

CMA submission:

DIGITAL HEALTH CARE AND COMPETITION – A PERSPECTIVE FROM THE CANADIAN MEDICAL ASSOCIATION

Submission to the
Competition Bureau Market Study
on Digital Health Care

June 25, 2021

Introduction

The Canadian Medical Association (CMA) is pleased to provide the following submission for the Competition Bureau's Market Study on Digital Health Care. Representing over 80,000 members across the country in the medical profession, CMA's focus is on creating strong and accessible health systems, fostering well-being and diversity in medical culture, and ensuring every person in Canada has equal opportunity to be healthy. As the national voice of the medical profession, we partner with physicians, medical learners, patients and others to advance these goals through advocacy, knowledge sharing, and granting.

While each of the research questions identified in the Notice of Study are important, in this submission, the CMA will primarily address the questions pertaining to data and information, and health care providers (as outlined in paragraph 13 of the Market Study Notice). In this submission, digital health is described as the integration of the electronic collection and compilation of health data, decision support tools and analytics with the use of audio, video, and other technologies to deliver preventive, diagnostic and treatment services that promote patient and population health.

The CMA strongly supports the important role of digital health care as a viable method of service delivery for patients and their caregivers as well as for health professionals. Technologies to deliver health care virtually, such as telemedicine/telehealth, have been around for decades. Work has also been underway for at least three decades to implement virtual care, but most of this work has been undertaken at the provincial/territorial level in the absence of a national framework. Digital platforms have the potential to greatly improve access to health services for all Canadians. This includes for those living in rural and remote areas as well as supporting older adults and others living with chronic conditions to remain in their homes/community. Provinces and medical associations have implemented temporary fee codes to varying degrees to support virtual care during the COVID-19 pandemic. Surveys continue to show high patient satisfaction in using virtual care with their practitioners (e.g., 92% patient satisfaction rate).¹

It is still relatively early days in the adoption of virtual care at this scale and there is considerable research underway to determine its appropriate use for both clinicians and patients alike (i.e., the right care, provided by the right provider, to the right patient, in the right place, and at the right time).² This includes determining when to have face-to-face visits versus virtual visits and how both types of interactions can complement one another to achieve quality outcomes rather than duplicate one another. As such, the following comments and recommendations are provided on challenges and opportunities for digital health delivery from the perspective of CMA's physician members and patients.

¹ Abacus Data. May 2020 survey. What Canadians Think About Virtual Health Care. <https://www.cma.ca/sites/default/files/pdf/virtual-care/cma-virtual-care-public-poll-june-2020-e.pdf>

² Canadian Medical Association. 2015. *Appropriateness in Health Care*. <https://policybase.cma.ca/en/permalink/policy11516>

Recommendations:

Digital Health Care Needs to Support Quality Health Care

Related to Market Study question: How do rules regarding the scope of practice for health care providers impact their ability to deliver digital health care to patients?

1. While issues pertaining to the privacy of digital health data and information, digital infrastructure (including broadband and cellular access), and issues pertaining to the appropriateness/efficacy of specific digital health care products and services are not included in this study, the CMA recommends they be important study considerations given their strong linkages to the dimensions of quality care.
2. While digital health services can improve access to care for patients, the CMA recommends these services also enhance and not hinder continuity of care (both relational continuity and informational continuity) and the provision of appropriate cost-effective care.

Interoperability

In response to Market Study questions: Are there barriers (regulatory or non-regulatory) that are preventing the access, use and sharing of digital health data and information? How have these barriers impacted the competitive landscape for digital health care? What changes can be made to reduce barriers to the access, use and sharing of digital health data and information? How can this encourage more competition and innovation in digital health care?

3. The CMA recommends the following to improve interoperability:
 - Develop a Pan-Canadian Framework for Patient-Centric Health Information Architecture that upholds enterprise interoperability and virtual care. This will include:
 - a framework for health information exchange;
 - a portable framework for health informatics legislation and policy;
 - technical architecture; and
 - a patient and provider registry framework
 - Develop national standards for patient health information access
 - Develop a framework for interprofessional teamwork to support pan-Canadian virtual care
 - Establish a framework for pan-Canadian quality-based virtual care governance
 - Develop a framework for privacy and security to support pan-Canadian virtual care.
4. The CMA recommends that the Competition Bureau examine the market consolidation of electronic medical record (EMR) vendors among a smaller number of private companies without any regulation on what they are able to charge for their services.

Health Information Governance

In response to Market Study questions: What changes can be made to reduce barriers to the access, use and sharing of digital health data and information? How can this encourage more competition and innovation in digital health care?

5. The CMA recommends moving away from the custodian model (a barrier to information sharing) to a patient-centric health information architecture that supports patient and provider access, and appropriate access for secondary purposes.
6. To effectively meet the needs of Canadians, the CMA recommends that a governance framework must also promote competition and innovation in a way that enhances health equity, including both equitable opportunities to access quality care and equitable health outcomes.

Personal Health Information Must be Safeguarded

In response to Market Study question: What changes can be made to reduce barriers to the access, use and sharing of digital health data and information?

7. The CMA notes that the digital health ecosystem must be supported by robust privacy and security requirements, governance, and oversight mechanisms to protect the privacy and security of all patient health information.

Pan-Canadian Licensure

In response to Market Study questions: How do rules regarding medical licensing impact the ability of health care providers to deliver digital health care? What steps can be taken to further enable the delivery of digital health care?

8. The CMA proposes the Competition Bureau recommend the provincial and territorial governments investigate and implement a pan-Canadian licensure system in consultation with relevant stakeholders.

Compensation Mechanisms

In response to Market Study questions: How do billing codes and compensation mechanisms for health care providers impact the delivery of digital health care? What steps can be taken to facilitate digital health care delivery?

9. The CMA recommends implementing: (a) permanent codes by the provinces to ensure the significant adoption of digital health services is not lost, and (b) reimbursement models to properly support the use of asynchronous means of communication (e.g., email, text messaging) to meet patient needs as well as to support integrated care provided by health care teams.

Digital Health Needs to Support Quality Health Care

Canadians deserve quality services that are appropriate for patient needs, respect individual choice and are delivered in a manner that is timely, safe, effective, and appropriate based on the most currently available scientific knowledge. Quality must encompass both the processes and the outcomes of care. More attention needs to be given to ensuring a system-wide approach to quality including the provision of digital care.

We note with interest that “quality of care” was the highest-rated feature (86%) among Canadians in the Competition Bureau’s December 2020 survey when using digital technology to access health services.³ Although respondents indicated they enjoy the convenience and time savings associated with digital health services, they stressed the importance of data security and privacy. Respondents also expressed that they would like control of their own health information, so that they have confidence in who it is shared with.

A review of the provision of digital health services requires a holistic approach to promote quality of care, understand its potential and to consider potential barriers. **While issues pertaining to the privacy of digital health data and information, digital infrastructure (including broadband and cellular access), and issues pertaining to the appropriateness/efficacy of specific digital health care products and services are not included in this study, the CMA recommends they be important study considerations given their strong linkages to the dimensions of quality care.**

For instance, there remains a digital divide in Canada with respect to broadband. Not all patients have the same access to technologies due to several crucial factors including economic circumstances, differing levels of digital literacy, and variability in the availability and accessibility of resources/infrastructure in different communities and contexts. The most recent information posted on the CRTC website indicates that while overall 87% of Canadians have access to broadband speed of 50/10 Mbps, just 45.6% of those in rural communities do. The connectivity gap for First Nations reserves is even greater, where access to 50/10 broadband is only at 28% of residents. The return on investment for internet service providers to build broadband infrastructure to many rural communities is often non-existent. This results in a market failure for remote connectivity across much of the country. For this reason, creative solutions are needed to help support projects that bring broadband to the most underserved communities.

Issues of equity also come into play as patients with certain disabilities (e.g., visual or hearing impairments) may have trouble benefiting from virtual care services to the same degree as other patients.

Equally important, while digital health services can improve access to care for patients, the CMA recommends ensuring these services enhance and not hinder continuity of care (both relational continuity and informational continuity) and the provision of appropriate cost-effective care. Continuity of care is rooted in a long-term patient-physician partnership in which the physician/clinician knows the patient’s history from experience and can integrate new information and decisions from a whole-person perspective efficiently without extensive investigation or record review. From the patient’s perspective, this includes understanding each person’s life journey and the context this brings to current health status, and the trust they have in their provider that is built over time.⁴

The Virtual Care Task Force (VCTF) (comprised of the Canadian Medical Association, the College of Family Physicians and Surgeons, and the Royal College of Physicians and Surgeons of Canada) noted that it is likely that the episodic use of virtual care outside an ongoing relationship and with no connection to a home practice-based electronic health record (EHR) will undermine continuity of care. This model can also lead to inappropriate use of health care resources (e.g., ordering of unnecessary additional tests). Indeed, the 2019 WHO guideline recommends client-to-provider telemedicine under the condition that it complements, rather than replaces, in-

³ Competition Bureau. *Digital Health Services Survey: What We Heard from Canadians*. February 24, 2021 <https://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/04573.html>

⁴ College of Family Physicians of Canada. 2019. *A vision for Canada. Family Practice: the patient’s medical home*. http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf.

person delivery of health services.⁵

While corporate investment and effort are important drivers of virtual care innovation, the VCTF members also noted that the corporatization of health information does not always align with quality care and strongly believe virtual care is best incorporated within the publicly funded system. The relationship between health technology enterprises and the publicly funded system is complex and nuanced and must be navigated on the foundational principles of quality patient care.

Interoperability

Interoperability is the ability of different information systems, devices and applications ('systems') to access, exchange, integrate and cooperatively use data in a coordinated manner, within and across organizational, regional, provincial and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations globally. Health data exchange architectures, application interfaces and standards enable data to be accessed and shared appropriately and securely across the complete spectrum of care, within all applicable settings and with relevant stakeholders, including by the individual.⁶

The challenges limiting interoperability are multi-factored. Some of these challenges identified from CMA's research (including discussions with patients, physicians, medical associations and vendors) are as follows:

- Insufficient nationally implemented and adopted common formats or standards for recording clinical information
- The high costs associated with the development, implementation and maintenance of interoperable records and the challenges with obtaining funding to support these costs
- Lack of shared governance, policy and leadership among health system entities to collectively drive improvement in interoperability
- Insufficient focused collaboration between industry, government, medical professionals and patients.

Currently, there is no transportability of patient or provider identifier information (registries) across and within some jurisdictions in Canada.

Previously, the VCTF offered the following recommendations to improve interoperability:

- **Develop a Pan-Canadian Framework for Patient-Centric Health Information Architecture that upholds enterprise interoperability and virtual care. This will include:**
 - a framework for health information exchange;
 - a portable framework for health informatics legislation and policy;
 - technical architecture; and
 - a patient and provider registry framework
- **Develop national standards for patient health information access**
- **Develop a framework for interprofessional teamwork to support pan-Canadian virtual care**
- **Establish a framework for pan-Canadian quality-based virtual care governance**
- **Develop a framework for privacy and security to support pan-Canadian virtual care.**

One issue that the Competition Bureau should examine is the market consolidation of electronic medical record (EMR) vendors among a smaller number of private companies without any regulation on what they are able to charge for their services. While the CMA has not systematically surveyed the membership on this issue the CMA has heard anecdotally about several cases where physicians/application developers were facing large charges to access electronic patient data for quality improvement and related purposes. This may also be

⁵ Report of the Virtual Care Task Force. February 2020. <https://www.cma.ca/sites/default/files/pdf/virtual-care/ReportoftheVirtualCareTaskForce.pdf>

⁶ Adapted from HIMSS. (2020). *Interoperability in Healthcare*. <https://www.himss.org/resources/interoperability-healthcare>

an issue among the proprietary EHR companies that dominate the hospital sector in terms of the cost and ability to interface with applications to improve the management and quality of patient care.

Health Information Governance

The VCTF identified Canada's existing health information governance framework as a barrier to quality health care in Canada and to unlocking the full potential benefits of health information. Developed during the paper-based, pre-digital era, it has led to a patchwork approach and calls for a multitude of health information custodians. As a result, it:

- fails to support patient's rights of access and control over their personal health information;
- leads to poor information exchange between patients and providers and among providers;
- leads to poor access by health system partners to health information for secondary use as health data; and
- has resulted in a competitive and innovation landscape that offers a multitude of digital health platforms, products and services that are not well-organized or integrated.

The solution to these issues includes moving away from the custodian model (a barrier to information sharing) to a patient-centric health information architecture that supports patient and provider access, and appropriate access for secondary purposes. The CMA is currently developing policy guidance on health information governance that proposes moving to a framework that includes pan-Canadian standards for health information exchange, improved access and enhanced use, quality, privacy, security, and data integrity. Clear and practical rules would promote a common playing field for competitors and innovators to develop digital health innovations that maximize the potential benefits of health information.

To effectively meet the needs of Canadians, the governance framework must also promote competition and innovation in a way that enhances health equity, including both equitable opportunities to access quality care and equitable health outcomes.

Personal Health Information Must be Safeguarded

Canada's health information privacy and security legislative framework is central to digital health information management. Further, health care providers owe a duty of confidentiality to their patients. Patient privacy and maintenance of confidentiality and security of health information and its exchange must therefore be a central concern in digital health information regulation just as it is for in-person care. The number of competitive actors in the digital health sector and their goals and interests can increase the risk to health information privacy and security if they are not appropriately addressed and regulated.

The digital health ecosystem must be supported by robust privacy and security requirements, governance, and oversight mechanisms to protect the privacy and security of all patient health information. These requirements must also ensure appropriate information access and exchange for patients, providers, and authorized secondary users for permitted purposes. Clear, well-calibrated, and modernized health information privacy and security governance rules would not only benefit patients and health care providers but would also support innovation and competition.

Pan-Canadian Licensure

The COVID-19 pandemic has discouraged the traditional face-to-face encounters between physician and patient. The practicalities and efficiencies of digital health care delivery are increasingly accepted leading to a re-imagined model of health care delivery.

At the present time, the physician-patient relationship is severed should one party move to a location some distance away from the other. Thus, physician-patient relationships that may have existed for years have their continuity of care broken by a provincial or territorial border. Exacerbating the problem, when the patient moves

to another province/territory, the patient is required to join a long waiting list to find a new family physician, creating delay in accessing care.

However, with the use of digital care the physician-patient relationship can continue – even across provincial/territorial borders. But the current provincial/territorial regulatory-licensure framework impedes access and continuity of care because licensing and compensation/billing codes are bound by provincial/territorial borders.

There are two major licensing questions that need answering when delivering digital health care across borders. The first is, what does the regulatory body (where the provider is licensed) say about its registrants/licensees providing digital care to patients in another jurisdiction? The answer to this question is similar across the country: comply with the requirements of the jurisdiction in which the patient is located. The second is, what does the regulatory body say about a non-jurisdictional (“outside”) physician providing digital health care to its residents/patients? The answer is mixed: some provinces require licensure, others are silent, while others indicate that compliance with their home licensing jurisdiction is sufficient.⁷ It is the CMA’s position that the requirement of separate provincial or territorial licenses is an unnecessary barrier to the delivery of health care that reduces access to care, patient choice and, ultimately, quality of care.

A tenet of the *Canada Health Act* is that there be access to quality health care without financial or other barriers in order to ensure and improve the health and well-being of Canadians. *The Canada Free Trade Agreement* also supports mobility rights of workers across provincial or territorial borders. Physicians have the qualifications and skills to deliver quality care to residents of all provinces. Recognizing that health care delivery is a commodity, then the rules governing the supply of that commodity should be modernized and status quo biases should be rejected.

In its Professions Study (2007), the Bureau found that restrictions on entry or mobility that limit professionals from offering their services elsewhere than where they are currently licensed can impair access to innovative and high-quality professional services that are important for the welfare of all Canadians. The Bureau recommended the elimination of professional regulations that unnecessarily restrict the inter-jurisdictional mobility of members of professions and, in the case of lawyers in particular, that provincial law societies should “facilitate the movement of lawyers between jurisdictions to ensure complete temporary and permanent mobility throughout Canada”.

The Professions Study also developed a set of competition principles for the development of regulations for professional services. It is clear, in the CMA’s view, that the mobility restrictions imposed by the current provincial/territorial licensure system are at odds with those principles. In particular, those restrictions are not directly linked to clear and verifiable outcomes, nor are they the minimum necessary to achieve stated objectives. The CMA believes that such restrictions on the inter-provincial/territorial mobility of physicians can and should be removed and replaced by a pan-Canadian licensure system without risk to patient safety.

The CMA also observes that two of the three questions designed by the Bureau to detect whether a given regulatory restriction raises a potential competition concern should be answered “yes” in respect of the provincial/territorial physician licensure/mobility restrictions. More particularly, those restrictions clearly limit the number and range of “suppliers” (physicians). As the Bureau noted in its Professions Study, “answering yes to one or more of the three questions signals a likely competition concern”.

A pan-Canadian approach to licensure would create a pan-Canadian authority (via the delegation of provincial and territorial government legislative authority) that is independent and at arm’s length to individual provincial and territorial governments’ political agendas and where the governance model includes public, subject-matter experts and provincial and territorial government involvement. The outcomes would include patient safety and patient access to health services in an economy that believes in taking advantage of a knowledge-based economy and technology. The national cooperative capital markets regulatory system approved by the Supreme

⁷ CMA and BLG, “Cross-Canada Virtual Care Licensure Requirements and Best Practice” (2021) <https://www.blg.com/en/insights/2021/06/cross-canada-virtual-care-licensure-requirements-and-best-practices>

Court of Canada in *Reference re Pan-Canadian Securities Regulation*⁸ provides a useful blueprint for the implementation of the recommended pan-Canadian licensure system.

The CMA proposes the Competition Bureau recommend provincial and territorial governments investigate and implement a pan-Canadian licensure system in consultation with relevant stakeholders.

Compensation Mechanisms

Compensation mechanisms must support the provision of high-quality, integrated, patient-partnered care (including continuity of care described above). For example, medical services that can be delivered through virtual means (e.g., some prescription renewals, discussion of test results or physician services delegated to other health professionals) should be billable rather than requiring an in-person medical appointment.

Since the COVID-19 pandemic began all provinces have implemented billing mechanisms for synchronous virtual care (i.e., phone, videoconference). In many cases, these billing codes are temporary. **Implementing permanent codes by the provinces is required to ensure the significant adoption of digital health services is not lost.**

The experience of Kaiser Permanente delivering care in the U.S. shows that 26% of all patient touches in 2017 were through secure email. Clearly there is great potential for the use of asynchronous means of communication (e.g., email, text messaging) to meet patient needs. **Reimbursement models are necessary to properly support the use of asynchronous means of communication as well as to support integrated care provided by health care teams.** Some experimentation will likely be required to find the most appropriate models.

Concluding Remarks

The CMA would be pleased to have further discussions on digital health care, including the VCTF recommendations as they relate to the Competition Bureau's study. As the national voice of the medical profession, CMA would be pleased to answer any questions stemming from the content of the submission and looks forward to seeing the findings of this consultation.

⁸ 2018 SCC 48