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The Regulation of Virtual Health Care Services in Canada

Due to the need to keep patients connected with their health professionals while limiting in-person interactions, the COVID-19 pandemic fast-tracked the adoption of virtual care in Canada. This unexpectedly rapid adoption of virtual care may have advantages, such as improving access to care for patients in a manner that may not have occurred without the pandemic and which many regarded as long overdue. However, the fast adoption of virtual care often meant that policy choices were based more on expediency than on a deliberate and thoughtful weighing of the pros and cons of different virtual care models and a regulatory strategy to mitigate their risks. Policy-makers are now playing catch-up in addressing the potential issues posed by virtual care products, issues such as continuity of care, quality and appropriateness of care, and health privacy. This policy brief will make recommendations for policy-makers as they consider how best to regulate virtual care.



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Background

The Landscape of Virtual Care Products in Canada

Over the past several years, a number of virtual health care products emerged in Canada. For example, there are products that serve as virtual walk-in clinics by connecting patients with health care professionals with whom they do not have a pre-existing clinical relationship. Conversely, there are virtual care products that health care professionals can adopt to connect with their existing patients. In some cases, virtual care products have been designed specifically for the health care sector, while in other circumstances generic videoconferencing software has been used.

Another important distinction relates to the financing of virtual care products. Prior to COVID-19, virtual walk-in clinics tended to be privately paid for by patients, which limited their uptake. Most provinces either had or created new virtual billing codes in response to COVID-19 so that physicians could continue to bill for patient visits.¹ However, a number of provinces also entered into agreements with corporate virtual walk-in clinic providers, such as Telus Babylon or Maple, to provide insured virtual care services. Even as provinces have eased their public health restrictions, some form of virtual health care services continue to be insured in all provinces. Patient demand for these services remains high. For example, a Canada Health Infoway Survey conducted prior to COVID-19 found that while 41 per cent of Canadians wanted virtual visits with their provider, only four per cent of family doctors offered this option.²

¹ Doctors Manitoba . Virtual Visit Tariffs. 2020. Accessed June 5, 2021. Available at: www.doctorsmanitoba.ca/wp-content/uploads/2020/03/Virtual-Visit-Tariffs.pdf; Nova Scotia Medical Services Insurance. Physician's Bulletin: Notice to Physicians. 2020. Accessed June 5, 2021. Available at: www.msi.medavie.bluecross.ca/wp-content/uploads/sites/3/2020/03/March-18-2020-Bulletin-COVID-19.pdf; Government of Alberta . New App Helps Albertans Access Health Care. 2020. Accessed June 5, 2021. Available at: www.alberta.ca/release.cfm?xID=69851809AA1B8-AEA8-D268-E2D1E54D6DF119C0.

² Canadian Medical Association. Virtual Care in Canada: Discussion Paper. 2020. Accessed June 5, 2020. Available at: https://www.cma.ca/sites/default/files/pdf/News/Virtual_Care_discussionpaper_v2EN.pdf.

Access Challenges Posed by Virtual Care

Virtual products can facilitate access, for example by connecting health professionals with patients who do not have a primary care provider, live in remote areas, or have mobility challenges. Where virtual care makes access easier or helps to satisfy unmet medical needs, it can serve to enhance access to health care services. However, the fact that services are provided virtually will exclude certain groups, such as those who lack the requisite hardware or Internet connection, or who have disabilities (e.g. hearing impairments) that are not adequately accommodated by virtual products. In other words, while overall access may improve, this access may not be equitably distributed. Access would also be inequitable for virtual products that are not publicly funded.

A U.K. study on virtual walk-in clinics found that users were more likely to be young, educated, and healthy. Furthermore, the utilization of virtual products was greater than what one would typically expect of this demographic group.³ This suggests that when access to care is very convenient, it may drive up health service utilization and its associated costs, which is particularly problematic if the virtual care is publicly funded. While some of this utilization may represent unmet medical need, other visits may be only marginally beneficial or even unnecessary. This may be exacerbated by corporate virtual care providers advertising their products to consumers, thereby encouraging utilization.

While some provinces insure virtual visits provided through certain apps, others require patients to pay for consultations. Maple, one popular platform, charges patients \$49 for weekday visits, \$79 for weekend visits, and \$99 for overnight visits. This raises equity concerns because it allows wealthier people (who, on average, tend to be healthier) to purchase quick access to medical care, which may be delivered by doctors who would otherwise spend their time treating patients in the public system according to need rather than ability to pay.

³ Ipsos Mori and York Health Economics Consortium. Evaluation of Babylon GP at Hand. London: Ipsos Mori and York Health Economics Consortium. 2019. Accessed June 9, 2020. Available at: www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf.

Quality of Care Challenges Posed by Virtual Care

Virtual walk-in clinics, in which patients do not see a consistent provider, lack continuity of care and raise a number of quality of care concerns. There is a significant body of literature exploring the impact of continuity of care on patient outcomes. One crucial element of continuity is an ongoing relationship with a primary care provider, particularly for patients with chronic or complex medical conditions. For example, studies link continuity of care to improved health outcomes, reductions in emergency department visits, and fewer hospitalizations.⁴ Continuity of care may also suffer due to limits on access to health information. Virtual walk-in clinic physicians may have access to some medical records (by virtue of being licensed in that jurisdiction and thus able to log onto the provincial electronic medical record system), but these records may not include notes made by family physicians or other reports. In addition, notes from virtual consults via virtual care providers may not be shared with the patient's regular doctor.

Although virtual platforms that connect patients with their own providers would maintain continuity of care, there may still be quality of care issues associated with virtual care. For example, some studies have found higher rates of antibiotic prescriptions when the patient used virtual care rather than traditional, in-person care⁵, and some professional health organizations have recommended that particular medical conditions not be assessed and treated virtually. For example, a Canadian Medical Association report listed a number of symptoms that are not amenable to evaluation via virtual care: ear pain, cough, abdominal/gastrointestinal symptoms, musculoskeletal issues, most neurological symptoms, anorexia nervosa, and congestive heart failure.⁶ Furthermore, virtual care may be inappropriately distant for some encounters such as sharing a cancer diagnosis with a patient or conducting certain mental health consultations.

The literature from the U.K. also indicates that there are quality of care issues with the artificial intelligence-generated medical recommendations that are incorporated into certain virtual products, such

⁴ Gray, DJP, Sidaway-Lee, K, White, E, et al. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*. 2018;8(6):e021161; Canadian Institute for Health Information. Continuity of Care With Family Medicine Physicians: Why It Matters. 2015.

⁵ Ray, KN, Shi, Z, Gidengil, CA, et al. (2019). Antibiotics prescribing during pediatric direct-to-consumer telemedicine visits. *Pediatrics*, 143(5).

⁶ Canadian Medical Association. Virtual Care Playbook. 2020. Accessed June 5, 2020. Available at: https://www.cma.ca/sites/default/files/pdf/Virtual-Care-Playbook_mar2020_E.pdf.

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as misdiagnosis and a tendency to direct users to hospital.⁷ The algorithms that produce these recommendations have not been subject to rigorous independent scrutiny which, given their proprietary nature, is oversight that may never occur. There is also a lack of regulatory oversight over these technologies.⁸

Privacy Challenges Posed by Virtual Care

In most provinces and territories, relevant laws include health information statutes and, in some provinces, privacy legislation that applies to the private sector. The federal *Personal Information and Protection of Electronic Documents Act* (PIPEDA),⁹ which governs personal information collected, used or disclosed by private-sector organizations in the course of commercial activities, can also apply to virtual care. This legislation applies to personal information that crosses provincial/territorial and national borders and is especially relevant to regulating virtual care provided by out-of-province or foreign healthcare professionals and businesses. Similarly, providers operating within Canada who move health information across borders are subject to PIPEDA.

When patients virtually consult their own doctors, custodianship and ownership of health information is likely not an issue. Generally, persons or entities designated as custodians can collect and share health information under health information protection statutes. Physicians delivering virtual care to their existing patients are health information custodians and are bound by routine rules regarding the collection, use, and disclosure of health information.

With the virtual walk-in clinic model, more vexing considerations arise. While a physician who delivers care under this model is a custodian under the health information statute of the jurisdiction where he or she is licensed, the status of companies that operate virtual walk-in clinics is less clear. Since these companies will inevitably have access to patient health information, it is concerning that they may escape regulatory reach.

⁷ Cook, J. AI doctor app Babylon fails to diagnose heart attack, complaint alleges. *The Telegraph*. July 13, 2018; Fraser, H, Coeira, E, Wong, D. Safety of patient-facing digital symptom checkers. *BMJ*. 2018;392(10161):2263–2264.

⁸ Vogel, L. Rise of medical AI poses new legal risks for doctors. *CMAJ*. 2019;191(42):e1173–e1174; Iacobucci, G. Row over Babylon’s chatbot shows lack of regulation. *BMJ*. 2020;368:m815.

⁹ Personal Information and Protection of Electronic Documents Act, SC 2005, c 5.

Another concern is the use of terms of service or click-through agreements to obtain consent from users of virtual care apps. These agreements typically ask patients to consent to the retention, use, and disclosure of collected health information for purposes that are not clearly specified or which are unrelated to providing medical care. Putting aside issues with lay comprehension of the legalese in these agreements, consent is assumed from “clicking-through” regardless of whether the user actually read or understood the agreement. Given the sensitive nature of health information, authorization obtained for broad, unspecified use, disclosure, or retention of health information is likely to be legally problematic.

Recommendations for Policy-Makers

Although virtual care was rapidly adopted in response to COVID-19, policy-makers now have an opportunity to re-evaluate before it becomes entrenched as a permanent feature of the healthcare delivery system.

Recommendations for Self-Regulatory Bodies

1. Develop specific standards of practice for members engaging in virtual care in order to ensure that quality and appropriateness of care is maintained. These standards may address, for example, symptoms that cannot typically be evaluated virtually, or pharmaceuticals or treatments that should not generally be prescribed virtually. These standards may also provide guidelines respecting the referral of patients where care cannot be provided virtually. Colleges should also review their policies relating to physician/industry relations in order to ensure that they minimize any conflicts of interest between physicians and corporate virtual care providers.
2. Given that virtual care may be provided by health professionals who do not reside in the same province as their patients, colleges ought to revisit their telemedicine policies to ensure that patients are able to easily raise concerns about inadequate care and that the college has the jurisdiction to sanction out-of-province providers. The acceleration of virtual care in Canada may also provide an opportunity for provincial regulatory colleges, and government to engage in a conversation about national licensure.

Recommendations for Government

1. Governments must ensure that they are collecting data on the utilization of virtual care services and, in particular, publicly funded virtual services in order to identify and address inequitable access issues.
2. Governments ought to build terms and conditions into the agreements that they enter into with virtual care providers to ensure that they are not encouraging unnecessary or inappropriate care. For example, these providers advertise very extensively to promote utilization, which governments could limit through their agreements with providers. Some virtual care applications aggressively market additional health services to patients (which they pay for out-of-pocket) and/or engage in significant data collection (e.g. by encouraging users to complete assessments, synch their wearable fitness devices, or link up with existing store loyalty programs). These issues could also be addressed through the agreements that governments enter into with virtual providers or restricted through legislation.
3. Governments ought to amend their health privacy laws to designate virtual providers as custodians in health information laws. This would ensure that they are bound by the same rules that bind health professionals in terms of the collection, use, and disclosure of health information.
4. Given the widespread collection of information by virtual care companies, their use of click-through agreements in order to obtain patient consent, and questions around how and where they store health information, it is imperative that provinces obtain a privacy impact assessment by the provincial privacy commissioner prior to the adoption of new virtual care platforms.¹⁰

¹⁰ Office of the Saskatchewan Information and Privacy Commissioner. Advisory From the Office of the Information and Privacy Commissioner of Saskatchewan on Apps That Offer Health Care Consultations. 2020. Accessed June 5, 2021. Available at: www.oipc.sk.ca/advisory-from-the-office-of-the-information-and-privacy-commissioner-of-saskatchewan-on-apps-that-offer-healthcare-consultations/; Office of the Information and Privacy Commissioner of Alberta. Commissioner Investigating Babylon by Telus Health App. 2020. Accessed June 5, 2021. Available at: www.oipc.ab.ca/news-and-events/news-releases/2020/commissioner-investigating-babylon-by-telus-health-app.aspx.

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