Canadian Doctors for Medicare Position Statement on Virtual Care

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Executive Summary

Virtual care[1] revolutionized health care delivery during the COVID-19 pandemic. While the expansion of virtual care has the potential to improve the overall health of Canadians, it could also exacerbate existing inequities in access to care.

It is clear that virtual care is here to stay. As we consider its role in both pandemic and post-pandemic health care delivery, we must look to the advantages of virtual care such as: reducing inconvenient in-person visits, increasing efficiency and accessibility, and reducing costs. Digital health[2] and information technology can also empower patients though expanded access to their medical information with electronic health records.

At the same time, we must be cognizant of the limits of virtual care so as to prevent exacerbating existing inequities in access to care. Without safeguards in place, private pay virtual care could worsen access to health care especially for those facing hardship, increase fragmentation of care, and lead to expansion of for-profit investor-owned health care delivery. The latter in particular comes with the risk of the commercialization of patients' health data, putting the privacy and security of health records in peril.

Canadian Doctors for Medicare (CDM) believes that the implementation of virtual care should be guided by the following principles:

1. Virtual care should be used to increase the efficiency of the publicly-funded health care system
2. Patient preference must come first when deciding between in-person and virtual care

[1] "Virtual care" is the practice of using remote technologies, such as phone calls, video conferencing, connected devices, text messages, and online chats.
[2] Digital health" is the larger universe of digital devices, algorithms, and apps that support informed decision-making and collaborative communication across the continuum of care.

3. Private pay virtual care should not replace or compromise our existing publicly-funded health care system
4. Virtual care should improve equitable access to care and reduce health disparities for all, including underserved and marginalized populations
5. Continuity of care must be enhanced, not be sacrificed
6. Patient data are for care, not profit

CDM believes that virtual care must be leveraged and incorporated within our public health care system to provide accessible, high quality, equitable, and sustainable health care for everyone in Canada.

Virtual care is here to stay. It should be used to increase the efficiency of the public health care system.

Canadians are demanding virtual care and digital access to information, with 82% wanting their prescriptions sent directly to their pharmacy, 79% wanting access to their personal health information electronically, and 57% wanting care via SMS-Text messaging.[1]

During the first wave of the pandemic, virtual care accounted for 70% of ambulatory care provided by physicians in June 2020[2]. At Women's College Hospital (WHC) in Toronto, over 90% of visits during this period were virtual.[3]

Virtual care delivers patient-centered care (and is often preferred by patients) as it reduces or eliminates some barriers to care.[4] Reducing barriers such as lost income due to time off work, lack of child care, and the cost or accessibility of transportation are important benefits of virtual care.

Long before its rapid expansion during the COVID-19 pandemic there was evidence that virtual care could reduce these barriers and improve access. In 2018- 2019 the Ontario 'Telemedicine Network Enhanced Access to Primary Care' (EAPC) project found that 93% of patients felt telemedicine visits saved them time while 92% believed it was more convenient than face-to-face care.[5] Data from *Canada Health Infoway* reveals that patients saved $105 per visit with virtual care compared to in-person care when factoring in time off work, transportation, childcare, and other costs.[6] During the pandemic, a study of patients accessing virtual cancer care at the University Health Network in Toronto, Ontario found savings of approximately $136-142 per patient in travel and opportunity costs.[7]

Costs related to accessing in-person care is disproportionately felt by hourly wage earners, those responsible for the care of children and the elderly (predominantly women), and those with transportation challenges related to geography or mobility.[8]

Virtual care has the power to improve efficiency by connecting health care providers quickly and easily with one another. A pre-pandemic study in Ontario found that 49% of in-person referrals could be avoided by using an eConsult telemedicine service, resulting in primary care

providers having quicker access to specialist consults while simultaneously reducing in-person wait lists.[9]

In the US, telehealth services have been used to provide acute stroke expertise in rural and remote settings which are over-represented in stroke morbidity. [10] Telestroke utilization has been cost-effective, improving continuity of care and shorten hospital length of stay.[11]

A study with patients and providers from five regions of Ontario using both synchronous (audio/video) and asynchronous (secure messaging) found that 81% of virtual visits required no follow up and 99% of patients would use the service again.[12]

To improve health care delivery and unlock these efficiencies, physicians and other health care providers must receive support by way of training, infrastructure, and other resources necessary to best utilize virtual care technology.

In the selection of virtual vs in-person care, patients must come first.

With a growing aspiration toward patient-centered care, the virtual doctor-patient relationship must be held to the same legal, ethical, and professional standards as traditional in-person care.

If patients require a physical examination for proper assessment, timely access to in-person care must be available. Physicians should consider patients' social context, health status, specific needs, other circumstances—especially patients' preference— in collaboratively determining with each patient whether in-person or virtual care best serves their patient, including which modality of virtual care is used.

Health provider preference, convenience and cost-savings should always be secondary to patient's needs and preferences. Physicians should be transparent about any potential limitations in their assessment if care is provided virtually.

Neither privately-funded nor investor-owned virtual care should compromise our existing services or compromise our single payer, publicly-funded health care system

At the beginning of the COVID-19 pandemic, there was an unprecedented shift from in-person to virtual care. Many provincial and territorial health plans did not initially cover virtual care modalities.[13] This enabled private for-profit investor-owned virtual care companies to exploit these gaps and undermine the core tenets of Medicare in Canada by offering virtual care to individuals willing to pay.

Some provinces and territories (PT) were slow to expand virtual care billing codes or limited which modalities of virtual care were covered, which created further opportunities for the expansion of private pay virtual care. For example, very few PTs include text messaging as a publicly-insured modality of providing virtual care. A survey of Canadians showed that only

73% of virtual care visits were covered by a government health plan in 2021, down from 76% in 2020.[14]

Care is care.[15] All medically necessary care should be publicly-funded, irrespective of how or where it is delivered. CDM encourages governments to be adaptable and ensure that virtual care modalities that provide high-quality and efficient care are reflected in relevant legislation, fee codes, and infrastructure. This will ensure that future investments in virtual care follow the principles of Medicare - that medically necessary care, regardless of the modality with which is delivered, is publicly funded and that access to care continues to be based on medical need and not the ability to pay.

CDM is against the siphoning off of personnel or resources from the public system to private-pay episodic "virtual walk-in clinic" models, as this will only exacerbate wait times for those who cannot pay and undermine the public health care system that most Canadians depend upon.

Virtual care should focus on equity and reducing health disparities among underserved and marginalized populations

Longstanding geographic inequities in internet access result in inequities in access to virtual care. With more providers relying on virtual care in their practices, we must ensure that we are not disenfranchising already marginalized populations. As virtual care begins to play a more permanent role in health care delivery, we must consider the digital divide as a social determinant of health - one that must be addressed.[16]

Many rural and remote communities in Canada, which would benefit most from expanding virtual care, do not have reliable access to high-speed internet and would therefore not be able to access some modalities of virtual care, such as video appointments.

A recent survey found that reduced digital health literacy was associated with patients in rural locations, household income less than $50,000, aged 65 and older and with less education.[17] While governments have made some progress in increasing access to wireless broadband internet to rural and remote areas, many still lack access to the internet. These same populations often already have limited access to in-person primary and specialty care, and implementing virtual care without addressing internet access will only exacerbate existing inequity in access to health care services.

Beyond rural and remote communities, many low-income patients or those living in poverty - including those facing housing insecurity - may not have reliable access to a private device to benefit from virtual care. In a study of patients with substance use disorders, including those with concurrent mental health disorders, 36% lacked a private space to participate in a virtual appointment and 38% found the cost of cell phone minutes or data to be a barrier. These circumstances can be dynamic and patients should always have the option to book in-person care in a non-stigmatizing way. Despite these limitations, virtual care is still an important tool

for providing patient-centered care to marginalized populations, with 68% of study patients believing that investing in virtual services should be a government priority.[18]

Care providers must consider barriers to virtual care and accessibility needs as they incorporate more virtual care in their work. Providers must ensure that in-person care is available for those who want it, in order to not avoid worsening inequities or undermining patient preference.

Cultural safety and inclusive virtual care

Patients need access to user-friendly resources to increase technological literacy and allow them to engage in virtual care, in particular elderly patients and those with visual or hearing impairments. In a recent study, two-thirds of deaf patients faced communication challenges accessing virtual care.[19]

To facilitate equitable care that meets the diverse needs of individuals who are deaf or hearing impaired, these patients need access to various virtual modalities, such as supplemented by multi-way video relay (provider, patient, and interpreter), American Sign Language interpreters, and real-time captionists or apps that are specialized in health care interpreting. Public coverage through appropriate billing codes for instant messaging for this population.[20] Similarly, policymakers should ensure approved telehealth programs are accessible for individuals who are blind or visually-impaired, with built in resources such as screen readers and magnification.

Virtual care can help bridge a linguistic divide between patients and providers. There are over 70 recognized Indigenous languages spoken in Canada and an increasing population of newcomers with various first languages. For patients whose first language is not English or French, digital technology can help access translational services and improve the quality of care.[21]

Phone and video visits can also be used to provide culturally safe care for Indigenous patients by enabling them to engage with health care providers from their homes rather than in clinical settings which may be unwelcoming or intimidating. Health Canada found that virtual visits allowed patients to more easily end a call and disengage from care that they felt was unsafe or disrespectful.[22] Traditional healers and gifted elders could be used virtually to provide culturally specific palliative care. Many patients prefer to have family members support them during clinical encounters, especially momentous ones such as a major diagnosis or the delivery of bad news. This can be facilitated through the use of virtual care. For remote Indigenous communities, where the travel of multiple family members is difficult, virtual care can help patients more safely go through their medical journey.

There are risks, however, that virtual care could lead to a reduced physical presence of physicians in rural and remote communities. To prevent this, policymakers must use the tools and levers at their disposal, including legislation and incentives, to ensure that virtual care does

not replace in-person care in these communities, but rather enhances culturally-competent care.

Continuity of care should not be sacrificed

Increased access to health care providers other than one's regular primary care provider may lead to more timely care in some instances, but it also introduces the risk of increasingly fragmented and discontinuous care. Virtual walk-in services and other stand-alone solutions that disrupt the continuity of care can result in lower quality care at higher costs.

Virtual care is more effective when patient and health care providers have a pre-established relationship.[23] A recent Ipsos poll found that 59% of respondents preferred an ongoing relationship with a family physician over more convenient virtual care without a traditional doctor-patient relationship.[24]

Just like in-person care, continuity of care is critical for virtual primary care. Virtual care platforms must support confidential information sharing to prevent the erosion of the relationship between patient and primary care provider.

There are risks when high-volume, episodic care is incentivized. Without legislation or incentives to ensure that primary care providers are informed about episodic care, the burden falls onto the patient, and disproportionately affects vulnerable populations with the lower health literacy.

One investor-owned corporation that has rapidly expanded into the virtual care space clearly states on their website: *"Maple does not provide your primary care provider with a report of the Healthcare Services that you receive. We strongly recommend that you at least notify your primary care provider that you received, and the reason for which you received Healthcare Services so that your primary care provider can take them into account, including any medications prescribed for you."*

Virtual care can increase inappropriate prescribing of antibiotics in virtual visits compared to in-person visits.[25] This is not surprising when high-volume, episodic, and fragmented care is incentivized over longitudinal, relational care between a primary care provider and a patient.

The expansion of virtual care could be an opportunity to improve continuity and enable patients to have easier access to their records. This has been shown to increase patient's involvement and knowledge about their health and disease management.[26] If patients can access their records when in the emergency department, hospitals, or specialist clinics, this could further improve continuity and even reduce duplication of investigations.

The rise of virtual "walk-in clinics", much like their in-person counterparts, is in part due to a lack of access to longitudinal primary care. Therefore, increasing access to longitudinal primary care for all patients must be a priority for governments and medical associations. It is well-

known that there is insufficient access to primary care in many regions of Canada. From Newfoundland and Labrador where 19% of residents don't have a family doctor[27] to British Columbia where the number is similar at 1 in 5 residents without access to a family physician totalling about 1 million British Columbians.

Security of health-related information must remain a priority shared by patients, health care providers, virtual care providers and government. Electronic Medical Records and patient data must not be exploited for financial gain of private investor-owned corporations.

There must be transparency about the ownership and security of patient-related data. The rapidly changing landscape of virtual care makes it essential that governments and policymakers act quickly to develop regulation to protect the security of patient data[28].

Past data breaches have resulted in the release of sensitive patient information including identifying specific patients accessing care and even revealing entire videos of patient-physician appointments.[29]

Electronic medical records (EMR) should be exclusively used for patient care, not profits. There are a number of instances in Canada and elsewhere where the patient-physician relationship has been exploited via the EMR for the benefit of for-profit entities. For example, digitally-inserted medical vouchers on prescriptions for brand name medications over generic medications. While sold as a convenient way to provide discounts for patients, these vouchers could give patients the impression their physician was recommending the brand name over the generic and ultimately result in higher premiums and co-pays if used.[30]

There have also been instances where patients' health information has been sold in aggregate to private companies for financial gain without patients' consent or even their knowledge.[31]

CDM believes that the confidentiality and security of patient information from virtual care should be paramount. Data collected for the purpose of delivering health care should not be used for commercial purposes even if this information is aggregated and anonymized.

Governments should also assess the security and privacy impacts of virtual care and protect against the inappropriate profiteering from personal health information. As there are evolving number of technologies and organizations involved in the virtual care ecosystem, we suggest governments and policymakers urgently regulate and monitor security of patient data. Privacy laws need to be updated as the realities of health care delivery are changing.

CDM believes that engaging stakeholders and collecting good data is essential to continuously improving virtual care

We have outlined many potential benefits, and also potential risks, of virtual care. To ensure that virtual care is meeting the needs of patients, and to minimize potential harms, governments must regularly collect, assess and act on data on the impact of virtual care.

These data should consider the unique perspectives of all patients, with particular attention to marginalized communities, as well as providers and policymakers. The use of these data will help to ensure that virtual care is achieving the Quadruple Aim[32]:

1. Improving the individual experience of care*;
2. Improving the health of populations;
3. Reducing the per capita cost of health care; and
4. Improving the work life of health care providers, including clinicians and staff.

To ensure that virtual care doesn't further entrench current health inequities, governments must pay special attention to collecting demographic data and studying the impacts on marginalized specific communities. The rapidly changing landscape of digital health delivery will require governments to be nimble and respond quickly to update legislation.

Policymakers should see virtual care as an opportunity to improve the efficiency of our health care system, if implemented appropriately. To ensure this happens, we need to collect good data on the use of virtual care and patient outcomes, including short-term proxy outcomes such as admission and re-admission rates, numbers of referrals avoided, and reductions in specialist wait times.

Virtual care fee codes were created in haste out of necessity during the COVID-19 pandemic, and we now encourage thoughtful but urgent consideration of when and where virtual care is most appropriate and how it should be regulated and incentivized. When virtual care improves access, efficiency, or health equity, for example, without compromising quality or exacerbating health inequities, it should be maintained and encouraged.

The rapid expansion of virtual care in a relatively short period of time in order to meet patients' needs is a testament to what can be achieved with the right combination of political will, ingenuity, and collaboration. These characteristics should continue to underpin our approach to health care delivery as we emerge from the pandemic.

Virtual care is here to stay. But health equity, a principle central to Medicare itself, must remain the cornerstone of how we implement virtual care going forward.

Further Reading

The state of virtual care in Canada as of wave three of the COVID-19 pandemic: An Early Diagnostique and Policy Recommendations (Health Canada)

CADTH Horizon Scan: An Overview of Direct-to-Patient Virtual Visits in Canada (Canadian Journal of Health Technologies)

Virtual Care: Recommendations for scaling up virtual medical services (Canadian Medical Association)

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