

Virtual Inequity: Do virtual visits risk leaving some people behind?

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The global COVID-19 pandemic has necessitated a dramatic shift in the delivery of primary care services in Canada. Health care delivery in the ambulatory setting has largely shifted to care from a distance through telephone or video consultation. A May 2020 College of Family Physicians of Canada survey showed that 80% of family medicine clinical encounters were occurring virtually¹ and many have written about "maintaining this momentum" of virtual care.²

The impact of this shift in the delivery of care, like much of what we are seeing with the COVID pandemic, affects communities unequally. While there are many possible benefits of virtual care, without a purposeful equity-oriented approach, it has the potential to exacerbate health disparities for low income families and individuals, new immigrants and refugees, homeless, and elderly, among others.^{3,4}

On the one hand, virtual care options may improve access to care. For many from low income communities, the burden of commuting to an appointment will be eased with the resulting savings in time and transportation costs. Negotiating child care to attend appointments may be less problematic for virtual care appointments. For those who are employed, virtual care may reduce the time required to be absent from work, and for those in precarious work environments who may not have been able to leave work to attend appointments, virtual care may facilitate improved access to primary care.

However, the transition to expanded virtual care risks creating barriers to care, particularly for those already facing socioeconomic marginalization. Some patients with limited financial means do not have access to cell phones and for those that do, the costs of phone and data plans may restrict access to calls, and to video calls in particular. Access to computers and home broadband internet remains out of the financial grasp of many. Furthermore, challenges with digital literacy, for example among elderly and those with limited prior access to technology, may limit their ability to engage in the breadth of virtual care options. Furthermore, patients with limited proficiency in English or French may face difficulties in accessing online patient portals and video visit applications without tailored assistance. Virtual care can be enhanced through patient self-monitoring with medical equipment at home, such as blood pressure monitors. However, despite the proliferation of sophisticated medical monitoring devices in the community, the costs of these devices remain prohibitive for some. Without deliberate strategies to mitigate this differential access to technology, virtual care programs may exclude already marginalized populations.

Additionally, some patients may struggle to find the physical space to safely and securely access the privacy required for virtual care. For those living in shelters or other shared facilities, for example, it can be difficult to find a quiet and safe area to discuss confidential issues. For patients in abusive relationships, there may be a risk of being overheard. Despite the convenience of virtual care, the safety and security of the clinician's office provide a safe environment to discuss personal issues. As virtual care expands, clinicians need to continue to be aware that the histories they are hearing are shaped by the surroundings of where their patients are housed. Measures to ensure patients can still access in-person care, when virtual care is not feasible or safe, are crucial.

A trusting relationship is at the core of providing quality primary care and this is particularly critical in caring for patients facing various forms of socioeconomic marginalization and with histories of trauma. Often this trust is

built through many appointments over prolonged periods of time. The ability to cultivate this relationship through virtual care assessments where the interaction often feels more distant may pose another challenge for clinicians and patients. This may be particularly acute where language barriers exist, even with the use of interpreters.

Policy makers, health professionals, and community members need to work together to ensure that marginalized communities benefit from this shift to virtual care. There are potent opportunities to design virtual care that is inclusive, accessible, and equitable. Patients need to have access to the appropriate technology to facilitate this type of care. While some Canadian telecom companies have developed programs to donate phones and to provide accessible phone and data plans to low income individuals, broader coverage is needed.^{5,6} Health care workers and others can highlight the benefit of these programs from a health care perspective and advocate to ensure that they are scaled up and maintained after the pandemic. Similarly, medical devices, such as blood pressure monitors, need to be covered by government plans for low income individuals. Digital patient platforms should be designed for ease of use by those with limited digital literacy and by those who are not proficient in English or French. Additional assistance to support patients in accessing virtual care (for example, assistance in setting up video applications for virtual visits) would also help to mitigate this digital divide. Additionally, integration of interpreter services into virtual care should be made accessible. Offering broader clinical hours for appointments can improve access to care, recognizing the constraints many patients face in attending daytime appointments, with competing work and other demands. While virtual care grows, it is critical that patients can access in-person appointments based on social needs, in addition to medical considerations. Importantly, patients from marginalized groups must be meaningfully engaged in the codesign of innovations and strategies to ensure interventions are responsive to their priorities and lived realities.

Much of the identified disparities around the impact of the COVID pandemic are tied to structural and social determinants of health. As the health care system pivots to provide more virtual care, it is imperative that we adopt a proactive, systematic approach to bridging the digital divide and promoting health equity. If such issues are not addressed, we risk further marginalizing low income patients and deepening existing health inequities. Urgent and sustained efforts with equity at the forefront are required to ensure health system transformations benefit all.

Dr. Rashid has had the privilege of working with newly arrived refugees for nearly twenty years. He is the medical director of the Crossroads Clinic, a medical clinic that serves refugees arriving in Toronto. He also co-founded the Canadian Doctors for Refugee Care, an organization founded to advocate for refugees to access health insurance and was on the steering committee of the CCIRH, a group that developed evidence-based guidelines for the assessment of newly arrived immigrants and refugees. He is a co-founder of the Christie Refugee Health Clinic, a health clinic located in a refugee shelter. He is on staff at Women's College Hospital in Toronto and is an Assistant Professor with the Department of Family and Community Medicine at the University of Toronto.

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References

1. Lemire F, Slade S. Reflections on family practice and the pandemic first wave. *Can Fam Physician*. 2020;66:468.
2. Schipper S. Maintaining the Momentum. *Can Fam Physician*. 2020;66(6):465

3. Crawford A, Serhal E. Digital health equity and COVID-19: The innovation curve cannot reinforce the social gradient of health. *J Med Internet Res*. 2020;22(6):e19361. doi:10.2196/19361
4. Nouri SS, Khoong EC, Lyles CR, Karliner LS. Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic. *NEJM Catal*. 2020;10:1056/CAT.20.0123. doi:10.1056/CAT.20.0123
5. Telus. TELUS delivering over 10,000 free mobile devices to help isolated seniors, hospitalized patients and vulnerable Canadians stay connected during the COVID-19 pandemic. <https://www.telus.com/en/about/news-and-events/media-releases/telus-delivering-over-10000-free-mobile-devices-to-help-canadians-stay-connected>. Accessed August 23, 2020.
6. Rogers. Connected for Success. <https://about.rogers.com/community-2/connected-for-success/>. Published 2020. Accessed August 24, 2020.