Intelligence MEMOS

From: Will Falk

To: Canadian Healthcare Observers

Date: April 1, 2025

Re: NO BACKSLIDING, PLEASE, ON VIRTUAL CARE

In 2021, I wrote a *report* for Health Canada, arguing that virtual care was no longer an emergency measure – it was a core part of modern healthcare.

Before COVID-19, fewer than 3 percent of ambulatory visits were virtual. At the peak of the crisis, that number exceeded 70 percent. Patients and clinicians adapted quickly, and for many, virtual care was not just a substitute but a meaningful improvement in how they accessed and delivered care.

A different way of making decisions allowed for more common sense and fewer arbitrary rules. This low-rules environment allowed the rethinking of past structures and payment models in the time of crisis.

The report made the case for making virtual care a permanent, equitable and fully integrated part of our healthcare system. It warned that without action, payment cuts, licensing barriers and bureaucratic inertia would erase progress. It argued that virtual care should be treated as a fundamental part of healthcare access, and that forcing in-person visits when virtual care is equally effective is an unnecessary barrier.

Five years after the start of COVID, those arguments remain true – but the system has slid back.

Good work by Health Canada on Bill 72 and the AI4Health Task Force Report both emphasize the need to get digitization right. Bill 72 aimed to modernize healthcare infrastructure, enforce interoperability standards and prevent data blocking, yet died on the order paper, leaving crucial digital health reforms stalled. Similarly, the AI4Health report underscored that ensuring core digital health assets – patient records, diagnostic imaging, lab results, and prescribing systems – are interoperable and universally accessible is fundamental to improving care delivery. These efforts point in the right direction, but without legislative follow-through, Canada remains far behind on healthcare digitization.

Canada's healthcare system claims to be universal, but in practice, it imposes significant costs on patients in time, travel and lost income.

A 2020 Infoway study found that the median out-of-pocket cost of an in-person visit was $100 – not for the care itself, but for travel, parking and childcare. For many Canadians, a 15-minute doctor's appointment can mean half a day of lost income. Patients in rural and remote communities don't just wait longer for specialists – they also face flight costs, overnight stays, and logistical headaches just to see them.

Virtual care was supposed to eliminate these unnecessary burdens. Yet, instead of treating virtual-first care as an essential part of an equitable system, many governments have rolled it back.

During the pandemic, provinces rapidly expanded virtual care reimbursement and removed administrative barriers. Once the crisis passed, many reverted to pre-pandemic policies – or worse.

Payment reductions for virtual visits have made it financially unsustainable for many providers, leading to unnecessary in-person appointments. Licensing restrictions remain, preventing patients from accessing providers across provincial borders, even when wait times are dramatically shorter elsewhere. Equity concerns have been ignored – despite clear evidence that low-income, rural, and time-constrained patients benefit most from virtual access. No physician should be having to force patients to be physically present only in order to get paid. Medically necessary virtual care should be fairly compensated.

These provincial failures have been made worse by the federal government's lack of clear guidance on virtual care.

The 2025 *Canada Health Act* (CHA) interpretation letter avoided taking a clear stance or even mentioning virtual care. This omission matters. The act is designed to ensure that medically necessary physician and hospital services are publicly funded, with no direct charges to patients. But when care shifts from in-person to virtual settings, it remains unclear whether virtual consultations – especially those provided outside traditional hospital or physician office settings – are covered.

Instead of clarifying this, the letter focused on expanding the concept of who delivers care (e.g., nurse practitioners and pharmacists) without addressing the mode of delivery. This leaves virtual services in a policy gray zone, where provinces have full discretion to fund, restrict or de-insure virtual care as they see fit.

We are left with a system that is neither public nor private, but confused, with different governments interpreting the rules in contradictory ways.

At this point, clarity is more important than perfection. Governments either need to fully integrate virtual care into the public system or explicitly allow a private-pay model.

Fish or cut bait on the public/private split. The situation has gotten smelly.

Modernizing digital infrastructure is no longer a matter of convenience – it is a necessity. Ensuring that healthcare is interoperable, accessible and ready for AI-driven improvements is critical to avoiding the mistakes of the past and preparing for the future.

It's time to stop debating and start doing. Care is care. The longer governments stall, the more patients suffer needlessly, and the more clinicians struggle under the weight of outdated systems. Action is long overdue.

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