Telehealth and Inequity during the COVID-19 Response

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**SUMMARY.** The COVID-19 pandemic has accelerated the use of telehealth to improve health care access and promote social distancing. However, telehealth introduces new challenges and barriers for health care access, particularly where patients are responsible for initiating a telehealth encounter without a facilitating provider (e.g., a health clinic as an originating site). A successful telehealth encounter requires capable technology, reliable high-speed internet, and sufficient digital literacy to use telehealth software. In addition to these telehealth-specific barriers, traditional health care barriers, such as cost, coverage, cultural competence, and disability, can be compounded or amplified by the confluence of telehealth and the impacts of COVID-19. Unfortunately, these barriers are disproportionately experienced by many populations that already face disparities in COVID-19 burden and risk. As such, health care disparities and inequities could widen for some populations with an increased focus on telehealth during the COVID-19 response. This Chapter supplements the recommendations provided in the first Volume with additional recommendations intended to address telehealth disparities and inequities including funding for community health workers to educate and train patients for telehealth services and subsidizing technology and internet access needed for telehealth services.

**Introduction**

Telehealth is a tool that improves health care access by connecting patients with distant providers (HRSA, 2018; Speyer et al., 2018). More recently, it has been used as a tool to promote physically distant care to protect providers and patients from COVID-19 infection (Schmit et al., 2020). In this way, telehealth addresses a singular, but critical, health care barrier: access to availability of health care services. A number of different factors determine the availability of health care services to a particular patient. For example, a patient in a rural area might be far from an available provider. Similarly, a patient might not have access to transportation to reach an available provider or available transportation (e.g., public transit) is prohibitively difficult or time consuming to use to access needed health services. During the COVID-19 pandemic, these barriers to health care services are compounded by safety concerns, like risk of transmission in provider offices or on public transportation. The effective use of telehealth in these situations can facilitate access to health care services while mitigating safety risks (Schmit et al., 2020).

However, telehealth does not eliminate all barriers to health care access. In fact, telehealth introduces new barriers to health care services (Nouri et al., 2020). In traditional health care, a patient needed a mode of transportation (e.g., a car), a way to travel (e.g., roads), and knowledge of how to get there. In telehealth applications, these barriers are swapped for new barriers: access to a telehealth-capable device, access to high-speed data transmission, and digital literacy (Velasquez & Mehrotra, 2020). A person without a telehealth-capable device (e.g., smartphone or computer with webcam) cannot access telehealth services. Similarly, a person cannot access telehealth services without access to reliable high-speed internet regardless of whether or not they have a telehealth-capable device. Moreover, telehealth can be challenging for those who are not comfortable with new technologies, have difficulty communicating on digital platforms, or do not have strong technical skills. While telehealth has no doubt made health care services more convenient for digitally-capable people with adequate technology and reliable internet in the COVID-19 pandemic, telehealth remains out of reach for many without these luxuries (Nouri et al., 2020; Hirko et al., 2020).

Unfortunately, many of the same individuals that previously faced health care access barriers, face these new barriers when accessing health care services through telehealth. (Nouri et al., 2020; Katzow et al., 2020). For example, elderly people, people of color, and individuals with low economic status all experience disproportionate challenges with access to telehealth-capable technology, digital literacy, and reliable internet coverage (Velasquez & Mehrotra, 2020). Notably, the populations facing disproportionate telehealth barriers also face disproportionate burden and risk of COVID-19 (Velasquez & Mehrotra, 2020). Moreover, these populations also face disproportionate barriers to
traditional health care including transportation, cost, health care coverage, language barriers, and lack of culturally competent care. Importantly, telehealth does not solve all barriers to health care access. The majority of governmental actions promoting telehealth have focused on supply-side barriers such as restrictions on provider types (e.g., nurse practitioners, occupational therapists, mental health professionals), and modalities (e.g., asynchronous, audio-only, secure messaging) (Schmit et al., 2020). Government interventions addressing these supply-side barriers are intended to promote telehealth delivery. Fewer governmental actions have focused on demand-side barriers, such as cost, location restrictions, and technology access. As health care providers shifted toward telehealth-only care, it is clear that many patients benefited from the expanded availability of convenient health care appointments from the comfort or safety of their homes. However, other patients experienced new and sometimes exacerbated barriers as in-person health care transitioned to telehealth modalities in the COVID-19 environment (Nouri et al., 2020). These exacerbated barriers are likely to be the most pronounced with telehealth services provided in a patient’s home, where the patient is responsible for acquiring needed technology, establishing a suitable network connection, and operating the telehealth application independently.

**Existing Health Care Barriers Compounded by Telehealth and COVID-19**

**Cost and Coverage**

Health care services are expensive, and individuals without health care coverage or with limited resources often face difficult budgeting decisions between competing essential needs (e.g., groceries, rent, health care) (Healthy People, 2020). Several state and federal actions in response to COVID-19 were intended to address costs but were limited in their scope. For example, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) contained provisions limiting patient costs, but these provisions were limited to COVID-19 testing and treatment. Additionally, several states took emergency actions to limit out-of-pocket expenses for telehealth services for those with health care coverage (Schmit et al. 2020). However, generally patients making decisions about whether to see a provider for a health concern during the COVID-19 pandemic still face the same cost challenges as they did prior to the pandemic. Moreover, a patient that needs telehealth faces additional costs (e.g., telehealth-capable device, high-speed internet).

Related to cost, the lack of health care coverage is a substantial barrier to health care services. People without health insurance face long-term financial consequences from an unexpected health condition (Healthy People, 2020). This often results in delayed care for uninsured persons, and worsening of existing conditions (Stop TB Partnership, 2020). COVID-19 has exacerbated this existing barrier by creating dire economic conditions resulting in lost employment, and consequently, lost employment-based health coverage. Health care coverage can be further magnified as a barrier if health care systems and providers focus scarce telehealth capacity on patients with health care coverage that provides the most lucrative reimbursement rates (i.e., private insurance) (Clair et al., 2020).

Telehealth has additional coverage challenges. As an emerging health care innovation, insurers reasonably were skeptical of the comparative quality of telehealth services as compared to similar in-person services. This initial skepticism resulted in health care coverage policies that provided less coverage and reimbursement for telehealth services than similar in-person services. Since then, federal and state governments have gradually enacted laws and policies that have required health plans to provide comparable coverage and reimbursement for telehealth services to the similar in-person service (CCHP, 2020; Schmit et al., 2019). This coverage expansion accelerated tremendously in response to COVID-19 (Schmit et al., 2020). Nevertheless, regulatory inertia — affected by political will, available resources, external influences, etc. — means that telehealth coverage still lags behind traditional in-person services. Consequently, coverage barriers are increased for people needing telehealth services.

**Cultural Competence**

Cultural competence is essential for productive provider-patient relationships and successful treatment outcomes (Healthy People, 2020). Cultural competence fosters patient trust and enables providers to understand the specific context, lived experience, and environmental conditions that shapes the lives, and ultimately, the health outcomes of their patients. Telehealth has potential to promote cultural competence because it allows providers a limited window into the lives (and perhaps homes) of their patients. However, telehealth also leaves a physical (and emotional) distance between the provider and patient. This distance can obscure social and cultural cues, slow the development of trusting relationships, and fortify a provider’s inherent biases that contaminate treatment decisions. Consequently, telehealth creates some additional challenges for culturally competent care. Community health workers are especially well-suited to address cultural barriers due to their specialized knowledge of the communities they serve and have promising potential to assist with telehealth education and training (Velasquez & Mehrotra, 2020).

**Language**

Language can be a substantial barrier to health care access (Healthy People, 2020; Katzow et al., 2020). Beyond the substantial and consequential difficulties that can result from language differences between the provider and the patient, language can be a substantial barrier to navigating the health care system generally. For example, a non-English speaker might have difficulty identifying a provider and making an appointment.

Language is a pronounced barrier for telehealth encounters (Katzow et al., 2020). In addition to navigating the health care system, patients need to learn how to use the telehealth platform, which can be difficult for non-English speakers in the United States (who might also have digital literacy challenges). Additionally, interpretation services must be available to facilitate the health care encounter and facilitate patient understanding of
the prescribed treatment. While interpretation services can be integrated into a telemedicine encounter, doing so requires the provider has established those processes and workflows. Given the rapid transition to telehealth and strain on the health system due to COVID-19, developing the processes and workflows for interpretive services is not trivial. In the meantime, language barriers to health care access are magnified.

Disability

Telehealth brings both benefits and challenges for people with disabilities. Telehealth has substantial potential to improve health care access to persons with disabilities that create travel challenges for in-person health care appointments (Noel & Ellison, 2020). In those cases, telehealth care eliminates the barrier by facilitating the health care encounter in a convenient location (especially if at the patient’s home). However, telehealth cannot address all barriers to health care access for people with disabilities. The disabled community is diverse and health care access challenges can be highly unique given the nature of a person’s disability. Moreover, people with disabilities face a technological disparity in that they are less likely to own a computer and less likely to be online (Noel & Ellison, 2020). Consequently, these technological disparities threaten to widen the existing health disparities for persons with disabilities as COVID-19 forces health care encounters to telehealth modalities.

Additional Barriers for Telehealth Services Technology Access

Telehealth requires a telehealth capable device and reliable internet coverage (Velasquez & Mehrotra, 2020; Nouri et al., 2020). Both of these requirements are significant costs particularly in the challenging economic environment caused by COVID-19. Life-changing events precipitated by the COVID-19 pandemic can cut a person off from the internet. The loss of a job, an eviction, or the closing of a local library can mean the loss of a computer used for online access. Individuals without a telehealth-capable device may be spared a co-pay by state or federal law, but cost of a new computer or smartphone is a much steeper entry requirement.

Federal and state actions in response to COVID-19 have sought to ameliorate technology access issues by authorizing new modalities of telehealth delivery, including "store-and-forward" asynchronous communications, audio-only (i.e., telephone) communication, and secure messaging (e.g., text, email). Previously, real-time interactive (i.e., synchronous) video communication was the dominant and preferred mode of telehealth delivery for quality health care encounters (CCHP, 2020; Schmit et al., 2019). Expanding telehealth services to include new modes of delivery that could be used by individuals with limited technology access certainly helped persons access needed services who would otherwise be cut off from health care during COVID-19 restrictions. Some care is better than no care (Schmit et al., 2020).

However, governmental efforts authorizing inferior modes of telehealth do not fix the inequities that result from unequal technology access. In fact, normalizing inferior modes of health care services (i.e., audio-only telehealth), only serves to bake unequal treatment into the system for those with fewer resources, ultimately leading to wider inequities in health care outcomes.

Addressing the technology access barrier is an immense challenge in the COVID-19 pandemic. Adding new community resources (e.g., publicly accessible library computers) create new opportunities for spreading the virus in the community. Addressing technology barriers while limiting opportunities for COVID-19 spread requires an individualized (i.e., expensive) intervention. For example, federal individual stimulus payments can be used to adopt the technology needed for telehealth (as well as remote work) during the pandemic. However, previous stimulus payments are likely to have been too little to provide much more than basic sustenance for those in need (i.e., food, utilities, rent), much less telehealth-capable technology.

Broadband Access

Similarly, regular payments for high-speed internet services are a luxury for many families in the present environment. With families making difficult decisions about groceries, rent, and utilities, the sustained cost for internet access can be an increasing burden. Utility cut-offs and evictions can abruptly eliminate previously available internet access. Additionally, previously available Wi-Fi hotspots have become more limited as businesses have reduced capacity, cut operating times, or closed (Lawton, 2020). Given the cost-savings associated with telehealth combined with the potential savings associated with preventing more costly services (e.g., emergency room visits) with early intervention, there is a fiscal argument for providing support for broadband access as a means to enable telehealth services (Nord et al., 2019). This fiscal argument is particularly strong for patients with chronic conditions and high utilizers of health care services during the COVID-19 pandemic, where many health conditions may be neglected as a result of current difficulties (e.g., economic constraints, physical distancing).

The federal CARES Act contained substantial funding, including providing $200 million to the Federal Communications Commission, to improve broadband infrastructure and funding to address telehealth technical barriers (Schmit et al., 2020). Much of this funding has gone to expand broadband access, especially in rural areas, as well as supporting public Wi-Fi access (e.g., libraries), and improving connectivity in clinics for telehealth services (e.g., Federally Qualified Health Centers) (Pew Charitable Trusts, 2020). While expanding available free Wi-Fi locations improves access, it is not a perfect solution. Public Wi-Fi locations create additional risks for viral spread, and raise privacy concerns for telehealth appointments (i.e., eavesdropping). More recently, Section 904 of the Consolidated Appropriations Act of 2021 created the Emergency Broadband Connectivity Fund and the Emergency Benefit Program that provides a monthly discount for broadband internet access and equipment during the COVID-19 response. As a discount, these programs help individuals that can afford standard internet connectivity upgrade to broadband, but it will have limited utility to those who cannot afford internet as an additional monthly expense. Still, the Emergency Broadband Connectivity Fund provides a new tool to address broadband access disparities.
Digital Literacy

Digital literacy is a barrier to telehealth services that is disproportionately felt by some populations, particularly for the elderly, people of color, and individuals with low socioeconomic status (Velasquez & Mehrotra, 2020). Utilizing telehealth requires comfort with technology, including operating the device (e.g., smartphone, computer) and navigating required applications (Katzow et al., 2020). A new telehealth encounter might require a patient to become familiar with a provider’s online patient portal to find appointment details and instructions. Telehealth patients might also need to identify, download, install, and operate a new telehealth application, which might differ between different health care providers. When patients have substantial technical difficulties, appointments can be missed, cut-short, or converted to a less than ideal format (e.g., phone) (Crawford, 2020). Since these challenges are disproportionately experienced within certain populations, continued reliance on telehealth as a dominant form of health care delivery risks widening inequities among these populations without adequate care or intervention (Velasquez & Mehrotra, 2020; Katzow et al., 2020).

Inequities and Disparities Compounding Telehealth Barriers

Inequities and disparities can be substantial barriers to health care access generally, but these disproportionate impacts are not felt in a vacuum. COVID-19 hit health systems, social structures, and economic sectors with existing disparities and inequities. Accumulating evidence shows that COVID-19 disproportionately affects certain populations through increased health risk as well as economic and social harm. Perhaps unsurprisingly, the populations that are hit the hardest by COVID-19 are many of the same populations that experience the most significant economic, social, and health inequities (Artiga et al., 2020).

These existing inequities and disparities contribute to barriers for telehealth services. The lack of education can contribute to digital literacy. Unemployment, underemployment, and low wages limit resources available for telehealth-capable technologies and high-speed internet. Consequently, the same populations that might have the highest need for health care services also experience substantial barriers to receiving telehealth services (Nouri et al., 2020; Velasquez & Mehrotra, 2020). As a result, telehealth’s value as a tool to promote health care access is inequitably limited for many disadvantaged populations.

Telehealth as a Health Care Access Solution

Without question, telehealth is a tool that promotes access to health care, reduces health care costs, and promotes the physical distancing necessary to slow COVID-19 transmission (Schmit et al., 2020). Telehealth can be an extremely convenient option for individuals who have a telehealth-capable device, like a smartphone or computer with a webcam, a reliable high-speed internet connection, and have good digital literacy. For these individuals, telehealth is an effective, convenient and cost-effective option (Nord et al., 2019). However, telehealth is not a panacea for all health care access barriers. Existing barriers, such as cost, coverage, cultural competence, language, and disability might remain despite a telehealth care option. Moreover, if telehealth is the dominant available option, these existing barriers can be amplified for some patients (Katzow et al., 2020). Additionally, telehealth creates new barriers that can be substantial for some patients. A telehealth encounter requires sufficient technology, network connection, and user knowledge to be successful (Velasquez & Mehrotra, 2020). These requirements can impede health care access where patients are expected to independently connect with providers (i.e., without a facilitating provider).

Most concerning is that these telehealth barriers are experienced disproportionately by populations already experiencing significant disparities and are facing high-risk for COVID-19 exposure and harm (Kaiser Family Foundation, 2020). As such, the convergence of disparities and telehealth access barriers will likely lead to widening inequities if not addressed. Indeed, a substantial drop in the proportion of at-risk populations (i.e., older adults, people of color, and individuals with low socioeconomic status) receiving telehealth services was observed in the early months of the COVID-19 response (Nouri et al., 2020). The reality is that telehealth is a tool with clear entry requirements. To the extent patients bear the burden of these entry requirements, telehealth will remain a tool for the privileged (Katzow et al., 2020).
Recommendations for Action

The previous Volume provided numerous recommendations to promote the use of telehealth during the COVID-19 pandemic and beyond. The recommendations below are intended to supplement those prior recommendations.

**Federal government:**
- Congress should authorize Medicare and Medicaid reimbursement for community health workers providing patient training and education relating to telehealth and encourage providers to target populations with known disparities in telehealth services.
- Congress should authorize technology and broadband subsidies (such as those in the Emergency Broadband Connectivity Fund) for high utilizers of Medicare and Medicaid programs to enable preventive health care services during the COVID-19 pandemic.
- The Department for Health and Human Services and the Centers for Disease Control and Prevention should monitor inequitable outcomes associated with telehealth policies and practices, especially in vulnerable populations.

**State governments:**
- State legislatures should provide funding for community health workers to provide telehealth training and education to vulnerable populations.
- State legislatures should provide technology and broadband subsidies for high health care utilizers and vulnerable populations to enable preventive health care services during the COVID-19 pandemic.
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References


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