation could increase general practitioner (GP) workload by 25%, 3%, and 31%, respectively.⁸ Telephone and video consultation technologies require patients and clinicians to acquire new skills and to adapt behaviours. Privacy and data protection concerns must be addressed: a qualitative study exploring GPs' experiences of managing safeguarding remotely during the pandemic revealed that GPs found it difficult to support vulnerable patients and almost

impossible to identify new or unknown vulnerabilities.⁹ At a system level, services require significant investment in digital technology, and accompanying information technology staff, in addition to training the workforce who provide remote care, all adding to the cost of remote services.

An health services research agenda for remote health and care

Williams et al. call for research to help identify what kinds of patient consultations work best remotely and suitable outcome measures.⁷ These are needed. We need to examine the efficiency and cost-effectiveness of remote care. There is a suggestion that remote primary care leads to greater prescribing, and possibly to increased referrals to secondary care.¹⁰ There is need for some quantitative and trial research, but also for detailed qualitative studies. For example, Hewitt et al.'s conversation analysis comparing telephone and face-to-face primary care consultations revealed that doctors in telephone consultations were less likely to elicit additional concerns, and asked fewer questions when patients presented self-diagnosed problems or described problems with treatment.¹¹ Neves et al. found that primary care doctors in Germany and Sweden were more conservative in triaging patients to virtual care than those in Italy and the UK, suggesting that more comparative cross-country research will be valuable.¹²

Catherine Pope

Professor of Medical Sociology

University of Oxford

Nuffield Department of Primary Care Health Sciences

Woodstock Road, Oxford, OX2 6GG

United Kingdom

References

1. Fraser, Fisher R. *How has the COVID-19 pandemic impacted primary care?* Health Foundation. <https://www.health.org.uk/news-and-comment/charts-and-infographics/how-has-the-covid-19-pandemic-impacted-primary-care> (2021, accessed 21 March 2023).
2. Vindrola-Padros C, Singh KE, Sidhu MS, et al. Remote home monitoring (virtual wards) for confirmed or suspected COVID-19 patients: a rapid systematic review. *EClinicalMedicine* 2021;37:100965.
3. Tang M, Mehrotra A and Stern AD. Rapid Growth Of Remote Patient Monitoring Is Driven By A Small Number Of Primary Care Providers. *Health Affairs (Millwood)* 2022;41:1248-1254.
4. NHS England and NHS Improvement. *Enablers for success: virtual wards including hospital at home*. https://www.england.nhs.uk/wp-content/uploads/2022/04/B1382_supporting-information-for-integrated-care-system-leads_enablers-for-success_virtual-wards-including-hos.pdf (2022, accessed 21 March 2023).
5. Pope C, MacLellan J, Prichard, J, et al. The remarkable invisibility of NHS 111 online. *Social Health Illn* 2022 Nov 29. doi: 10.1111/1467-9566.13591.
- ~~6. Turner J, Knowles E, Simpson R, et al. Impact of NHS 111 Online on the NHS 111 telephone service and urgent care system: a mixed-methods study. *Health Serv Deliv Res* 2021;9(21).~~
6. James HM, Papoutsis C, Wherton J, et al. Spread, Scale-up, and Sustainability of Video Consulting in Health Care: Systematic Review and Synthesis Guided by the NASSS Framework. *J Med Internet Res* 2021; 26:23:e23775.
- ~~8. Assing Hvidt E, Christensen NP, Grønning A, et al. What are patients' first-time experiences with video consulting? A qualitative interview study in Danish general practice in times of COVID-19. *BMJ Open*. 2022;12:e054415.~~
- ~~9. McGillion M H, Parlow J, Borges F K, et al. Post-discharge after surgery Virtual Care with Remote Automated Monitoring 1 (PVC-RAM 1) technology versus standard care: randomised controlled trial. *BMJ*. 2021; 374 :n2209 doi:10.1136/bmj.n2209~~
7. Williams
8. Salisbury C, Murphy M and Duncan P. The Impact of Digital-First Consultations on Workload in General Practice: Modeling Study. *J Med Internet Res* 2020;22(6):e18203.
9. Dixon S, Frost L, Feder G, et al. Challenges of safeguarding via remote consulting during the COVID-19 pandemic: a qualitative interview study. *Br J Gen Pract* 2022;72: e199-e208.
10. Morris J. The remote care revolution in the NHS: understanding impacts and attitudes. London: The Nuffield Trust, 2020.
11. Hewitt H, Gafaranga J and McKinstry B. Comparison of face-to-face and telephone consultations in primary care: qualitative analysis. *Br J Gen Pract* 2010;60:e201-12.
12. Neves AL, van Dael J, O'Brien N, et al. Use and impact of virtual primary care on quality and safety: The public's perspectives during the COVID-19 pandemic. *J Telemed Telecare* 2021;22:1357633X211066235.