# Never Let a Crisis Go to Waste

INTRODUCTION

*Owen Adams,* PhD
Guest Editor
Senior Advisor to the CEO
Canadian Medical Association
Ottawa, ON

## Overview

The adage "Never let a good crisis go to waste," widely attributed to Winston Churchill (Gruère 2019), has echoed throughout the COVID-19 pandemic. It aptly describes the rapid uptake of virtual care since March 2020 and other developments that it has inspired, including renewed attention to health information and data governance, interoperability, health equity, appropriateness and cross-border licensure.

It was a privilege to be asked to be guest editor for this issue. My interest in virtual care comes from supporting the work of the Virtual Care Task Force (VCTF) that was convened by the Canadian Medical Association (CMA), College of Family Physicians of Canada (CFPC) and Royal College of Physicians and Surgeons of Canada (RCPSC) in March 2019. The VCTF issued its first report on February 11, 2020, just weeks before the COVID-19 pandemic was declared (CMA, CFPC and RCPSC 2020). Will Falk did a panoramic stock taking in early 2021 for Health Canada (Falk 2021), and I thank him for agreeing to revisit it for the lead paper for this issue and also thank the commentators for their thoughtful perspectives.

## Emerging Themes: Teamwork and Access

Some interesting themes have emerged from the commentaries that highlight important issues yet to be addressed. Teri Price (2022) underscores the potential for virtual care to support team-based care. She clearly defines what we mean by teamwork and sets out a scenario of what it could look like. She credits the leadership of Ewan Affleck on the Alberta Virtual Care Working Group (AVCWG), which included representatives from nursing, pharmacy, medicine and Alberta's regulated health professions as well as patients (AVCWG 2021). Erik Sande (2022) describes the success of mobile integrated health programs during the pandemic. Affleck (2022) notes the preponderance of the word "physician" in Will Falk's paper (Falk 2022). Bibliometric analysis would reveal whether this reflects the literature, but, in any case, more work is needed on how virtual care can enable team-based care. There are some papers that address this (Mitzel et al. 2021; Sinsky et al. 2021), and the development of guidance and tools would be helpful. One barrier to the adoption of team-based virtual care is the continued narrow interpretation of "insured services" by provincial and territorial

insurance plans as applying only to physician and hospital services.

Access to primary care has become a major issue in Canada. Statistics Canada has released the results of the 2021 Canadian Community Health Survey, which shows that 4.7 million Canadians aged 12 and over do not have a regular healthcare provider (Statistics Canada 2022). Those who are fortunate to have a family physician may experience long waits to get an appointment. Michael Anderson (2022) outlines the potential for virtual care to improve access to remote Indigenous communities, where there can be high travel and opportunity cost to seek in-person care. Opportunity cost is also an issue in large centres if people have to take several hours off work to visit a clinic. Bell and Chow (2022) are critical of the discounting of episodic virtual care relative to that provided in an existing patient–physician relationship in the recent Ontario Physician Services Agreement (SEAMO 2022). Episodic virtual care may be the only realistic timely option for many Canadians short of going to the emergency room, a point also made by Timothy Foggin and Zayna Khayat (2022).

## Digital Health Equity

"Digital divide" is a term that refers to the risk of members of equity-deserving groups being left behind with advances in virtual care. Tharmalingham and Hagens (2022) note that in the 2021 physician survey more than one in two physicians indicated that each of several groups may need additional supports to access virtual care, ranging from 52% for low-income households to 63% for older adults and 71% for low levels of technology literacy. Affleck (2022: 40) makes a forceful call for "greater definitional and taxonomic rigour and the support of an established equity framework" to better address digital health equity. In their consensus statement on best practices for virtual care, the Canadian Rheumatology Association applied an equity lens to identify 10 equity-related factors and associated considerations for the decision making on virtual care versus in-person care (Barber et al. 2022). Equitable access to high-quality healthcare, whatever the mode, is important, but the issue is broader. A landmark Senate committee report on population health estimated that social determinants account for 50% of population health status and generously estimated that healthcare accounts for 25% (Standing Senate Committee on Social Affairs, Science and Technology 2009). Social inequalities account for a significant amount of healthcare use, and unless and until serious consideration is given to upstream population health strategies, we will never alleviate the pressures on the healthcare system (Mackenbach et al. 2011).

## Health Data Governance and Interoperability

Virtual care has rekindled interest in health information governance and interoperability. Trevor Jamieson and Denise Zarn (2022) remind us of the core purpose: that Canadians need access to digital health technology and information in order to pursue the highest level of health. A 1992 Supreme Court of Canada (SCC) decision addressed the ownership of personal health information clearly: "While the doctor is the owner of the actual record, the information is held in a fashion somewhat akin to a trust and is to be used by the physician for the benefit of the patient" (SCC 1992: Preamble). Two decades later, I have yet to see this spelled out adequately in legislation or policy. Similarly, existing privacy legislation and policy have never really satisfactorily addressed the secondary use of personal health information for the public good. The Public Health Agency of Canada (PHAC) convened an expert group to

develop a pan-Canadian health data strategy in December 2020. Its third and final report sets out a proposed Canadian Health Data Charter that puts the person at the centre (PHAC 2022). Its recommendations call for a shift from a custodial to a stewardship model of data governance that would mandate the appropriate exchange and reuse of health data. Similarly, with the guidance of its Patient Voice advisory committee, the CMA has proposed a framework for a patient-partnered approach to health information governance (CMA 2022).

Jamieson and Zarn (2022) describe interoperability as the Achilles heel of digital health, noting the progress that the United States has been achieving. The Competition Bureau of Canada initiated a digital healthcare market study in 2020, and its first report addressed interoperability, including a call for electronic medical record vendors to comply with "anti-blocking" rules (Competition Bureau of Canada 2022). The federal, provincial and territorial privacy commissioners and ombudspersons with responsibility for privacy oversight recently called on all actors in the health sector to work in a concerted fashion to implement a "secure and interoperable digital health communication infrastructure" and set out roles and responsibilities for the parties (Office of the Privacy Commissioner of Canada 2022). Health Canada provided funding to the provinces and territories and Canada Health Infoway in 2020 to advance work on interoperability standards and related issues (Health Canada 2021), but it remains to be seen if the federal government will act on the PHAC expert group recommendations to address the unfinished business identified in this and other reports.

## Appropriateness

Virtual care has stimulated interest in the appropriateness of virtual versus in-person care and the merits of telephone versus videoconference platforms. The Federation of Medical Regulatory Authorities of Canada (FMRAC) has developed model standards for virtual care, and several provincial and territorial medical regulators are making similar revisions to their policies (FMRAC 2022). In his 2021 paper, Falk called for specialty societies to develop specialty-specific guidelines, and the Canadian Medical Protective Association (CMPA) supports this call in a recent White Paper (CMPA 2022; Falk 2021). The Canadian Rheumatology Association took an interesting approach to this in its 2022 consensus statement (Barber et al. 2022). It classified seven reasons for the clinical encounter, ranging from reviewing test results to undifferentiated disease, and assessed them against clinical considerations, type of virtual care available and preference and access considerations. Segal et al. (2022) developed a framework for the appropriate use of virtual care in primary care that classifies care as either in-person optimal, virtual optimal or either mode acceptable depending on the clinical situation and contextual factors. More research is needed on the issue of telephone versus videoconference and on the appropriate role of asynchronous communication via secure e-mail or text.

## Education

Issues of team-based care, digital health equity, data governance and appropriateness all need to be incorporated into health professional education. Kendall Ho (2022) puts forward well-rounded perspectives on education that focus on evidence, mentorship, professional culture and social accountability and calls for an all-inclusive stakeholder partnership. Interprofessional education should be emphasized going forward.

## Payment

In the early days of the pandemic, governments introduced temporary fee-for-service (FFS) billing codes for virtual care provided over the telephone and via videoconference. Tharmalingham and Hagens (2022) note that as of May 2021, almost all physicians were providing virtual care over the telephone (93%), followed by videoconference (51%), e-mail and text messaging (36%) and remote patient monitoring (5%). A comparison to the 2020 experience of the US Kaiser Permanente health system suggests that there would be a much greater role for asynchronous virtual care in Canada if there was a payment mechanism for it. In 2021, Kaiser reported that 38% of their outpatient touches were done using secure e-mail – almost as many as the telephone (41%) and approaching double the proportion of office visits (21%) (Kaiser Permanente 2021). Bell and Chow (2022) also note the potential of remote patient monitoring and the need for a satisfactory funding model. In a study for Doctors Nova Scotia and the Nova Scotia Department of Health and Wellness, Deloitte recommended a stipend-based model to compensate physicians for asynchronous secure messaging (Deloitte 2022). More generally, the pandemic was certainly a disruptor to the long-established FFS model, and there is elevated interest in several jurisdictions in primary care capitation, but FFS is having a long goodbye. In 1999–2000, FFS accounted for 89% of physician clinical earnings in Canada; by 2009–2010, this figure dropped to 73% but has since stabilized at that level, reaching 72% in 2019–2020, and it will likely be around for a long time to come (CIHI 2021).

## Pan-Canadian Licensure

Pan-Canadian licensure has long been a dream of physicians who want to do locums in the rural and remote parts of other jurisdictions, and virtual care has stimulated considerable interest. Falk (2022) lists several use cases for cross-border virtual care, and I would add specialized consulting services from academic centres. Cross-border virtual care is also an issue for disciplines such as psychology, physiotherapy and dietetics, just to name the ones that have come to my attention. Anderson (2022) underscores the potential of cross-border virtual care to leverage the small number of Indigenous clinicians to provide culturally and linguistically congruent care to Indigenous communities. Temporary arrangements were put in place early in the pandemic, mainly between the territories and neighbouring provinces. Since then, medical regulatory authorities have been revising their regulatory standards and policies, and two have made significant changes. The College of Physicians and Surgeons of Ontario (CPSO) has now put in place a requirement that physicians providing virtual care to patients located in Ontario *must* be licensed in Ontario, and the Northwest Territories (NWT) has amended its legislation to permit an out-of-territory licensed physician to provide virtual care to NWT residents if they have a referral from an NWT physician (CPSO 2022; Government of the Northwest Territories 2022). One of the issues – aside from accountability for quality of care – is that cross-border care also implicates issues of billing and credentialing/privileging (i.e., access to laboratory and diagnostic imaging services). Governments are starting to show interest more generally in cross-border licensure. Premiers raised the issue of health worker mobility at their July 2022 meeting and indicated that they would work with regulatory authorities to address this (Council of the Federation 2022). The Council of Atlantic Premiers recently wrote to its medical regulators to propose "a regional approach that would ensure physicians licensed in the

region are able to practice in all Atlantic provinces without the need to acquire more than one license and pay additional licensing fees" (Houston 2022). Sweatman and colleagues (2022) reviewed models of licensure in sectors outside health to dispel the usual knee-jerk reaction that pan-Canadian medical licensure would require a constitutional amendment.

## Conclusion

As I monitor the developments in virtual care, it seems to me that we have no idea just how good and useful the technologies of virtual care and information systems are going to get. As Anderson (2022) noted, any medical device that can be attached to a computer can be incorporated into a virtual care program. To cite one example, Myers et al. (2017) reported on the promising results of a touch-capable technology that enabled a patient's own hands to serve as remote surrogates for the physician's in the screening of acute abdominal pain. The growing pains and reservations about virtual care that we see now remind me of Amara's law, attributed to 1960s computer scientist Roy Amara, who said that we tend to overestimate the impact of a new technology in the short run but underestimate it in the long run.

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