The future of telemedicine after COVID-19

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The use of telemedicine, or remote clinical consultations, was limited in most OECD countries before the COVID-19 pandemic, held back by regulatory barriers and hesitancy from patients and providers. In early 2020, as COVID-19 massively disrupted in-person care, governments moved quickly to promote the use of telemedicine. The number of teleconsultations skyrocketed, playing a vital role in maintaining access to care, but only partly offsetting reductions in in-person care. This brief describes how governments scaled up remote care during the pandemic and explores the impact that this massive shift to remote care has had on health care system performance.

Key findings

- Prior to the COVID-19 pandemic, nine countries (Estonia, Hungary, Iceland, Ireland, Korea, Luxembourg, Mexico, Türkiye and the United States) allowed medical consultations to be performed only in the physical presence of the patient. While it was possible to use telemedicine services in other countries, many governments had requirements specific to telemedicine that effectively disincentivised its use. Although the number of services was growing, in countries such as Australia, Canada and Portugal, teleconsultations were only between 0.1% and 0.2% of all appointments.
- 23 out of 31 countries[1] are currently allowing teleconsultations to be performed by health workers other than doctors, six more that before the COVID-19 pandemic (Estonia, Germany, Iceland, Luxembourg, Portugal and the United States).
- Despite the rapid adoption of policies to promote the use of telemedicine, only 17 countries state that rules and regulations governing the provision of telemedicine services are well established and clear.
- During the pandemic, eight countries (Belgium, Czech Republic, England, Estonia, Hungary, Korea, Latvia and Luxembourg) have begun paying for teleconsultations through government/compulsory schemes, and eight countries (Belgium, England, Estonia, Germany, Hungary, Ireland, Latvia and Switzerland) have begun paying for remote patient monitoring services through government/compulsory schemes.
- Many of the changes that have enabled greater use of teleconsultations during the pandemic are temporary and have not been made permanent. In 16 OECD countries, changes to regulations are temporary and subject to ongoing or periodic review, while in 12 countries changes in financing were or are temporary and may be subject to review.

The COVID-19 pandemic massively disrupted in-person health services

As health systems focused on preventing and treating COVID-19, and with populations drastically altering their behaviours to limit infections, many essential in-person health services were either postponed or simply cancelled. In May 2020, the number of in-person primary care consultations plummeted, falling by 66% in Portugal, about 40% in Australia, 18% in Austria and 7% in Norway, compared with the same month in 2019 (OECD, 2021[1]). In-person consultations per capita dropped in seven of eight countries reporting data for 2020, and by up to 30% in Chile and Spain. In Australia, average daily visits to hospital emergency departments were down by 38% between early March and early April 2020, compared to the same period in 2019. In the United Kingdom, emergency department visits in March 2020 were 29% lower than in March 2019. In Italian regions, paediatric emergency department visits fell by 73% to 88% in March 2020, compared with March 2019.

This brief describes how governments scaled up remote care during the pandemic and explores the impact that this massive shift to remote care has had on health care system performance.[2]

[1] 31 OECD countries that participated in the OECD Survey on Telemedicine and COVID-19, administered in December 2021.

[2] For a more in-depth analysis, see OECD (2023[3]), from which this policy brief is based.

Governments swiftly adopted policies to promote the use of telemedicine

Governments promoted remote care services by relaxing restrictions to their use

Before the COVID-19 pandemic, the number of telemedicine services was growing, but it still represented a very small proportion of the overall volume of health services provided in OECD countries, between 0.1% and 0.2% of all in-person appointments in Australia, Canada and Portugal (Oliveira Hashiguchi, 2020[2]). While it was possible to use telemedicine services in most countries, many governments had requirements specific to telemedicine that effectively disincentivised its use.

According to an OECD Survey on Telemedicine and COVID-19,[3] before March 2020, nine countries[4] allowed medical consultations to be performed only in the physical presence of the patient (Figure 1). In early 2020, in response to the unfolding COVID-19 crisis, governments and health care providers moved quickly to use remote care services.

After March 2020, all but one dropped this requirement. Austria, Türkiye and the United States dropped requirements that prescriptions could only be written in the physical presence of the patient, and seven countries relaxed a prerequisite that patients were only allowed to have teleconsultations with physicians with whom they had already consulted in-person before. Estonia and Türkiye introduced new legislation, and revised existing laws, to authorise or regulate the use of telemedicine after the start of the pandemic. In the United States, Medicare telehealth restrictions that previously only allowed providers located in rural areas to offer telehealth were waived. Korea made it possible to temporarily use telemedicine services at the highest alert level of COVID-19.

From the onset of the COVID-19 pandemic, a significant change in policy has been put in place to allow health care workers other than doctors (such as nurses) to perform teleconsultations. Six countries (Estonia, Germany, Iceland, Luxembourg, Portugal and the United States) have changed policies on which medical staff can perform teleconsultations, with 23 countries currently allowing teleconsultations to be performed by health workers other than doctors. In 20 OECD countries, it is the sole responsibility of the health worker to determine whether a teleconsultation is appropriate. In 23 countries, patients must give their written or oral consent to participate in teleconsultations. In 28 countries, in-person appointments are not required after a teleconsultation, and in 23 countries, teleconsultations between providers are allowed.

Despite the rapid adoption of policies to promote the use of telemedicine, only 17 countries state that rules and regulations governing the provision of telemedicine services are well established and clear. While this may give providers some freedom, it also leads to uncertainties among providers and may make it difficult for some of them to offer remote care services. In Canada, differences in licensing requirements for physicians providing virtual care, which are determined at the provincial and territorial level by regulatory authorities, make it difficult for health professionals to provide care for patients across Canadian borders.

[3] The OECD Survey on Telemedicine and COVID-19 was sent to OECD countries in December 2021, and responses were accepted until the end of April 2022. A total of 31 OECD countries participated in the survey. Telemedicine was defined as the use of information and communication technologies to deliver health care at a distance (Oliveira Hashiguchi, 2020[2]). Three categories are considered, which can be combined as appropriate: telemonitoring, store and forward, and interactive telemedicine.

[4] Estonia, Hungary, Iceland, Ireland, Korea, Luxembourg, Mexico, Türkiye and the United States.

Figure 1. Pre-pandemic restrictions to the use of telemedicine were relaxed in early 2020

Use of telemedicine before and after the start of the COVID-19 pandemic

Medical consultations can only be performed in the physical presence of the patient		Teleconsultations are only allowed if the patient has consulted the health care worker in-person in the past		Real-time (synchronous) teleconsultations are covered by government / compulsory financing schemes		Remote patient monitoring services are covered by government / compulsory financing schemes	
BEFORE	AFTER	BEFORE	AFTER	BEFORE	AFTER	BEFORE	AFTER
Korea		Australia*		Australia		Canada	
Estonia	Estonia	Czech Republic		Canada		Finland	
Hungary	Hungary	Netherlands		Costa Rica		France	
Iceland	Iceland	Mexico		Finland		Iceland	
Ireland	Ireland	Estonia	Estonia	France		Israel	
Luxembourg	Luxembourg	Luxembourg	Luxembourg	Germany		Japan	
Mexico	Mexico	France	France	Iceland		Netherlands	
Türkiye	Türkiye	Iceland	Iceland	Ireland		Norway	
United States	United States	Ireland	Ireland	Israel		Poland	
Australia		Japan	Japan	Japan		Portugal	
Austria		Lithuania	Lithuania	Lithuania		Sweden	
Belgium		New Zealand	New Zealand	Netherlands		Türkiye	
Canada		United States	United States	New Zealand		United States	
Costa Rica		Korea	Korea	Norway		Belgium	Belgium
Czech Republic		Austria		Poland		England	England
England		Belgium		Portugal		Estonia	Estonia
Finland		Canada		Slovenia		Germany	Germany
France		Costa Rica		Sweden		Ireland	Ireland
Germany		England		Switzerland		Latvia	Latvia
Israel		Finland		Türkiye		Switzerland	Switzerland
Japan		Germany		United States		Hungary	Hungary
Latvia		Hungary		Belgium	Belgium	Australia	
Lithuania		Israel		Czech Republic	Czech Republic	Costa Rica	
Netherlands		Latvia		England	England	Czech Republic	
New Zealand		Norway		Estonia	Estonia	Lithuania	
Norway		Poland		Latvia	Latvia	Luxembourg	
Poland		Portugal		Luxembourg	Luxembourg	Mexico	
Portugal		Slovenia		Hungary	Hungary	Korea	
Slovenia		Sweden		Korea	Korea	New Zealand	
Sweden		Switzerland		Mexico		Slovenia	
Switzerland		Türkiye		Austria		Austria	

Legend:	Yes	No	Missing

Note: * Only applicable for General Practitioners and other Medical Officers practicing in general practice, with limited exceptions. Agreement with statements is shown for both before March 2020 (i.e. before the start of the pandemic) and after March 2020 (i.e. after the start of the pandemic).

Source: OECD (2023[3]), *The COVID-19 Pandemic and the Future of Telemedicine*, https://doi.org10.1787/ac8b0a27-en.

Countries used financial incentives to boost telemedicine

Governments promoted the use of telemedicine through changes in providers' payment systems. Since the onset of the COVID-19 pandemic, eight countries (Belgium, Czech Republic, England, Estonia, Hungary, Korea, Latvia, and Luxembourg) have begun covering real-time (synchronous) teleconsultations through government/compulsory schemes. Eight countries (Belgium, England, Estonia, Germany, Hungary, Ireland, Latvia, and Switzerland) have begun covering remote patient monitoring services. In 16 OECD countries, fee-for-service is used by key purchasers to pay providers for each discrete telemedicine service they provide, whereas in six countries telemedicine services are included in the

capitated payment to providers. In Belgium, Germany, Japan, Portugal, and the United States, key purchasers use both fee-for-service and global budgets to pay providers of telemedicine services.

Besides covering telemedicine services through government/compulsory schemes, several countries also adopted financial incentives to promote the use of telemedicine services. These included increasing payment for telemedicine services to set parity with equivalent in-person services, and payment add-ons to separately reimburse ancillary costs (e.g., technical support, equipment, connectivity) associated with providing telemedicine services (Figure 2).

Figure 2. Some countries used financial incentives to promote telemedicine during COVID-19

Country agreement with statements before and after the start of the COVID-19 pandemic

There is payment parity between telemedicine services and equivalent in-person services		Cost-sharing for telemedicine services is similar to cost-sharing for equivalent in-person services		There are payment add-ons to separately reimburse ancillary costs (e.g. technical support, equipment, connectivity) associated with providing telemedicine services	
BEFORE	AFTER	BEFORE	AFTER	BEFORE	AFTER
Australia		Australia		Australia	
England		Costa Rica		England	
Finland		England		France	
Netherlands		Finland		Germany	
France		France		Iceland	
Norway	Norway	Germany		Israel	
Poland	Poland	Israel		Japan	
United States	United States	Japan		Portugal	
Hungary	Hungary	Lithuania		Estonia	Estonia
Korea	Korea	Netherlands		Ireland	Ireland
Costa Rica		New Zealand		United States	United States
Czech Republic		Norway		Costa Rica	
Estonia		Poland		Czech Republic	
Germany		Portugal		Finland	
Ireland		Hungary	Hungary	Lithuania	
Israel		Korea	Korea	Luxembourg	
Japan		Czech Republic		Mexico	
Lithuania		Estonia		New Zealand	
Luxembourg		Ireland		Netherlands	
Mexico		Luxembourg		Norway	
Portugal		Mexico		Poland	
Belgium	Belgium	United States	United States	Switzerland	
Latvia	Latvia	Belgium	Belgium	Türkiye	
Iceland		Latvia	Latvia	Belgium	Belgium
New Zealand		Iceland		Hungary	Hungary
Switzerland		Switzerland		Latvia	Latvia
Türkiye		Türkiye		Korea	

Legend: Yes | No | Missing

Note: Agreement with statements is shown for both before March 2020 (i.e. before the start of the pandemic) and after March 2020 (i.e. after the start of the pandemic). Austria, Slovenia, Canada and Sweden did not respond to this section of the survey. Payment parity means paying for telemedicine and equivalent in-person services at equal rates.

Source: OECD (2023[3]), *The COVID-19 Pandemic and the Future of Telemedicine*, https://doi.org10.1787/ac8b0a27-en.

After the start of the pandemic, the number of countries that used payment parity to encourage providers to use telemedicine doubled to 10. Portugal stands out as, from 2013, hospital teleconsultations contracted nationally with National Health Service hospitals are priced at a 10% higher rate than in-person consultations. Eight countries already had payment add-ons to separately reimburse ancillary costs associated with providing telemedicine services before the COVID-19 pandemic. After the start of the pandemic, three more countries – Estonia, Ireland and the United States – began paying for ancillary costs separately.

Telemedicine policies introduced with the pandemic are often temporary

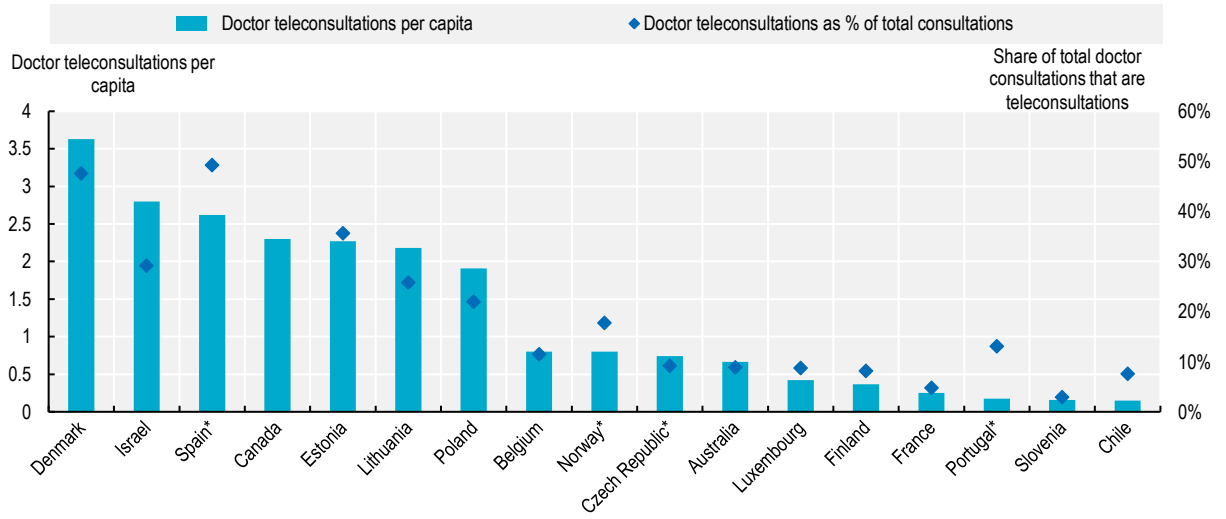
In 16 OECD countries surveyed, changes to regulations are temporary and subject to ongoing or periodic review, while in 12 countries changes in financing were or are temporary and may be subject to review. In Austria, temporary regulations have been extended multiple times since the onset of the pandemic. In Korea, the use of teleconsultations is strictly limited to exceptional situations like pandemics and is a temporary service put in place to prevent the spread of infectious diseases in hospitals. In eight countries (Belgium, Costa Rica, Czech Republic, Hungary, Iceland, Lithuania, Mexico and the United States), work is ongoing to assess and develop frameworks for legislating and regulating the use of telemedicine services. In six countries (Estonia, France, Israel, Luxembourg, Portugal and Türkiye), at least parts of the regulations published after March 2020 are or have become permanent.

Australia, England, Estonia, Lithuania, Luxembourg, Poland and Türkiye have all made changes to financing and/or provider payment mechanisms permanent, while in Switzerland, some changes have been made permanent. In Australia, from 1 January 2022, many of the COVID-19 telehealth services transitioned to permanent arrangements under a National Telehealth programme, including retaining all video services made available during the pandemic, as well as enabling unrestricted access to general practitioner consultations for patients affected by natural disasters. In Canada, the provinces and territories have primary jurisdiction over the administration and delivery of health care, which includes financing, so that changes and whether they are permanent or temporary vary by province and territory.

The use of telemedicine has skyrocketed during the COVID-19 pandemic, partly compensating for the disruptions to in-person care services

The number of teleconsultations skyrocketed in the early months of the pandemic, offsetting to some extent the reduction in in-person health care services. In Australia, in the quarter ending September 2020, 13.3% of all 15.5 million Medicare Benefits Schedule services were telehealth consultations. In Belgium, there were no teleconsultations at all in January and February of 2020; by April 2020, 44.4% of all appointments were done via telemedicine, and EUR 238 million were paid in associated benefits. In Canada, 73.7% of all primary care visits and 63.9% of specialty care visits were delivered virtually in the second quarter of 2020, compared to 1.8% of total ambulatory visits in the fourth quarter of 2019. In Costa Rica, one-third of consultations in 2020 took place via teleconsultation (OECD, 2021[1]). In France, in the first half of 2020, the number of teleconsultations invoiced to *l'Assurance Maladie* rose from 40,000 acts per month to 4.5 million in April, and during the lockdown in 2020, one in four consultations was a teleconsultation. In Iceland, in March and April 2020, the use of telephone consultations delivered at primary health care centres increased by 69% compared to that period in 2018/19, and remote services made up more than 80% of the consultations delivered at that time. The number of Medicare fee-for-service beneficiary telehealth visits in the United States increased 63-fold in 2020, to nearly 52.7 million. In Denmark and Spain, almost 50% of all doctor consultations provided in 2020 were teleconsultations (Figure 3).

Figure 3. Doctor teleconsultations in OECD countries, 2020



Note: * Norway excludes teleconsultations by medical specialists, Spain covers consultations to generalist and paediatricians who work in primary health care centres of the National Health System; values for the Czech Republic are estimates. Data for Portugal are from the "Portal da transparência", a data website of the National Health Service.
Source: OECD (2023[3]), *The COVID-19 Pandemic and the Future of Telemedicine*, https://doi.org10.1787/ac8b0a27-en.

Telemedicine has improved access to care and patient experience, but the equity and efficiency implications need further analysis

In the last OECD data collection on telemedicine conducted before the COVID-19 pandemic (Oliveira Hashiguchi, 2020[2]), country experts agreed overwhelmingly that telemedicine services have the potential to generate a positive impact on several aspects of health system performance (i.e. equity, efficiency, access, cost-effectiveness and quality, including effectiveness, safety and patient-centredness).

The COVID-19 pandemic has provided a natural experiment, creating opportunities to assess empirically the impact of remote care services on different aspects of health system performance, although not all countries have collected data and conducted studies. Ten countries (Belgium, Canada, England, Estonia, France, Israel, Mexico, the Netherlands, Norway, and the United States) have collected indicators or metrics to assess the quality of telemedicine services, such as safety and outcomes. Administrative data on teleconsultations are very limited, with fewer than half of 31 OECD reporting countries having data on patient characteristics, type of telemedicine service, reasons for telemedicine use, and subsequent care. Without such data, it is difficult to understand the impact of telemedicine on health system performance. Moreover, only 12 countries refer to telemedicine in national legislation or policy on the quality of health care.

Access to telemedicine in rural areas remains a key concern; use and satisfaction among older people have grown over time

While telemedicine generally improves access to care for patients, there is concern that the rapid uptake of remote care services during the pandemic may have exacerbated pre-pandemic inequalities in access to care. Available evidence suggests that the impact of telemedicine on access to health services among subgroups of patients since the onset of the pandemic has been mixed, and possibly not as clear-cut as before the pandemic. Still, access among older, poorer and patients living in rural areas remains of concern, especially in some OECD countries.

The age distribution of telemedicine users varies across countries and seems to be changing with the pandemic. In Canada, the highest rates of telemedicine use were reported among adults aged 65 years and older, while in England, patients older than 74 years were up to 28% more likely to have an in-person consultation than those aged 25-44 years. Data from the United States suggests that younger patient groups were most likely to use telehealth in 2020, but, from April to October 2021, telehealth use rates were similar across age subgroups, except for those aged 18-24. Older patients seem to be satisfied with remote care. In survey data from Austria and Belgium, older respondents were more likely to be satisfied than younger patients were. In Poland, concerns that older adults would not be able to manage using telemedicine were not confirmed.

Patients living in rural areas still seem to use telemedicine services less than other patients. Available data from the United States and Canada show steeper increases in telemedicine use among urban populations.

Patient income remains an important correlate of telemedicine use, although recent data from the United States suggest that the association between income and telemedicine use may be changing. In Canada, patients in the highest income quintile had higher proportions of use of telemedicine during the first wave of the pandemic. In the United States, the increase in telemedicine use in 2020 was greatest among patients in counties with low poverty levels, but more recent data for 2021 suggest that telemedicine use was highest among patients earning less than USD 25,000. Analyses from the United States also show that there are significant differences across groups of patients in the use of audio-only versus video telehealth.

Patient experiences with telemedicine are positive and satisfaction is very high

There is much more agreement on the value of telemedicine services among patients across and within countries, than among physicians. In Australia, among fellows of the Royal Australasian College of Surgeons, 77% felt that satisfactory care could be delivered via telehealth in half or more consultations, but only 38% of respondents felt that the quality of care was equivalent to an in-person consultation. In the United States, among respondents to multiple waves of McKinsey Surveys conducted in 2020 and 2021, two-thirds of physicians and 60% of patients agreed that virtual health is more convenient than in-person care for patients, but only 36% of physicians agreed remote care was more convenient for themselves.

In Canada, 78% of the physicians agree that virtual care enables them to provide quality care for their patients, and over two-thirds of physicians were satisfied with video visits and 71% were satisfied with telephone consultations. A national poll of 1 800 people conducted between 14-17 May 2020, found that 91% of patients who connected with their doctor virtually during COVID-19 being satisfied, which is 17 percentage points higher than the satisfaction rate for in-person emergency room visits. In yet another Canadian survey of over 12 000 people conducted between 14 July and 6 August 2021, 89% of respondents felt they were involved in the decision making around their care and 88% felt the visit was effective in helping with the health issue they consulted about. For patients using e-mental health services, an astounding 74% of users of e-mental health services agreed that remote care had helped them deal with a moment of crisis and distress that would have resulted in physical harm or suicide.

Around two in five patients who used remote care services during the pandemic prefer them over in-person services, while physicians have more mixed views

Surveys from across OECD countries indicate patients' preferences with using remote care services also in the future. In Australia, 41% of patients who participated in surgical telehealth consultations indicated they would prefer telehealth to in-person appointments in the future. In Canada, 46% of respondents who used virtual care after the start of the pandemic stated they would prefer a virtual appointment as a first point of contact with their doctor. In Israel, around 82% of men, 73% of women, and 80% of patients with chronic conditions agreed that they would continue to use telemedicine. In Poland, 43% of respondents believe that telehealth should be one of the main ways to contact their primary care provider. In the United States, in November 2021, 55% of consumers said they were more satisfied with telehealth visits than with in-person appointments.

Compared to patients, physicians have more mixed views of the role of remote care services in a new phase of the pandemic when most people are vaccinated, and in-person services have mostly resumed. For example, in Australia, 85% of surgeons recently surveyed expressed a desire to continue providing access to telehealth, and in Canada, nearly 25% of physicians expect to increase their use of virtual care in the future. In Norway, general practitioners estimate that they will conduct about one in every five consultations by video in the future, and in England, 88% of 2,000 general practitioners felt that greater use of remote consultations should be maintained in the longer term. However, in Sweden, approximately four in ten doctors do not want to work more with digital care visits at all, and in the United States, 62% of physicians state that they would recommend in-person care over remote care to patients.

Surveys also show that patients generally report saving time and money by using remote care, making telemedicine services very good value for money for them. In an Australian survey, 60% of patients reported cost savings due to teleconsultations, and 77% felt that their telehealth appointment was value for money. In Canada, patients using teleconsultations instead of in-person care reported saving on average CAD 144 by not having to arrange for care for a dependent, to take time off work and by avoiding travel and associated costs. In England, between 1 April 2020 and 31 March 2021, video consultations saved patients a combined 530 years of travel and waiting time and GBP 40 million in travel costs.

It is unclear whether remote care substitutes for or complements in-person care, and whether telemedicine adds value or is wasteful for health systems

Spending on telemedicine services is wasteful when it does not deliver benefits and when it could be replaced with cheaper alternatives with identical or better outcomes. On the one hand, there is a good deal of data suggesting that telemedicine services reduce subsequent health care utilisation (especially more costly services like emergency care and hospitalisations) and lower the chances that patients will miss appointments. On the other hand, teleconsultations can lead to subsequent in-person care, and – under certain provider payment schemes – may lead to higher spending at no extra value for health systems and patients.

In a 2021 Canadian survey, 81% of people using video consultations and 77.1% of e-mental health patients reported that remote care had avoided them at least one in-person visit to a doctor or emergency room. In the same survey, 11% of virtual visits resulted in a patient referral to an in-person appointment with a specialist and 10% in advice to patients to make an in-person appointment with their family doctor. In a study in England, 18% of patients were discharged following a telephone or telemedicine appointment in April 2020, compared to 25% in February 2020, while the proportion of patients discharged after in-person appointments remained consistent at around 22%. The same analysis also shows increased prescribing and referrals following a teleconsultation. The reasons behind these trends are unclear.

Analyses from Sweden show that before 2018, users of remote care had lower primary care utilisation rates than users of in-person care services, but that in 2018 the opposite became true. While remote care services did replace some in-person care, overall it led to higher numbers of total consultations. It is unclear, however, whether increased utilisation was due to previously unmet needs or whether it represented inappropriate demand.

Policy priorities for telemedicine

As governments, societies and economies adapt to a virus that will become endemic, this is an appropriate time for health care providers, policy makers and citizens to discuss whether to continue using telemedicine services, how to regulate their use, how to pay for them, and how to make sure that they constitute good value for money for all. There are important differences in how remote care is organised, regulated and financed across the OECD, and large differences in the extent of telemedicine services use. There are three priorities for policy makers to consider in the future, and all three are heavily reliant on data being collected, analysed and reported:

- First, more evidence about which patients are using remote care services, why they are using these services and what happens after they use them is essential to inform discussions of the impact of telemedicine services on health system performance.
- Second, there is a need to better investigate whether payment and organisational arrangements for provision of telemedicine services are encouraging appropriate and effective use of services. Some patients clearly want to use telemedicine more, and there is potential for it to save costs. So the challenge is to adapt payment systems to enable this to happen and to be of high quality, whilst still accepting that for some conditions and some patients, in-person consultations will be preferable There are few costs and utilisation data, as well as analyses, to inform decisions concerning provider payment arrangements and prices.
- Third, remote and in-person care services need to be integrated, so that they are fully co-ordinated and part of a seamless care pathway. In-person care and telemedicine services are currently fragmented, with significant disagreement among providers on the merits of telemedicine services. This is not optimal and does not serve the interests of patients.

Telemedicine is only a tool and, like any other tool, it can be well used or misused. When well used it can be beneficial for patients and health systems, providing we continue to work on overcoming some pitfalls.

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