COMMENTARY

Telehealth to Address Health Disparities: Potential, Pitfalls, and Paths Ahead

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Abstract: Telehealth has the potential to address health disparities, but not without deliberate choices about how to implement it. To support vulnerable patients, health policy leaders must pursue creative solutions such as public-private partnerships, broadband infrastructure, and value-based payment. Without these initiatives or others like them, health disparities are likely to persist despite telehealth's tantalizing potential.

As COVID-19 spread and strained our health systems, large sectors of the economy, including healthcare, went remote. But closing doors also meant opening screens — smartphone, tablet, and computer. Blake et al. argue that telehealth, and remote health care delivery in general, is a key tool to mitigating health inequities, even beyond the pandemic.[1] Because telehealth can reach beyond traditional office locations, it can be used even in communities where many doctors never set foot. Patients spend less time traveling and waiting; physicians may be able see a greater number, and more diverse array, of patients. Not only can telehealth increase access to health services, but telehealth also promises to be cheaper than in-person care — both for the patient and the provider.

But making good on telehealth's potential to address health disparities requires several assumptions, which, as the authors point out, cannot always be assumed. One is technological. Many of those who could benefit most from telehealth are the least likely to have the technology required to use it. Sometimes this is because of affordability: they lack the resources to purchase a smartphone, tablet, or stable internet access. Even if lower-income patients own a smartphone or computer, they may live in communities that lack access to technological infrastructure, like high-speed internet, necessary to use many dominant telehealth services, such as virtual video visits.

In some cases, alternative modes of communication (such as using phone calls, text messaging, or online questionnaires) rather than video conferences for consultation and ancillary services, can mitigate technological concerns.[2] Where a computer program automatically translates text from English to a foreign language, for example, non-visual communication can actually increase healthcare accessibility. But some consultations require devices with a particular kind or quality of visual display, which patients may not have. Finally, some populations like the elderly or persons living with disabilities may not have the technological aptitude or physical ability to use digital tools if accessibility features are neither required by law nor built-in by developers.

To ensure that the benefits of telehealth are not drowned by the weight of these challenges, policy makers will need to consider creative technological, attitudinal, and financial solutions. On the technology side, existing infrastructure could be repurposed to address concerns about affordability and access. Com-

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munity centers, houses of worship, and public libraries could dedicate space, technology, and resources to telehealth. This would reduce overall investment costs in high-speed internet and technology by centralizing access points. Using centralized telehealth locations like houses of worship and senior centers would also move telehealth to familiar environments, which may increase uptake.

It is important to be mindful of not reproducing or reinforcing health disparities when using existing infrastructure to build out access to telehealth. Senior centers, for example, already play a significant role in providing community and educational activities, including home-based activities to those with physical disabilities, to the elderly or disabled. But they tend to play this role most prominently for certain demographic groups (mostly white, single/widowed older women with moderate to low incomes and minimal physical disability) who tend to use senior centers the most. Increasing the role of senior centers ccounting for current access issues, then, could exacerbate, rather than reduce, current inequities in access to telehealth.[3]

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When such access points are not feasible or would fail to meet the needs of underserved populations, there are opportunities for other public-private partnerships. Big-Box stores, pharmacies, and insurers — like Walmart, Target, CVS, Walgreens, and Express Scripts — may also provide affordable access points within marginalized or rural communities. Another solution is to supply the required technological devices, as the Veteran's Administration has recently done by providing patients with physical devices (tablets) to increase telemedicine uptake.[4] Combining these solutions as the delivery of prescription pharmaceuticals becomes more popular — by, for example, subsidizing companies to distribute technological hardware with prescriptions — could further increase telehealth uptake. Municipal-owned broadband rollout would also help increase the ability of low-income patients to utilize such devices. Given the current administration's proposal to spend $100 billion to expand broadband access, there appears to be both the political will and financial support to do so.

Another concern is social. Patient attitudes toward telehealth vary.[5] Some patients may be more hesitant than others to adopt telehealth because of distrust, cost, or contextual factors, such as age, income, and education. These attitudes may differ not only across demographic groups, but also across technology. Relatedly, and importantly, all of these issues also affect provider use of telehealth.[6] Put another way, technological and attitudinal factors influence whether providers, not just patients, adopt and use telehealth services.

Changing attitudes will in some ways be a more significant challenge than building out infrastructure. One truism of telehealth is that aversion decreases as exposure increases,[7] but high aversion makes repeat exposure difficult. COVID-19 has, in part, overcome this difficulty by forcing many providers to operate remotely, increasing public exposure, and decreasing public aversion, to telehealth. But the pandemic telehealth boom has focused largely on translating existing care relationships, rather than establishing new healthcare relationships. Unfortunately, this can disadvantage Black, Indigenous, and People of Color (BIPOC) populations, who are less likely to be connected into care in the first instance. Continued, widespread use of telehealth will require additional educational efforts and community outreach to help ameliorate these concerns. Patient education should include information about the various types of telehealth and how they can be adapted to meet their needs. Provider education on telehealth should also

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focus on establishing new relationships and diagnoses, rather than only translating chronic care, to ensure that no individuals are left behind.

Incentivizing payors to adopt telehealth will also require different techniques. Payors, of course, will need evidence that telehealth is as effective as in-person healthcare, or at least less expensive. While some payors, such as the Centers for Medicare and Medicaid Services,[8] have been willing to expand telehealth coverage during the pandemic, it is not clear how their reimbursement policies will change once the pandemic ends. Providers, too, will need assurance of profitable reimbursement, especially because telehealth visits can result in fewer diagnostics, procedures, and interventions to charge for.[7] This suggests that payment parity requirements alone are not sufficient to make telehealth financially attractive to fee for service providers.

Here value-based care payment structures can help align incentives to promote telehealth, including to underserved populations. Because providers receive a monthly ("capitation") payment based on patient outcomes, providers have incentives to provide patients the most effective, rather than the most expensive, care. At least one provider focused on lower-income patients reports that a value-based payment model enabled it to shift quickly and seamlessly to telehealth without sacrificing significant care.[9]

Blake et al. are right to flag that telehealth as a useful tool to address health disparities. But without focused policy initiatives to promote its use in BIPOC communities, it will not realize this potential. These policies can and should vary. Developing alternate sites of telehealth delivery, expanding community broadband access, educating providers to utilize telehealth at the start of care relationships, and utilizing alternate payment structures can all contribute to normalizing and expanding telehealth in vulnerable communities.

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