

# COVID-19 in 2021

## *Is it the major disrupter that eHealth needs?*

**Deborah Claire Saltman**

**THE COVID-19 PANDEMIC** has been a major healthcare disrupter. In disruption's wake, COVID-19 also has precipitated a new range of activities, including expanding the content, context and funding of telehealth. This article will explore how electronic healthcare (eHealth) delivery has changed in the wake of the global pandemic and suggest some new ways forward.

The diminishing physical aspect of the clinician-patient interaction has been evident for some time, leading not only to increasing telehealth consultations, but also to patients increasingly seeking their own healthcare solutions online.<sup>1</sup> 'Health' is the second most frequently searched term in Google, accounting for 57% of the more than two trillion searches in 2016. Currently, there are more than 300,000 health apps listed on the internet. If you looked at one per day, it would take more than 800 years to review them all.

Unfortunately, quantity does not necessarily equate with quality. Patients are often bewildered by content and lured by the promise of user-friendliness. During isolation, increased use of health apps persists, even though they deliver much less than they promise. A systematic review of 23 trials of health apps that promised a specific outcome, such as losing weight, showed a meaningful result in fewer than half of them, and most of the trials were only small studies over short periods of time.<sup>2</sup>

For-profit eHealth apps typically focus on frequently occurring conditions. Examples include single topic areas that have been well researched, such as diabetes or hypertension. Even then, out-of-date information, inaccessible or expired sites, and lack of supporting references and author information are common. The limitations of some men's health apps and sites are well documented. For example, only one in four prostate cancer websites identified the author of the information.<sup>3</sup> More than half had no references; when references were provided, fewer than a quarter cited were reliable. Half of recently reviewed health apps for gout were either no longer available to download or had not been updated since their release (over a year or more before).<sup>4</sup>

Poor health apps can have unintended consequences for underserved or marginalised populations.<sup>5</sup> For example, people living with disabilities and chronic illnesses spend more time online with apps than their abled counterparts and caregivers.<sup>6</sup> eHealth apps require regulation, and regulators and global health agencies are beginning to turn their attention to these apps. Increased activity is warranted.

On the other side of the eHealth coin are telehealth consultations. In 2020, the Australian Government introduced a range of telehealth services to the Medicare Benefits Schedule. Some of the services, as seen in the rest of world, were not based on any real evidence of need and additional benefit (eg services to people with eating

disorders and children with autism). Other services were grounded in some evidence (eg mental health treatment) or fulfilled a public health gap, such as the provision of pre- and post-exposure prophylaxis.

To date, telehealth has focused on talking assessment and therapy. The physical examination component has been limited to home-based measurements such as blood pressure and temperature and gross observational assessments of skin, respiratory rate and musculoskeletal movements.<sup>7</sup>

More challenging in the pandemic environment is the investigation of other ailments via telehealth, such as sexually transmissible infections. Primary care clinicians who provide these services in environments where the COVID-19 burden is high are already reporting a lack of personal protective equipment; limited supplies, such as swabs, due to categorisation as a 'nonessential' service; and limited laboratory services when state health departments maximise COVID-19 testing and private laboratories no longer collect specimens but require them to be delivered by patients.<sup>8</sup>

Notwithstanding all these issues, flat-screen health is here to stay. Global medical entrepreneurs – such as Babylon Health, bots or macros in electronic medical records – will be taking over diagnostic interviewing.<sup>9</sup> This provides an opportunity for a broader range of remote and technical skills. For example, digitised electronic stethoscopes and electrocardiography via smartphones have been on the market for some time.<sup>10</sup>

Using these remote technologies requires training and supervision not often provided in medical schools and specialty training to urban physicians. Programs of technical training need to be introduced so that telehealth can provide a more complete consultation.

There are many challenges to clinicians undertaking telehealth, and even more to researchers who will need to conduct deep-dive assessments to supplement the growing literature evaluating patient satisfaction and the talking part of telehealth, and to observe and correlate a broader range of technical, diagnostic and therapeutic aspects. Regulators and global health agencies also might consider working on ways to ensure ethical practices and outcomes are maintained.

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