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Patient experiences with virtual health care in Canada: Modes of delivery and satisfaction with care

by Kristyn Frank and Danielle Bader

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Patient experiences with virtual health care in Canada: Modes of delivery and satisfaction with care

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ABSTRACT

Background

The COVID-19 pandemic expanded virtual care through telephone, video, and digital communication, with usage patterns varying by patients' sociodemographic and health characteristics. Continued virtual care use after the pandemic highlights the need for updated information on modality choice and patient satisfaction.

Data and methods

Data from the 2023 Canadian Social Survey – Quality of Life, Virtual Health Care and Trust were used. Descriptive statistics estimated the distribution of virtual care modes by provider type, positive and negative aspects of patients' last virtual appointment, and satisfaction levels. Multinomial regression models examined associations between sociodemographic and health characteristics and virtual care modality (telephone, video, and other or multiple modes), and factors associated with patients' satisfaction with their last virtual appointment.

Results

Most virtual appointments with family doctors or nurse practitioners (77.9%) and specialists (62.1%) were by telephone only. Age, gender, population group, having a regular health care provider, payment for virtual appointments, and multimorbidity were associated with modality. Commonly reported benefits of virtual appointments were similar across modalities, including not needing to travel, saving time, and services addressing needs. Most were either satisfied (40.3%) or very satisfied (40.5%) with their last virtual appointment. Age, rural or urban status, financial well-being, and having a regular provider were associated with satisfaction.

Interpretation

Virtual care was primarily delivered via telephone, reflecting ease of use and accessibility. The modality of appointments differed by provider type and patient sociodemographic and health characteristics. Satisfaction with virtual care was high overall, but lower among those without a regular provider and those with financial difficulties, suggesting unmet needs for these groups.

Keywords

health service accessibility; patient satisfaction; telemedicine; virtual health care

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What is already known on this subject?

- Before the COVID-19 pandemic, 4% of patients used video consultations and 10% used digital communication such as email, text, or an online chat for health care appointments.
- In 2021, most Canadian health care workers using virtual care relied on the telephone (87%), followed by video (47%) or text-based (26%) modes.
- Virtual care use differs across sociodemographic and health characteristics (e.g., age, gender, income, and multimorbidity), but less is known about how these factors are associated with modality or satisfaction with virtual care.

What does this study add?

- Telephone consultations were the main modality for virtual visits with family doctors or nurse practitioners (77.9%) and medical specialists (62.1%).
- The modality of virtual appointments differed by sociodemographic characteristics (e.g., age and gender) and health-related characteristics (e.g., multimorbidity, having a regular provider, and payment for virtual care).
- Most patients were either satisfied (40.3%) or very satisfied (40.5%) with their last virtual appointment, with convenience factors (e.g., no need to travel and time savings) cited as key benefits across modalities.
- Patients without a regular health care provider and those with financial difficulties reported lower satisfaction with virtual care.

The COVID-19 pandemic accelerated patients' access to virtual health care in Canada.¹ Before the pandemic, 4% of patients used virtual video consultations and 10% used digital communication such as email, text, or an online chat.² At the onset of the pandemic, 54% of patients reported having had a virtual appointment for a non-COVID-19 issue in April 2020.³ Although virtual visits declined to about 33% from January 2021 to March 2022,³ their continued high uptake⁴ highlights the important role of virtual care. Because the expansion of virtual care was driven by infection control rather than patient experience, examining patient experiences is key for informing sustainable, patient-centred care models.

In July 2021, the Virtual Care Policy Framework was introduced to improve virtual care adoption through \$200 million in federal funding and coordination across federal, provincial, and territorial governments.⁵ As virtual care has remained a component of Canadian health systems, understanding patients' experiences is essential for ensuring equitable, high-quality care.

Across Canada, reimbursement rates for in-person and synchronous virtual care are generally equivalent, with exceptions: Newfoundland and Labrador compensates synchronous virtual care at a premium compared with in-person consultations, Saskatchewan reimburses it at a reduced rate, and Ontario reimburses physicians 100% of the standard rate for video virtual visits and 85% for telephone visits. Eligibility for these billing codes typically requires an established patient–primary care provider relationship.⁶

Research shows phone visits are the most common modality, followed by video.^{7–9} Beyond adoption of virtual care, appointment modalities differ by provider practices and patient

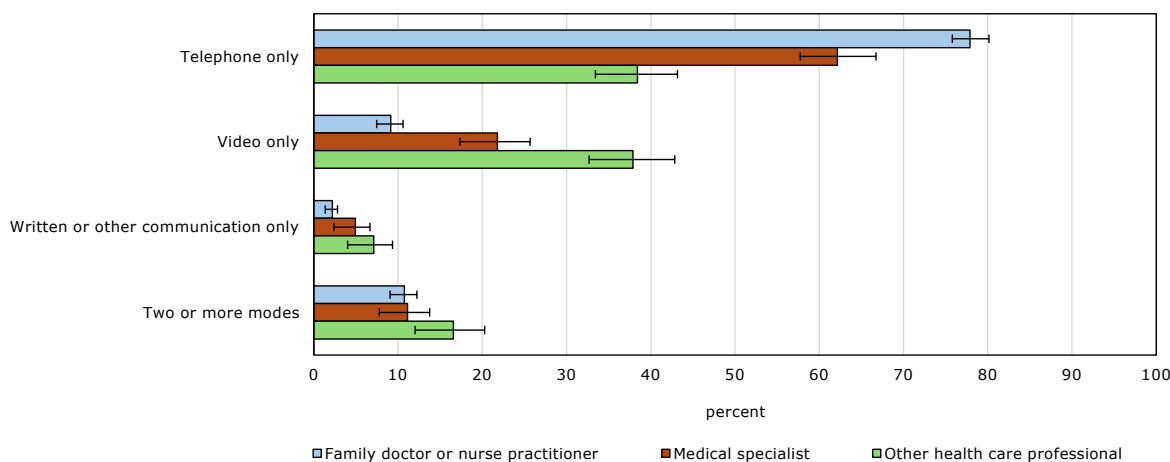
preferences. In 2021, Canadian health care workers primarily used the telephone (87%), with smaller proportions using video (47%) or text (26%).¹⁰ Among patients, most preferred secure messaging (82%) over audio (11%) or video (7%).¹¹ Preferences may reflect convenience, comfort with technology, or type of health concern.

Virtual care use varies by sociodemographic and health-related characteristics. In 2023, primary care telehealth use ranged from 16.5% in Nunavut to 49.3% in Newfoundland and Labrador.¹² Females, individuals with chronic conditions, and frequent health care users were more likely to use virtual care,¹³ though less is known about modality preferences.

U.S. studies indicate older adults (65 years and older), uninsured individuals, racial/ethnic minority groups (e.g., Black and Hispanic), lower-income individuals, and those lacking Internet were less likely to use video than audio-only consultations,^{13–15} reflecting sociodemographic inequities in technology access and use—or the “digital divide.”^{16,17}

Although policy makers and health professionals have questioned virtual care quality,¹¹ patients report high satisfaction and comparable quality to in-person visits.^{11,14} Video visits are associated with better doctor communication, care coordination, and global ratings.¹⁸ Canadian patient advisors highlighted benefits of virtual care, including greater efficiency, reduced time and travel burdens, improved accessibility, convenience, and more patient-centred care.¹⁹ In Ontario, 87% of patients reported that quality was similar to in-person care and 12% reported better quality.¹¹ Satisfaction with specialty care in Alberta was similar between virtual and in-

Chart 1
Modes of virtual health care appointments, by type of health care provider, individuals who had a virtual appointment in the past 12 months, Canada, 2023



Source: Canadian Social Survey – Quality of Life, Virtual Health Care and Trust, 2023.

person visits,²⁰ while 91% of patients in British Columbia found virtual visits helpful.²¹

Patients reported convenience, improved efficiency and access, and reduced travel and wait times as benefits, whereas they reported technical issues, lack of physical examination, and privacy concerns as drawbacks.²¹⁻²⁵ Virtual care supports the continuity of care for patients with chronic diseases¹¹ and benefits vulnerable groups by enabling observation in patients' home environments.

As virtual care becomes integrated into Canadian health care, questions remain about implementation and patient experiences. Although research shows variation in modalities by provider and patient characteristics, and high satisfaction, most studies rely on small samples,²³ and population-level patterns of modalities and satisfaction with virtual care remain underexplored. While billing data accurately capture the number and modality of virtual visits, population-based survey data are needed to understand patient experiences with virtual care in Canada.²³

This study addresses these gaps through the following research questions:

1. Among individuals who had virtual health care appointments in the past 12 months, what modes of service delivery did they use?
2. Were sociodemographic or health characteristics associated with the likelihood of using a particular modality?
3. What were the most common positive and negative aspects patients reported about their last virtual appointment, by modality?
4. How satisfied were patients with their last virtual appointment, and did satisfaction vary by sociodemographic or health characteristics?

Data and methods

Data from the 2023 Canadian Social Survey (CSS) – Quality of Life, Virtual Health Care and Trust were collected from July 14 to September 7, 2023. The survey employed a cross-sectional, stratified two-stage sampling design. First, 20,000 dwellings were selected probabilistically, stratified by province and expected number of household members aged 15 or older. One individual per household was then randomly chosen using the age-order selection method. Households received an invitation with a link and secure access code to complete the online survey. Alternatively, respondents could complete the survey via telephone interview with a trained professional. Participation was voluntary, with a 51.7% response rate.

The sample included non-institutionalized individuals aged 15 or older across Canada's 10 provinces, excluding residents of the territories and reserves and full-time residents of institutions. The total sample was 9,288, but analyses were restricted to those who had a virtual health care appointment in the past 12 months (n=3,410). Descriptive statistics for the study sample are provided in Appendix Table 1.

Measures

Sociodemographic and health characteristics

Age was grouped into six categories (15 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, and 65 and older). Gender was categorized as men+ (boys, men, and some non-binary people) and women+ (girls, women, and some non-binary people). Sexual orientation was grouped as heterosexual or as lesbian, gay, bisexual, or sexual orientation not elsewhere classified. Marital status was married or common-law; single (never married); or separated, divorced, or widowed. Immigrant status was categorized as non-immigrants and immigrants (including non-permanent residents).

Table 1
Multinomial regression results, likelihood of using video appointments only or other or multiple modes of appointments versus telephone appointments only, individuals who had a virtual appointment in the past 12 months, 2023

Mode of virtual care ¹	Video appointments only			Other or multiple modes of appointments		
	RRR	95% confidence intervals		RRR	95% confidence intervals	
		from	to		from	to
Age group						
15 to 24†	...	...	...	...	...	...
25 to 34	0.95	0.43	2.10	0.90	0.36	2.25
35 to 44	0.91	0.40	2.08	0.85	0.36	1.99
45 to 54	0.57	0.25	1.28	0.44	0.19	1.01
55 to 64	0.38 *	0.17	0.87	0.64	0.28	1.48
65 or older	0.36 *	0.13	0.96	0.45	0.18	1.14
Gender						
Men†	...	...	...	...	...	...
Women†	0.69 *	0.48	0.99	1.38 *	1.01	1.89
Marital status						
Married or common-law†	...	...	...	...	...	...
Single (never married)	0.86	0.52	1.42	0.54 *	0.30	0.97
Separated, divorced or widowed	1.10	0.66	1.84	0.92	0.62	1.38
Immigrant status						
Non-immigrant†	...	...	...	...	...	...
Immigrant or non-permanent resident	1.02	0.62	1.69	1.39	0.84	2.30
Population group						
Non-racialized and non-Indigenous†	...	...	...	...	...	...
Racialized	0.91	0.53	1.56	0.83	0.49	1.40
Indigenous	2.83 *	1.20	6.69	1.09	0.57	2.09
Education level						
High school or lower†	...	...	...	...	...	...
Postsecondary below bachelor's level	1.21	0.74	2.01	1.23	0.84	1.80
Bachelor's degree or higher	1.28	0.80	2.06	1.18	0.77	1.79
Sexual orientation						
Heterosexual†	...	...	...	...	...	...
LGB+	0.90	0.45	1.83	1.29	0.61	2.71
Urban or rural status						
Urban†	...	...	...	...	...	...
Rural	0.60	0.33	1.10	0.76	0.47	1.25
Province of residence						
Ontario†	...	...	...	...	...	...
Newfoundland and Labrador	0.25 **	0.09	0.68	0.38 *	0.18	0.79
Prince Edward Island	1.05	0.28	3.96	1.56	0.28	8.83
Nova Scotia	0.41 *	0.18	0.94	0.68	0.37	1.24
New Brunswick	0.46	0.16	1.36	1.31	0.60	2.87
Quebec	1.52	0.96	2.42	0.69	0.42	1.14
Manitoba	0.58	0.25	1.34	0.60	0.27	1.33
Saskatchewan	0.33	0.03	3.18	0.52	0.21	1.32
Alberta	0.63	0.32	1.24	0.91	0.50	1.64
British Columbia	0.67	0.39	1.16	0.94	0.63	1.39
Ability to meet household needs (financial well-being)						
Easy or very easy†	...	...	...	...	...	...
Neither difficult nor easy	0.75	0.47	1.18	1.00	0.67	1.49
Difficult or very difficult	0.88	0.57	1.34	1.00	0.69	1.44
Main activity						
Paid work†	...	...	...	...	...	...
Retired	0.62	0.32	1.22	0.93	0.59	1.47
Other (not in paid work or retired)	1.13	0.70	1.80	1.12	0.74	1.70
Disability status						
Does not identify as a person with a disability†	...	...	...	...	...	...
Identifies as a person with a disability	1.20	0.69	2.08	1.64 *	1.11	2.42
Has a regular health care provider						
Yes†	...	...	...	...	...	...
No	2.65 ***	1.72	4.09	1.15	0.67	1.98
Number of chronic conditions						
None†	...	...	...	...	...	...
One	0.92	0.61	1.38	1.27	0.82	1.98
Two or more	0.47 **	0.29	0.79	1.43	0.92	2.22
Paid for any virtual appointment						
No†	...	...	...	...	...	...
Yes	5.01 ***	2.70	9.31	2.49 *	1.20	5.18
Appointment types						
Family doctor, general practitioner, or nursing practitioner only†	...	...	...	...	...	...
Medical specialist only	6.06 ***	3.93	9.33	1.12	0.65	1.94
Other or multiple appointment types	10.18 ***	6.09	17.03	67.79 ***	45.01	102.08

... not applicable

† reference category for predictor variables

* significantly different from reference category ($p < 0.05$)

** significantly different from reference category ($p < 0.01$)

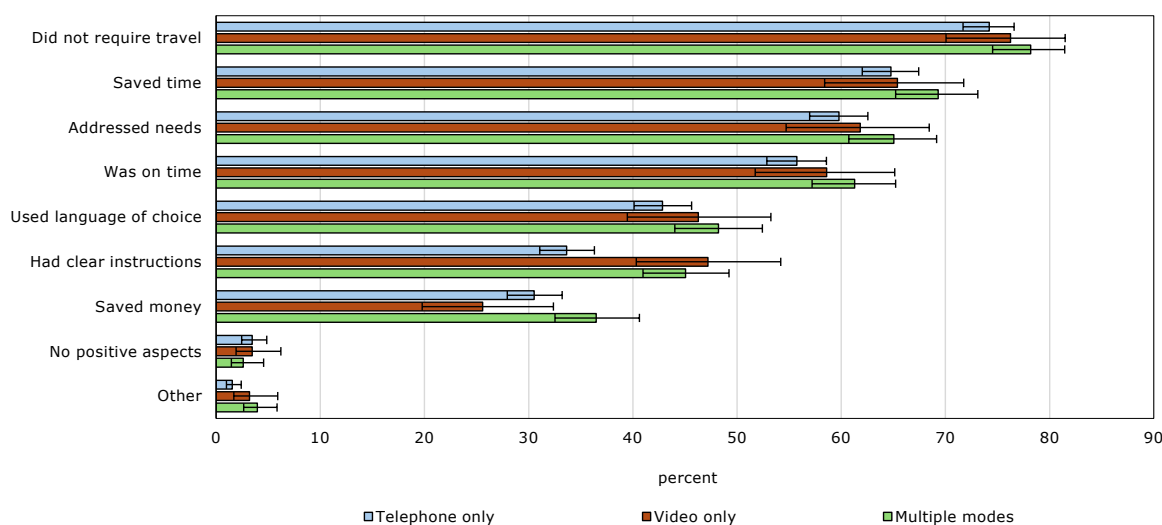
*** significantly different from reference category ($p < 0.001$)

1. The reference category for modes of virtual care is telephone appointments only.

Notes: RRR = relative risk ratio; LGB+ = lesbian, gay, bisexual, or other identity not elsewhere specified.

Source: Canadian Social Survey – Quality of Life, Virtual Health Care and Trust, 2023.

Chart 2
Patient-reported positive aspects of the last virtual care appointment, by modality, individuals who had a virtual appointment in the past 12 months, Canada, 2023



Source: Canadian Social Survey – Quality of Life, Virtual Health Care and Trust, 2023.

Population groups were based on a question about racialized identity, defined by the *Employment Equity Act* as individuals, other than Indigenous people, who are “non-Caucasian in race or non-white in colour.”²⁶ Racialized groups included South Asian, Chinese, Black, Filipino, Arab, Latin American, Southeast Asian, West Asian, Korean, Japanese, and other racialized groups, which were all combined into one category. The three Indigenous identity groups—First Nations, Métis, and Inuit—were collapsed into one category because of small sample size; status and non-status Indigenous people could not be distinguished. A derived, three-category population group variable was thus created: racialized, Indigenous, and non-racialized and non-Indigenous (reference group).

Education was grouped as high school or less; trade, college, CEGEP, or certificate below bachelor’s degree; and university degree. Geographic variables included province and rural or urban status, derived from respondents’ census metropolitan area (CMA) or census agglomeration (CA). Respondents who were not in a CMA or CA were identified as rural (population under 1,000); otherwise, they were urban (population of 1,000 or more). Economic measures included main work activity (paid work, retired, or other activity) and financial well-being. Financial well-being measured how easy it was for households to meet their financial needs (e.g., housing, food, and transportation) and was categorized as difficult or very difficult, neither difficult nor easy, or easy or very easy. Income was unavailable in the data.

Health measures captured whether respondents had a regular health care provider (yes or no), the number of chronic conditions (none, one, or two or more), and disability status (yes or no). Chronic conditions included long-term conditions diagnosed by a health professional, based on a predetermined list from previous Statistics Canada surveys. The survey

categorized virtual appointment types as with a family doctor, general practitioner, or nurse practitioner (hereafter called “family doctor or nurse practitioner”); with a medical specialist; or with another health professional.

Virtual care measures

Virtual care was defined as “any interaction between patients and health professionals, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.”²⁷ The survey did not distinguish between care received from patients’ regular care providers or on-demand virtual clinics, limiting assessment of continuity of care.

Measures included provider type, mode of appointments, and payment for any virtual visit in the previous 12 months. Although most health care in Canada is universally covered, payment captures whether individuals paid out of pocket, possibly for convenience or because they lacked a regular health care provider.

Other measures refer only to respondents’ last virtual appointment, including the main purpose (regular check-up, prescription refill, treatment of chronic or acute condition, or other) and positive and negative aspects based on predefined lists developed with input from Health Canada and informed by Canada Health Infoway’s 2021 Canadian Digital Health Survey. Positive aspects included services addressing perceived needs, the appointment being on time, not needing to travel to the appointment, saving time, saving money, instructions on how to access the appointment being clear, the appointment being in the language of choice, or other. Negative aspects included services not addressing perceived needs, the start time of the appointment being delayed, concerns about privacy and

security, health issues requiring an in-person follow-up appointment, instructions being unclear, problems with equipment or connectivity occurring, not being comfortable with technology, having to pay for the appointment, the appointment not being in the language of choice, or other.

Dependent variables

Modality was derived from aggregated responses on virtual visit modes, representing all virtual appointments in the previous 12 months: telephone only, video only, written (email, text, or instant message) or other only, and two or more modes. Because of the small sample size for written or other modes only, this category was combined with multiple modes for the regression analysis.

Patient satisfaction with the last virtual appointment was grouped into three categories: very satisfied, satisfied, and a combined neutral or dissatisfied category (i.e., neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied).

Analytical techniques

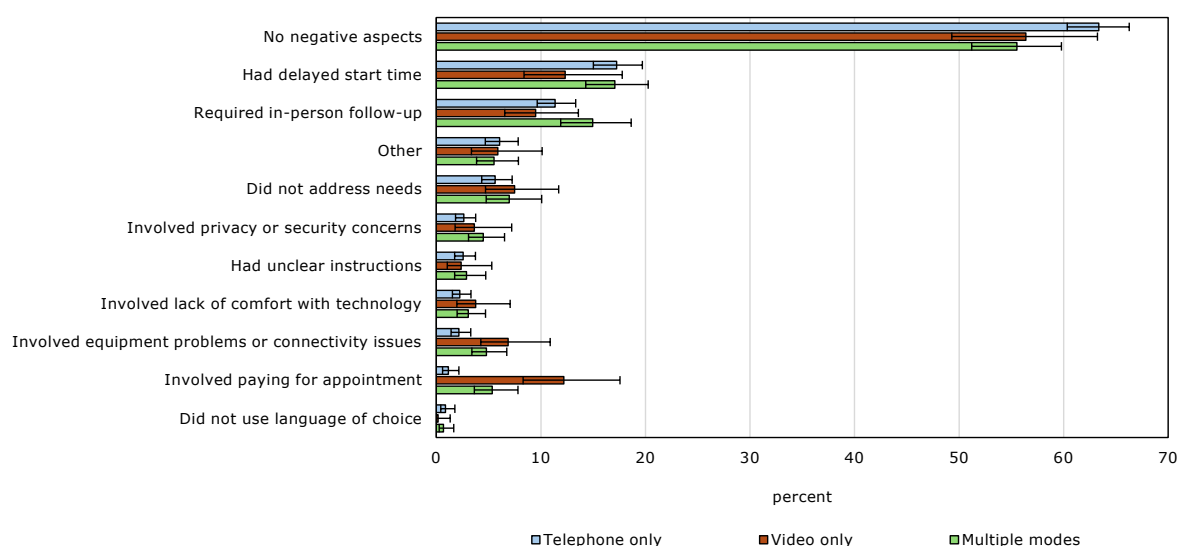
Descriptive statistics estimated the distributions of virtual care modality by provider type, positive and negative aspects of the last virtual visit, and satisfaction. Variable selection was guided by the literature and conceptual relevance regarding virtual care use and patient satisfaction. Positive and negative aspects were disaggregated by modality. For patients who used only one modality type, the modality of the most recent visit could be inferred. While results for multiple-modality users were analyzed, the most recent modality is unknown. Written or other modes only were excluded from these results because of data quality (large confidence intervals).

Multicollinearity was assessed using variance inflation factors (VIFs) from an ordinary least squares regression with a binary outcome (telephone only versus other appointment types). VIFs were generally below 4, except for one category (oldest age group) with a VIF of about 6; this group was retained because of its theoretical importance, although the elevated VIF is noted as a minor limitation.

A multinomial regression model was used to examine associations between sociodemographic and health characteristics and appointment modality; telephone only (the most common modality) was the reference category. Video only and other or multiple modes were compared with telephone only appointments. Predictors included sociodemographic and health characteristics, payment for any virtual appointment, and provider type.

A second multinomial regression examined factors associated with patients' satisfaction with their last virtual appointment. Very satisfied and satisfied responses were compared with neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied responses. A supplementary test compared satisfied and dissatisfied responses with neither satisfied nor dissatisfied responses; because of the small sample and wide confidence intervals for several covariates in the dissatisfied group, a decision to focus on higher satisfaction levels was made. Sociodemographic characteristics, health characteristics, and the main purpose of the last virtual appointment were included. Payment and provider type were excluded because they referred to any virtual appointment in the past 12 months, not specifically the last visit; when included, these variables were not statistically significant and did not affect other results.

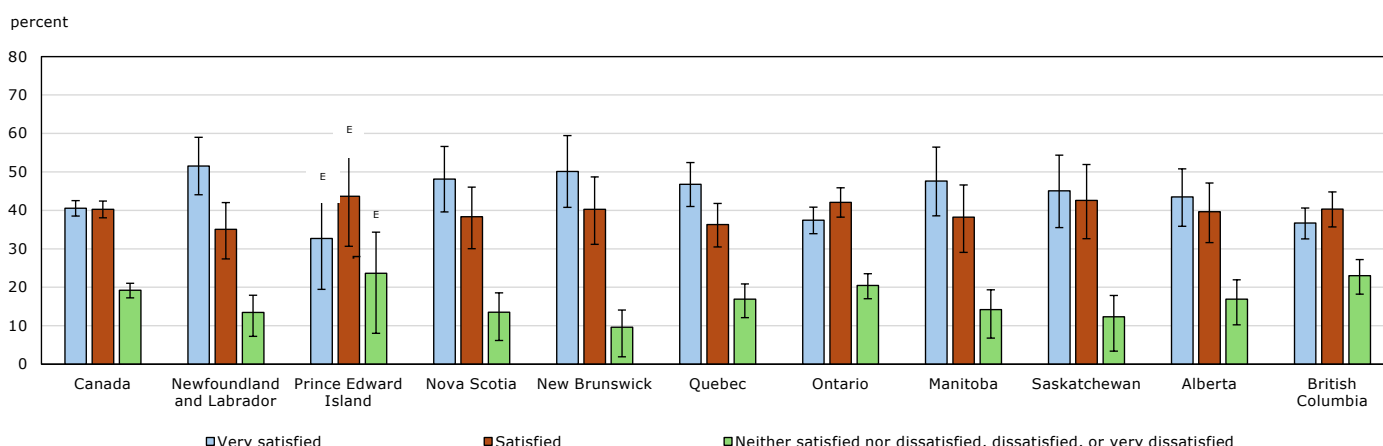
Chart 3
Patient-reported negative aspects of the last virtual care appointment, by modality, individuals who had a virtual appointment in the past 12 months, Canada, 2023



Source: Canadian Social Survey – Quality of Life, Virtual Health Care and Trust, 2023.

Chart 4

Patient satisfaction levels with last virtual appointment, individuals who had a virtual appointment in the past 12 months, Canada and provinces, 2023



^E use with caution

Source: Canadian Social Survey – Quality of Life, Virtual Health Care and Trust, 2023.

Results are presented as relative risk ratios (RRRs) with 95% confidence intervals, indicating the relative likelihood of an outcome compared with the reference group. CSS sample weights and bootstrap weights for variance estimation were applied, using Stata 18 (StataCorp, College Station, Texas).

Results

Modes of virtual care

Most virtual appointments with family doctors or nurse practitioners (77.9%) or medical specialists (62.1%) were by telephone only (Chart 1). For appointments with other provider types (e.g., psychologist, dietician, pharmacist), similar proportions used telephone only (38.4%) or video only (37.9%). A higher proportion of patients used video only for virtual visits with medical specialists (21.8%) than with family doctors or nurse practitioners (9.1%).

Across all provider types, similar proportions of patients used multiple modes, ranging from 10.8% for family doctor or nurse practitioner appointments to 16.6% for appointments with other provider types. The use of written or other communication modes was less common.

Sociodemographic and health characteristics by virtual care modality

Older patients (55 and over) were less likely than 15- to 24-year-olds to use video appointments only rather than telephone only (Table 1). Women were less likely than men to use video only rather than telephone only, but more likely to use other or multiple modes. Additionally, Indigenous patients were more likely than non-racialized and non-Indigenous patients to use video only rather than telephone only. Since most Indigenous respondents (87%) who had a virtual appointment in the past 12 months lived in urban areas, these results largely reflect the experiences of urban Indigenous patients.

Compared with patients in Ontario, those in Newfoundland and Labrador and Nova Scotia were less likely to use video only rather than telephone only for virtual appointments. Additionally, patients in Newfoundland and Labrador were less likely to use other or multiple modes rather than telephone only.

Patients with two or more chronic conditions were less likely to use video only than telephone only than those with no chronic conditions. Additionally, patients with a disability were more likely to use other or multiple modes than telephone only compared with those without a disability. Individuals without a regular health care provider were more likely to use video appointments only rather than telephone only compared with their counterparts with a regular provider. Notably, patients who paid for a virtual visit were much more likely than their counterparts who did not to use video only than telephone only (RRR=5.01) and more likely to use other or multiple modes rather than telephone only.

Compared with individuals who consulted family doctors or nurse practitioners, those who consulted specialists only or other or multiple provider types were more likely to have video appointments only than telephone only. Those who consulted other or multiple provider types were also more likely to use other or multiple modes; the large RRR for this result reflects the large proportion of patients in this group who used other or multiple modes.

Positive and negative aspects of virtual care

The most commonly reported positive aspects of patients' last virtual appointment were similar across modalities, including not needing to travel, saving time, services addressing needs, and appointments starting on time (Chart 2). One notable difference was that patients who had telephone appointments only were less likely (33.6%) than those who used video only (47.2%) or multiple modes (45.1%) to report instructions being clear as a positive aspect, likely reflecting less need for instructions when using telephone technology, compared with other modalities.

Table 2

Multinomial regression results, patient satisfaction with last virtual appointment, individuals who had a virtual care appointment in the past 12 months, Canada, 2023

Level of satisfaction [†]	Very satisfied			Satisfied		
	RRR	95% confidence intervals		RRR	95% confidence intervals	
		from	to		from	to
Age group						
15 to 24 [†]	...	...	...	...	...	...
25 to 34	1.50	0.74	3.05	1.12	0.58	2.16
35 to 44	1.90	0.91	3.97	0.91	0.46	1.78
45 to 54	2.50 *	1.20	5.20	1.10	0.57	2.12
55 to 64	2.30 *	1.10	4.81	1.19	0.61	2.32
65 or older	3.17 **	1.40	7.19	1.25	0.59	2.67
Gender						
Men [†]	...	...	...	...	...	...
Women [†]	1.08	0.81	1.44	0.99	0.74	1.33
Marital status						
Married or common-law [†]	...	...	...	...	...	...
Single (never married)	0.96	0.63	1.45	0.95	0.63	1.45
Separated, divorced, or widowed	1.38	0.91	2.09	1.25	0.81	1.93
Immigrant status						
Non-immigrant [†]	...	...	...	...	...	...
Immigrant or non-permanent resident	0.92	0.60	1.42	0.92	0.60	1.40
Population group						
Non-racialized and non-Indigenous [†]	...	...	...	...	...	...
Racialized	0.74	0.47	1.15	1.27	0.82	1.97
Indigenous	2.13	0.70	6.51	3.08	0.98	9.72
Education level						
High school or lower [†]	...	...	...	...	...	...
Postsecondary below bachelor's level	1.09	0.75	1.58	1.07	0.73	1.57
Bachelor's degree or higher	1.38	0.93	2.05	1.24	0.83	1.86
Sexual orientation						
Heterosexual [†]	...	...	...	...	...	...
LGB [†]	1.35	0.76	2.38	1.21	0.68	2.16
Urban or rural status						
Urban [†]	...	...	...	...	...	...
Rural	1.89 **	1.20	2.98	1.72 *	1.07	2.77
Province of residence						
Ontario [†]	...	...	...	...	...	...
Newfoundland and Labrador	1.63	0.91	2.89	1.08	0.60	1.95
Prince Edward Island	0.81	0.31	2.14	0.90	0.34	2.38
Nova Scotia	1.38	0.74	2.59	1.20	0.65	2.23
New Brunswick	2.40 *	1.03	5.55	1.93	0.83	4.48
Quebec	1.44	0.91	2.27	1.07	0.67	1.71
Manitoba	1.45	0.74	2.83	1.22	0.63	2.38
Saskatchewan	1.55	0.67	3.59	1.50	0.67	3.37
Alberta	1.34	0.76	2.37	1.17	0.65	2.10
British Columbia	0.75	0.52	1.10	0.77	0.53	1.12
Ability to meet household needs (financial well-being)						
Easy or very easy [†]	...	...	...	...	...	...
Neither difficult nor easy	0.38 ***	0.26	0.55	0.63 *	0.44	0.92
Difficult or very difficult	0.42 ***	0.29	0.60	0.61 **	0.42	0.88
Main activity						
Paid work [†]	...	...	...	...	...	...
Retired	1.36	0.87	2.15	1.73 *	1.09	2.74
Other (not in paid work or retired)	1.03	0.71	1.49	1.22	0.85	1.76
Disability status						
Does not identify as a person with a disability [†]	...	...	...	...	...	...
Identifies as a person with a disability	0.94	0.63	1.40	0.92	0.64	1.34
Has a regular health care provider						
Yes [†]	...	...	...	...	...	...
No	0.46 ***	0.31	0.68	0.66 *	0.45	0.97
Number of chronic conditions						
None [†]	...	...	...	...	...	...
One	1.02	0.70	1.50	1.06	0.73	1.55
Two or more	0.79	0.54	1.15	0.73	0.50	1.06
Main purpose of last virtual appointment						
Regular check-up or routine appointment [†]	...	...	...	...	...	...
Medication or prescription refill	1.32	0.90	1.95	1.08	0.73	1.59
Treatment of chronic physical or mental health condition	0.81	0.51	1.29	0.60 *	0.37	0.98
Treatment of acute physical or mental health condition or infectious disease	0.80	0.50	1.29	0.64	0.40	1.02
Other reason	0.68	0.43	1.09	0.82	0.53	1.28

... not applicable

[†] reference category for predictor variables

* significantly different from reference category (p < 0.05)

** significantly different from reference category (p < 0.01)

*** significantly different from reference category (p < 0.001)

1. The reference category for level of satisfaction is neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied.

Notes: RRR = relative risk ratio; LGB+ = lesbian, gay, bisexual, or other identity not elsewhere specified.

Source: Canadian Social Survey – Quality of Life, Virtual Health Care and Trust, 2023.

In terms of negative aspects of virtual appointments, most patients who used telephone only (63.4%), video only (56.4%), or multiple modalities (55.5%) reported no negative aspects (Chart 3). The most reported negative aspect across modalities was the start time of the appointment being delayed. Patients also reported health issues requiring an in-person follow-up appointment as a negative aspect across modalities. Notably, a higher proportion of those who used video only (12.2%)—compared with telephone only (1.1%) or multiple modes (5.3%)—reported having to pay for the appointment as a negative aspect. Additionally, those with video appointments only were more likely to report problems with equipment or connectivity issues occurring (6.9%) than those with telephone appointments only (2.1%).

Patient satisfaction with virtual appointments

Overall, about 8 in 10 patients were either satisfied (40.3%) or very satisfied (40.5%) with their last virtual appointment, while smaller proportions were neither satisfied nor dissatisfied (13.0%), dissatisfied (4.6%), or very dissatisfied (1.7%).

Across the provinces, about half of Newfoundland and Labrador (51.5%) and New Brunswick (50.1%) patients were very satisfied, while lower proportions in British Columbia (36.7%) and Ontario (37.4%) were very satisfied (Chart 4). About 2 in 10 British Columbia (23.0%) and Ontario (20.5%) patients were neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied. Prince Edward Island patients also had lower satisfaction, but this result should be interpreted with caution because of the small sample size.

Patients aged 45 or older were more likely than those aged 15 to 24 to be very satisfied with their last virtual appointment (Table 2). Rural patients were more likely than their urban counterparts to be very satisfied or satisfied with their virtual appointment. Few provincial differences were observed—only patients in New Brunswick were more likely than patients in Ontario to be very satisfied after controlling for other characteristics.

Patients experiencing financial hardship (their ability to meet household needs was neither difficult nor easy or was difficult or very difficult) were less likely to be very satisfied or satisfied with their last virtual appointment than those with higher financial well-being (their ability to meet household needs was easy or very easy). Retired patients were more likely than those in paid work to be satisfied.

Individuals without a regular health care provider were less likely than their counterparts with a regular provider to be satisfied or very satisfied with their last virtual appointment. Moreover, patients whose last appointment was to treat chronic physical or mental health conditions were less satisfied than those whose appointments were for regular check-ups or routine appointments.

Discussion

Patients who accessed virtual health care primarily consulted with primary and specialist care providers via telephone only, aligning with the literature indicating a preference for this modality because of ease of use, low cost, and familiarity among patients and providers.^{28,29} Telephone visits accounted for a higher proportion of virtual appointments with family doctors or nurse practitioners than other provider types, echoing other Canadian research.³

Having video consultations only was more common for appointments with specialists and other provider types than family doctors and nurse practitioners, suggesting a preference for, or greater access to, video technologies for these providers or their patients. This finding may be partly attributable to higher use of video consultations for mental health or addiction-related appointments.³⁰

Sociodemographic differences in modality were connected to the digital divide. Compared with patients aged 15 to 24, those aged 55 or older were less likely to use video only rather than telephone only, aligning with previous research showing age-related differences in digital access and comfort with telephone use.^{15,16} Geographic differences indicated that patients in Newfoundland and Labrador and Nova Scotia were less likely to use video only rather than telephone only compared with those in Ontario. This finding may reflect digital infrastructure limitations in some regions or health-system differences, such as different billing models for virtual care.

Compared with men, women were less likely to use video only rather than telephone only and more likely to use other or multiple modes. Women's higher likelihood of using multiple modes may reflect their higher service use.^{31,32} U.S. research suggests women's high level of child care responsibilities¹⁴ and privacy concerns because of the presence of children or other household members³³ may explain their lower use of video appointments.

Indigenous patients were more likely than non-racialized and non-Indigenous patients to use video only than telephone only for virtual appointments. Although Indigenous populations face greater service barriers and digital infrastructure challenges than non-Indigenous populations,^{34,35} this finding represents Indigenous patients who accessed virtual care and largely lived in urban areas. Higher video use may stem from Indigenous-focused virtual care initiatives developed to support chronic disease management and primary care access for on- and off-reserve populations^{36,37} and the expansion of virtual care accessibility during the COVID-19 pandemic.³⁸ Video visits may also be preferred as they better support relationship building with providers³⁹ and allow family members, Elders, or traditional healers or knowledge keepers to participate.³⁸ However, the relatively small sample size of Indigenous respondents should be considered when interpreting these results.

Multimorbidity was associated with a lower likelihood of using video rather than telephone appointments. This supports previous research¹⁴ showing a higher use of telephone instead of video appointments among those with comorbidities, suggesting patients with complex health needs may rely more on telephone-based care because of barriers in technology access, digital literacy, and usability.^{4,13}

Individuals without a regular provider were more likely to use video only rather than telephone only for virtual appointments, possibly to facilitate visual assessment or establish rapport as new patients.²³ Those who paid for virtual appointments were also much more likely to use video only instead of telephone only. This could be connected to income—higher-income individuals may be more willing to pay for health care and generally have higher levels of digital literacy,⁴⁰ contributing to greater comfort with video visits.

Consistent with previous studies,^{22,23,25} convenience factors were the main benefits patients reported for virtual care across modalities. Other positive aspects included appointments starting on time and services meeting patients' needs, supporting previous research showing that virtual care adequately addressed patients' health concerns,^{21,41} although small proportions of patients indicated delayed start times and unmet health needs as negative aspects across modalities. Consistent with previous studies,^{22,41} few patients reported technological challenges. Problems with equipment or connectivity issues were more common among patients who used video only or multiple modes, compared with telephone appointments only, in line with the higher technological requirements for video visits.

Overall, most patients were satisfied with their last virtual appointment. Individuals aged 45 or older were more likely to be very satisfied than younger patients, supporting studies showing greater satisfaction with telemedicine among older adults^{42,43} despite potentially lower digital literacy. This may relate to age-related differences in expectations, appreciation for the conveniences of virtual care, or reluctance to criticize health care providers.⁴⁴ Rural patients were also more likely to be satisfied than urban patients, possibly because of improved access and reduced travel and cost burdens.^{41,45,46}

Financial well-being was also associated with satisfaction. Patients with greater difficulty meeting household needs were less likely to be satisfied than their counterparts with less difficulty meeting these needs. This is consistent with lower satisfaction among patients from lower-income neighbourhoods⁴⁷ and their preference for in-person care. Lower digital literacy may also play a role.⁴⁸

Individuals without a regular provider were also less likely to be satisfied, reflecting the importance of continuity of care in patient satisfaction.⁴⁹ Additionally, patients whose last virtual appointment was for chronic physical or mental health conditions were less satisfied than those attending a routine check-up, suggesting that virtual care may create additional burdens for individuals with chronic conditions.^{50,51}

These findings highlight how virtual care and patient experiences are shaped by individual characteristics and technological accessibility. Older adults and some subgroups relied more on telephone-based care, likely reflecting differences in digital literacy, infrastructure, or comfort with video technology. Across modalities, patients reported similar positive aspects, mainly convenience, while video users were more likely to experience problems with equipment or connectivity issues and out-of-pocket costs. Satisfaction was lower among patients with lower financial well-being and those without a regular health care provider, indicating less favourable experiences for some groups. Together, these results demonstrate how differences in access, comfort with technology, and social determinants of health shape patients' experiences with virtual care.

Strengths and limitations

This study presents new information about patient experiences with virtual care in Canada, including modality used, positive and negative aspects, and satisfaction with virtual appointments. Examining sociodemographic and health characteristics highlighted potential differences in patients' experiences with virtual care at the population level.

One limitation is that individuals living in the territories, on reserves, or in institutions were excluded from the sample. This especially limits the Indigenous sample, preventing distinctions-based analysis and affecting generalizability to the wider Indigenous population, as most who had a virtual appointment resided in urban areas. Additionally, financial well-being was used instead of income, which was unavailable in the CSS.

Patient satisfaction was affected by a ceiling effect, where high ratings limit variability,⁵² and a single-item measure prevented the assessment of different dimensions of satisfaction.⁵³ Moreover, satisfaction was measured only for patients' last appointment, whereas other virtual care questions (e.g., modality) did not specifically refer to the last appointment, preventing analysis of other factors associated with satisfaction.

Conclusion

This study presents new population-level evidence on patient experiences with virtual care in Canada, highlighting differences in modality, satisfaction, and perceived benefits and drawbacks. Primary and specialist appointments were mainly via telephone, while video was more common for other provider types. Sociodemographic and health-related factors shaped modalities and patient experiences. Overall, patients reported high satisfaction, citing convenience factors as key benefits; however, satisfaction was lower among those without a regular provider or experiencing financial difficulties, suggesting unmet needs for these groups.

Findings can inform policy makers and health professionals about barriers to virtual care and patient needs and preferences, which can help to address equity issues in virtual care design to ensure that all patients benefit. Future research on access

challenges for vulnerable populations, more nuanced satisfaction measures, and provider perspectives on virtual care modalities would help to better understand virtual care effectiveness and areas for improvement.

Appendix Table 1
Sociodemographic and health characteristics of individuals who had a virtual care appointment in the past 12 months, Canada, 2023

	percent	95% confidence intervals	
		from	to
Age group			
15 to 24	11.1	9.6	12.7
25 to 34	16.7	15.3	18.2
35 to 44	18.0	16.8	19.3
45 to 54	16.6	15.5	17.8
55 to 64	15.9	14.8	17.0
65 or older	21.8	20.6	23.0
Gender			
Men+	42.3	40.5	44.1
Women+	57.7	55.9	59.5
Marital status			
Married or common-law	63.3	61.2	65.3
Single (never married)	23.0	21.0	25.1
Separated, divorced, or widowed	13.8	12.5	15.1
Immigrant status			
Non-immigrant	71.5	69.6	73.4
Immigrant or non-permanent resident	28.5	26.6	30.4
Population group			
Non-racialized and non-Indigenous	71.6	69.5	73.6
Racialized	25.1	23.2	27.1
Indigenous	3.4	2.5	4.4
Education level			
High school or lower	33.3	31.4	35.2
Postsecondary below bachelor's level	31.7	30.2	33.4
Bachelor's degree or higher	35.0	33.4	36.6
Sexual orientation			
Heterosexual	91.9	90.5	93.2
LGB+	8.1	6.8	9.5
Urban or rural status			
Rural	10.9	9.7	12.1
Urban	89.1	87.9	90.3
Province of residence			
Newfoundland and Labrador	2.2	2.0	2.5
Prince Edward Island	0.3	0.2	0.4
Nova Scotia	3.2	2.8	3.6
New Brunswick	2.5	2.2	2.9
Quebec	13.9	12.6	15.3
Ontario	41.9	40.1	43.6
Manitoba	3.2	2.8	3.8
Saskatchewan	2.4	2.0	2.8
Alberta	8.5	7.5	9.6
British Columbia	22.0	20.7	23.4
Ability to meet household needs (financial well-being)			
Easy or very easy	37.0	34.9	39.2
Neither difficult nor easy	34.2	32.1	36.4
Difficult or very difficult	28.7	26.9	30.6
Main activity			
Paid work	56.1	54.0	58.2
Retired	21.1	19.8	22.4
Other (not in paid work or retired)	22.8	20.9	24.8
Disability status			
Does not identify as a person with a disability	82.5	80.7	84.1
Identifies as a person with a disability	17.5	15.9	19.3
Has a regular health care provider			
No	14.8	13.2	16.6
Yes	85.2	83.4	86.8
Number of chronic conditions			
None	37.7	35.5	40.0
One	27.1	25.2	29.1
Two or more	35.2	33.2	37.2
Paid for any virtual appointment			
No	89.3	87.7	90.7
Yes	10.7	9.3	12.3
Appointment types			
Family doctor, general practitioner, or nursing practitioner only	62.1	59.8	64.3
Medical specialist only	10.2	8.9	11.7
Other health care provider only	5.4	4.5	6.5
Multiple appointment types	22.2	20.5	24.1
Main purpose of last virtual appointment			
Regular check-up or routine appointment	28.5	26.6	30.6
Medication or prescription refill	30.7	28.9	32.6
Treatment of chronic physical or mental health condition	12.9	11.4	14.5
Treatment of acute physical or mental health condition or infectious disease	13.1	11.6	14.7
Other reason	14.8	13.3	16.5

Note: LGB+ = lesbian, gay, bisexual, or other identity not elsewhere specified.

Source: Canadian Social Survey – Quality of Life, Virtual Health Care and Trust, 2023.

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