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Disconnected: Inside Canada's Patchwork of Virtual Care

Virtual care is transforming access to healthcare in Canada, but the federation's patchwork of rules and different approaches affects access, the scope for private virtual care operators, continuity of care and system integration. This report maps the rapidly-evolving landscape and shows how governance can turn virtual care into a true strength rather than a source of fragmentation.

Katherine Fierlbeck and Rosalie Wyonch

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Disconnected: Inside Canada's Patchwork of Virtual Care

by Katherine Fierlbeck and Rosalie Wyonch

- **Virtual care has rapidly expanded across Canada, improving convenience and access for many but also creating a fragmented governance landscape. Provinces differ widely in how they regulate, fund and integrate virtual care, making cross-border delivery complex and leaving major gaps in continuity of care for patients navigating their journey through the health system.**
- **Despite efforts to align public systems with modern care delivery, large loopholes in how "insured services" are defined by provinces in practice have enabled significant growth of private, for-profit virtual care. These services operate both within and across provinces, raising concerns about equity, data fragmentation and uneven access based on patient resources or employer benefits.**
- **As virtual care becomes a permanent feature of the healthcare system, provinces must strengthen regulatory frameworks, protect continuity of care from fragmentation, and clarify the scope of insured services. Choices made now will determine whether virtual care reduces access gaps and enhances integration or contributes to greater inequity and system fragmentation.**

Introduction

The healthcare landscape in Canada has shifted significantly since the COVID-19 pandemic. The most "disruptive" aspect of this shift has been the widespread adoption of virtual care. But as with any form of rapid policy evolution, the cumulative consequences of these shifts can be difficult to discern. Furthermore, unlike other health system transformations that can often be addressed within discrete provincial and territorial (PT) jurisdictions, virtual care has challenged geographically defined healthcare governance itself. Because many healthcare services can now be offered seamlessly across provincial (and even national) borders, attempts to determine the terms on which these services can be offered have resulted in a complex and confusing governance landscape.

While virtual care and "telemedicine" were not entirely unknown before COVID-19, formal and informal decisions to limit social interaction during the pandemic drove both patients and providers to

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engage with various modalities of virtual care on a much wider scale.[1] As the pandemic abated, patient and provider satisfaction with this mode of care led to ongoing adoption and scaling-up of some of the temporary and experimental approaches that emerged in 2020. This was an international phenomenon with regional variations, even within Canada. Canada's highly decentralized healthcare system, resting largely in provincial/territorial (PT) legislative authority, meant that some provinces actively integrated and encouraged continued use of virtual care, while others reverted to policies similar to the pre-pandemic period. Variations in provincial policy and differing technical and logistical challenges of virtual care uptake were further exacerbated by jurisdictional fragmentation.

Virtual care offers the opportunity for PTs to bolster primary care access where it is stretched thin, but it also threatens to undermine their ability to shape healthcare in a coordinated and comprehensive manner. This *Commentary* examines the post-COVID evolution of virtual care in Canada. It identifies both the ways PTs have converged towards common practices in virtual care provision and governance, and the ways they have established distinctive approaches. Further, the *Commentary* investigates the impact that virtual care has had on the ability of Canadian PTs to maintain a coherent system of healthcare defined by the *Canada Health Act* (CHA). While most virtual care is in the area of primary care, it can also be used in specialist care (e.g., surgical post-op monitoring or mental healthcare).[2] In some circumstances, it can also facilitate urgent or emergency care (CADTH 2021). This *Commentary* focuses on virtual primary care provision, although the boundaries between primary care, specialist care, and urgent care are quite porous, and caution should be taken when addressing primary care in isolation.

Many of the concerns related to continuity of care, rapid access to treatment, and integrated patient records affect both public and private channels. Virtual care both complicates and facilitates achievement of these goals. While virtual delivery goes hand-in-hand with digital patient records and enables multi-provider coordination and asynchronous communication, the potential for both public and private providers to treat a patient – along with the potential for data fragmentation if records are not shared across channels – complicates integration and continuity and raises privacy concerns about other potential uses of patient medical information. Private for-profit virtual care has significant legal space in which to operate, and there is clear market demand for access to primary care services.

The space for private for-profit care is any service that is not included within provincial public insurance systems, and therefore outside the scope of the CHA. Provinces have full discretion to set the scope of both public and private virtual care, as the text of the CHA itself is not explicit about the mode of delivery (beyond provision by physicians and in hospitals), the inclusion of other professions delivering "physician-equivalent" services (outside of hospitals), or the definition of "medically necessary." Beyond individual provinces, there is also space for virtual care platforms and providers to operate between provincial boundaries. In the current complex legal and regulatory landscape,

1 For example, in Ontario, 1.6 percent of ambulatory care visits were virtual in the second quarter of 2019. In the second quarter of 2020, 70.6 percent of ambulatory visits were virtual. Over the same timeframe, the proportion of doctors who provided at least one virtual visit per year increased from 7 percent to 85.9 percent (Bhatia et al 2021).

2 The scope of virtual care services extends to many important areas, including provision of specialist services, improved access for rural and remote communities, Indigenous communities, post-op monitoring from a community setting, and specialized programs such as Kids Help Line or Health 811.

there is significant scope for the growth of private virtual care, and the landscape is not likely to simplify anytime soon.

Provinces should approach virtual care as a useful tool to fill gaps in care and improve access, though there are potential trade-offs that should be monitored and managed where necessary. These trade-offs include access and equity, public/private provider labour market dynamics, and public healthcare delivery balanced with public fiscal sustainability.

The Evolution of Virtual Care

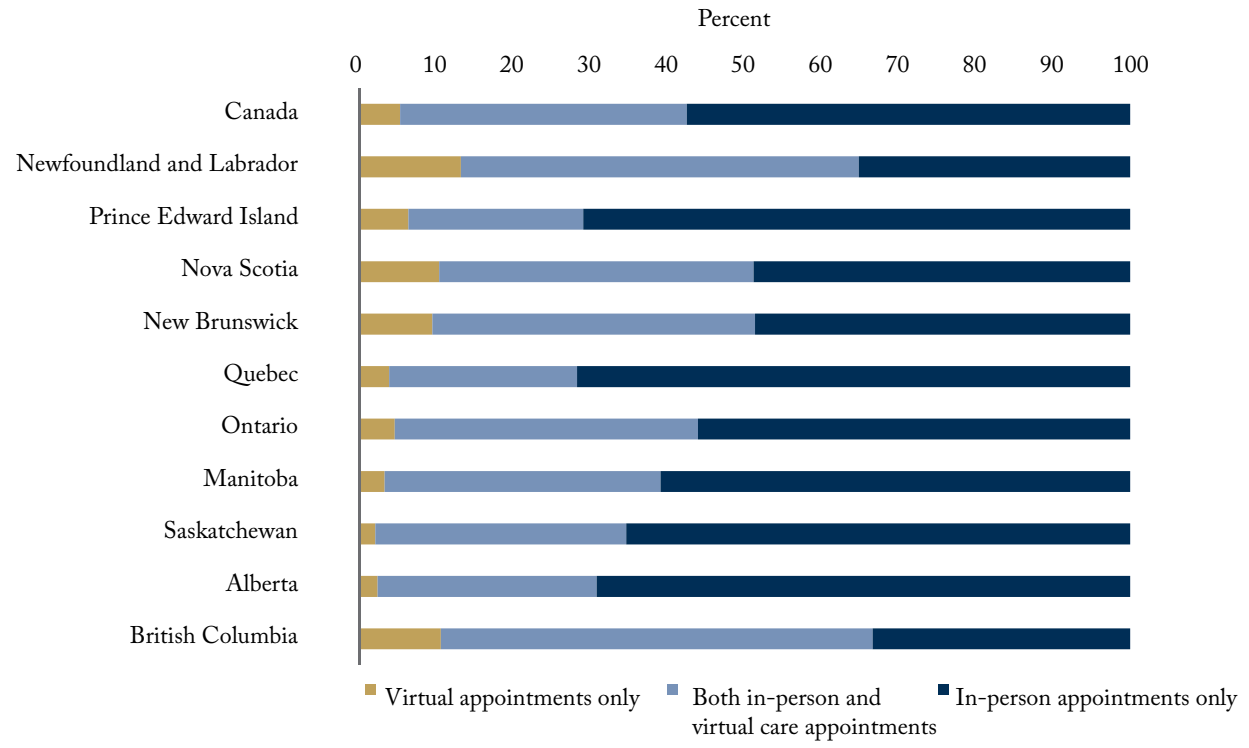
The growth of telemedicine in the 1990s was generally a strategy of extension, where teleconferencing technology allowed those in rural and remote areas to access the services of specialists in urban areas (Picot 1998; Reid et al. 1998). Building on this, eConsult platforms were constructed to facilitate asynchronous communication between primary care providers and specialists (Agarwal et al. 2020). The expansion (however uneven) of electronic medical records also supported the growth of patient-provider interface; in 2017 alone, Ontario reported nearly 900,000 patient events supported via videoconferencing on the Ontario Telemedicine Network (OTN Annual Report 2017/18). At the same time, private virtual care companies began to emerge as well. Ontario physician Brett Belchetz established Maple in 2016 as a virtual walk-in clinic and, by March 2018 it had a roster of around 100 doctors. Eighteen months later, it raised $14.5 million from private investors (Frangou 2023). Maple now provides services to more than 7 million Canadians and has a waitlist of over 1,000 physicians interested in joining the platform (Maple 2025). At the same time, virtual care became embedded in the benefit packages offered by large employers. Dialogue, which supplies virtual care for many of the larger employer benefit plans, was also founded in 2016.

When stringent social distancing measures were enacted in 2020, the infrastructure for virtual care already existed. But the pandemic led to an explosion of demand for these services, new provincial billing codes created incentives for physicians to provide virtual appointments, and the platforms that facilitate virtual visits expanded rapidly. The private company Dialogue grew by 1,600 percent throughout the pandemic, making it one of Canada's fastest-growing companies (Frangou 2023). In 2021, it went public with a market capitalization of over $1 billion (Falk 2021). Other large Canadian companies partnered with international companies that already specialized in virtual care: in 2018, for example, TELUS Health worked with Britain's Babylon Health to create a virtual care platform. In 2021, the total capitalization of the Canadian digital health market was between $15 to $20 billion (Falk 2021).

At the same time, the federal government created a funding stream to support the development of publicly insured virtual care through provincial healthcare systems. In May 2020, Ottawa announced $240.5 million earmarked for virtual care, including Canada Health Infoway's Rapid Adoption of Virtual Care Fund. Provinces developed discrete "action plans" to develop and expand various components of virtual care in exchange for federal funding. The expansion of this space was not merely technical and logistical but also involved the navigation of considerable regulatory changes (such as standards of care and billing codes) distinct to each province or territory.

By the end of 2020, rather than "things getting back to usual," it appeared that a new and permanent healthcare regime had emerged. A sense of urgency and a search for creative solutions produced a governance climate that was much less risk-averse, more supportive of novelty, and more willing to commit financial resources to these novel programs (likely directly related to the success of some pandemic initiatives and the access gaps and health system problems that it highlighted).

Figure 1: Virtual Care Access and Usage, by Province, 2023



Source: Authors' compilation.

Patient demand for virtual care remained high, and practice patterns in both primary and specialty practices began to crystallize. The first wave of forensic scrutiny was available in 2021-2022, with numerous reports[3] beginning to take in the new lay of the land. After this point, virtual care governance started to gain some permanence, and it became clearer where PTs were taking similar approaches and where they were diverging. With the dust settling, it also became easier to focus on how these structures influenced the way virtual care was provided, not only within but between PTs, across both the public and private sectors.

Following the pandemic, virtual care use declined but remained above pre-pandemic levels. About 45.2 percent of people accessing healthcare had virtual care appointments in 2023. 5.3 percent only had virtual appointments (Figure 1). Most people (57.5 percent) had in-person appointments only, showing a significant decline from the peak (about 70 percent of ambulatory visits in the second quarter of 2020 in Ontario, Bhatia et al

3 HC Equitable Access (2021); VC Policy Framework (2021); VC Statement by Family Physicians (2022), Virtual Care Task Force (2022), Falk (2021), BLG (2021); CADTH (2021), Patterson et al. (2022).

2021). British Columbia and Newfoundland and Labrador have the highest uptake of virtual care, followed by Nova Scotia, New Brunswick and Ontario. Quebec and PEI have the lowest usage, with more than 70 percent of people only accessing in-person appointments.[4] Notably, there is no significant difference in the type of appointment by immigration status, sexual orientation, financial well-being or main work activity (Frank and Bader 2025).[5] Differences between provincial policies and health systems significantly influence the virtual healthcare market; provincial insurance coverage, billing rates, and regulatory or governance policies all influence physician and patient uptake of virtual care, as well as the balance between publicly and privately paid services.

The Wider Parameters of Virtual Care Governance in Canada

"Virtual care" is generally defined as any interaction between patients and/or members of their circle of care, occurring remotely, using synchronous or asynchronous forms of communication (e.g., Canadian Institute for Health Information [CIHI] 2023, p. 6). This definition covers a considerable breadth of modalities and functions (Table 1). Generally, virtual care is either synchronous (video link or phone call) or asynchronous (chat or email). There are also many possible combinations and modes of in-person and virtual care. For example, a patient may have an in-person visit with a primary or urgent care provider where they will also have access to a specialist who appears virtually. A patient might initially be seen in person, but the follow-up results of blood work and care guidance might be communicated over the phone and/or by email. Some virtual care platforms might enable multiple types of virtual care to be coordinated, allowing booking of video appointments, phone calls and messaging with providers within one platform. Others focus on discrete aspects such as secure asynchronous messaging between patients and physicians.

Also important is platform design and how it is (or is not) integrated into the public healthcare system. Some PTs simply support an IT platform that permits individual practices or practitioners to connect with their patients directly. Others have contracted commercial virtual care companies like Maple, Teladoc, or TELUS Health to provide publicly insured services online to individuals within the PT. In all PTs, commercial virtual care companies offer uninsured healthcare services directly to patients for a fee, although, as explained in more detail below, these uninsured services can duplicate publicly insured, medically necessary services depending on how they are defined in each province. Another modality is the expansion of employer benefit plans that offer access to virtual healthcare. These services focus on uninsured services, but again, these "uninsured" services can take the form of medically necessary services that duplicate insured services. These four modalities of virtual care provision (Table 1) are not mutually exclusive; they can (and often do) coexist within individual PTs. There are also examples of new modalities that function similarly to private insurance provision, such as owners of large rental properties contracting with private virtual care platforms to provide health services for tenants (Feinstein 2025). Table 2 specifies which provinces have contracts with commercial virtual care companies to provide insured virtual care services, and which do not.

4 For an in-depth discussion of Quebec's primary care reforms see Zhang 2025.

5 People in rural areas were less likely to access only virtual appointments and those with a university degree were more likely to access virtual or mixed virtual/physical appointments than those with a high school diploma or less.

Table 1: Modalities of Virtual Care Provision

Public and Private Modalities	Payer
Provincial governments host a platform that enrolled physicians can use to interact virtually with their patients.	Publicly funded insurance.
Provincial governments contract with a commercial virtual-care company, which uses its own practitioners to provide care.	Publicly funded insurance.
Commercial virtual-care company uses its own practitioners to provide care directly to individual patients for a fee.	Direct private payment by patients, either for services or for membership (or both). Payments may be reimbursed by individual or employer-sponsored insurance coverage.
Employer benefit plan contracts with a commercial virtual-care company, which uses its own practitioners to provide care.	Direct private payment by employers (not patients).

Source: Authors' compilation.

Table 2: Provinces Contracting Commercial Virtual Care Companies to Provide Insured Services

Province	Description of Policy
AB	NA
BC	In December 2023, the BC Ministry of Health issued a request for proposals (RFP) for a service contract to deliver insured services virtually. To date, contracts have been issued for remote patient monitoring, but there is no evidence of large-scale outsourcing of virtual primary care to commercial operators.
MB	NA
NB	The province of NB has contracted with Maple to run eVisitNB for patients currently without a primary healthcare provider or patients currently with a primary healthcare provider who cannot access their provider in a timely manner for non-urgent medical concerns. For government-funded eVisitNB, but the service is limited to nurse practitioners.
NL	Provincial virtual primary care services are available to individuals who do not have a primary care provider and have registered with Patient Connect NL. A contract valued at $11 million annually has been awarded to Teladoc to provide virtual technology and physician coverage.
NS	The province of NS has contracted with Maple to run VirtualCareNS. Those on the "Need a Family Practice Registry" can register for services free at the point of provision; those with a family practice can register and receive two free services per year.
ON	NA
PEI	The province of PEI has contracted with Maple to provide publicly insured virtual healthcare services to those without a primary care provider through the PEI Unaffiliated Virtual Care Program.
QC	NA
SK	NA

Source: Authors' compilation from publicly accessible provincial government sources.

The framework of billing codes for each province will have a direct influence on the kind of virtual services that are provided both publicly and privately (Table 3). There may be advantages and disadvantages to reimbursing both video and phone calls at parity, and whether asynchronous responses are publicly insured at all will determine whether and how private providers utilize them. "Any service left out of the fee schedule in a province," notes Falk (2021, p. 43), "will be privatized."

While provinces diverge in the way they approach both the public and private provision of virtual care, it is useful first to discuss the governance of virtual care in Canada in general terms. While we tend to think of Canadian healthcare as a bifurcation between "public" and "private" realms, the governance of healthcare systems is somewhat more complex. Wendt et al. (2009) note that health system governance is three-dimensional; it can be situated in the public (state), private (market), or social (non-governmental) spheres.[6] This is particularly relevant for virtual healthcare. The governance framework for health systems more broadly is situated firmly in PT legislation, but the parameters for virtual care provision are generally embedded in the licensure requirements, practice guidelines, and standards of care set out by professional regulatory colleges. While the authority of these bodies is also defined in legislation, they are nonetheless non-governmental entities that possess the authority to set out the terms and conditions under which their members can provide virtual care. In practice, these guidelines are established in consultation with the respective PTs.[7]

Policies and bylaws governing certain aspects of virtual care can also be implemented at the health authority or facility level. Nova Scotia is the only province that has articulated a formal provincial policy on the practice of virtual care. But the Nova Scotia Health Authority (NS Health) has also had, since 2024, an "authorized prescriber policy" which precludes any non-resident health provider, even if licensed in the province, from ordering diagnostic tests within the province (Nova Scotia Health 2020, 2024). Finally, the broader "vision" that a PT (or professional association) may have regarding the development and maturation of virtual care is articulated as a "strategic plan." These aspects of virtual care governance are discussed in detail in the following section and summarized in Table 3.

There are many similarities between different regulatory documents across professions and provinces, extant or forthcoming. Common, but not universal, requirements are that providers are responsible for:

- following existing care practice standards for in-person care;
- verifying and following rules set out in their location of practice and the patient's location (and ensuring they have the relevant professional practice insurance coverage);
- being able to refer the patient to in-person care where appropriate (either their own practice or a professional agreement with another provider to provide in-person care);
- restrictions on the prescription of controlled substances (particularly opiates/opioids and addiction treatment);
- ensuring the environment (virtual and physical) is appropriate for the care needs and privacy of the patient.

Existing guidance documents address many of the largest potential concerns raised by the growth

6 Such as the Colleges of Physicians and Surgeons, Medical Associations, Hospital and Charitable Foundations (and their Boards), and other third-party institutions.

7 Billing codes remain at the PT's discretion, although they are generally negotiated with physicians' professional associations. Billing codes are normally set out in provider agreements, payment schedules, or physicians' manuals. At the same time, however, the parameters of virtual care governance can also be set out in PT policies (distinct from provincial statutes).

Table 3: Summary of Virtual Care Practice Standards and Public Billing Rates (for physicians), by Province

	AB	BC	MB	NB	NF	NS	ON	PEI	SK
Billing code equivalency compared to in-person care (synchronous virtual).*	parity	parity	parity	parity	higher	parity	parity/lower	parity	lower
In-person care practice standards apply (including appropriateness, maintaining medical records)	√	√	√	√	√	√	√	√	√
Following rules set out in their location of practice and the patient's location	√	√	√	√	√	√	√	√	√
Being able to refer the patient to in-person care where appropriate	√		√no referral, must have in-person option.	√	√	√	X assist/advise only		√
Restrictions on the prescription of controlled substances**	Opioids	Opioids, addiction treatment, psychotropic medications and cannabis	Opioids, benzodiazepine, Z-drugs, cannabis	Opioids, controlled substances and cannabis	Opioids, controlled substances	Opioids, controlled substances		Advice, but left to clinical judgement	Opioids, controlled substances
Ensure patients are adequately investigated before referral	√	√	√	√	√documented rationale for referral required				√
Out of province providers are allowed to provide care***	No***	Yes – complaints referred to the appropriate governing body	No	No***	Yes – maximum 90 days, must be physically located outside NF	Yes	No***	No***,	Yes, with virtual care license

Notes: This table is a generalized summary of care practice standards and does not capture minor distinctions between provinces. Refer to the guidance documents for details.

* See table A3 for details. ** Common requirements include the physician has examined the patient in person, they have a longitudinal relationship or they are in direct communication with a regulated health professional who has examined the patient. NF allows for opioid prescription if the patient has an ongoing record of regular prescriptions. *** Except if care is unavailable in the province, to provide follow-up or continuity of care associated with existing physician-patient relationship, for emergency purposes when there is no other option. PEI includes additional exceptions for off-island test results, poison control, genetics consulting, seeing federal employees.

Sources: See Table A1 and A2 for details.

of virtual care delivery. They address continuity of care, the availability to get in-person care when appropriate, and safeguards on controlled substances. There is significant variability across provinces, and some regulations remain in draft or less official guidance forms. As experience with virtual care grows, professional standards and regulations will continue to evolve. Given that the guidance is developed within individual PTs and professions, significant variation is likely to remain, and each PT and profession should regularly evaluate and update existing guidance to ensure compatibility both with other professional scopes of practice, and across PT boundaries.

Publicly Funded Insurance, Virtual Care and the *Canada Health Act*

Technology and circumstance have facilitated a rapid and extensive growth of virtual healthcare. However, the ways in which these services are governed and provided differ considerably depending on region, mode and modality of provision. At first glance, one might assume that the extension of healthcare into virtual forms is simply an expansion of current forms of care provision; in-person appointments are merely being offered via phone or online. Rather, it is a substantive challenge to the way healthcare systems as a whole are structured. Virtual care has opened more loopholes in the single-tier system of healthcare grounded in the CHA.

Specifically, the way in which virtual care works across geographic space (provincial boundaries), time (asynchronous and episodic care), and payment mechanisms (such as employer-based plans) has facilitated the growth of private for-profit, direct-to-patient care. As with the growth of private for-profit in-person care, the key factor is the way in which "insured services" are defined. While the foundational principle of Canadian medicare is that "all medically necessary care should be publicly insured," this is not what the CHA actually states.[8] Rather, the CHA only stipulates that insured services must be provided on equal terms and conditions to all eligible recipients in each jurisdiction (Fierlbeck 2024). Nor do PTs explicitly define "insured services" as "all medically necessary services," despite the fact that any services that are not considered medically necessary are rarely insured. Rather, "insured services" are defined in the CHA as those provided by physicians or in hospitals. To the extent that "medically necessary" is used in provincial legislation, it is to limit insured physician or hospital services to those deemed medically necessary.[9] Rather than a precise definition of "medically necessary," the extrapolation is that only services with a designated billing code are medically necessary. Prior to 2025, only services with a designated billing code and provided by physicians or in hospitals were considered medically necessary; the latest CHA interpretation letter has made this more complicated (Fierlbeck 2025). Nonetheless, it is this restrictive formal definition of "insured services" which expands the space for legally compliant for-profit and not publicly insured virtual care provision.

8 Cf. common usages, including: "A key aspect in upholding these principles is to ensure that patients do not face charges for medically necessary care when a service would otherwise be covered if provided by a physician" (Holland 2025).
"The virtual walk-in model may also violate the Canada Health Act by charging patients for medically necessary care, leading to a two-tiered system" (College of Family Physicians of Canada).
"Specifically, sections 18 to 21 of the CHA prohibit user fees and extra billing for "medically necessary" services (Bacchus 2024).

9 PTs generally define "insured services" as simply those services with respect to which a resident is entitled to receive insurance.

In the first place, the ability of physicians to provide medically necessary services to patients across provincial boundaries is facilitated by a definitional loophole in most PTs that limits "insured services" to those physicians enrolled in a PT insurance plan. Physicians providing virtual care across PT borders are rarely enrolled in health insurance plans in a PT in which they are not resident, so the services they provide are not insured – regardless of whether they are "medically necessary". Thus they can be provided on a private for-profit basis. In contrast to in-person care within single jurisdictions, where physicians had to declare whether they wished to work within or outside of the public insurance system at any given time (except Ontario, which does not allow this option),[10] the ease of cross-jurisdictional care provision means that physicians can work both in and out of "the public system." In effect, they may work within the public system in one PT, and outside of it in another. A similar reasoning applies to patients; if a resident in province A receives services from a physician in province B, is the location of care A or B? The patient is not insured in province B, and the physician is unlikely to be enrolled in public insurance in province A. In either case, the appointment could be conducted outside the public insurance system.[11]

There was, in the past, technically no prohibition against a physician working in-person within the public system in one province and in-person outside the public system in another. However, the logistics of this kind of in-person arrangement were so unwieldy that it was not considered an issue of concern. With the development of robust virtual care systems, a physician could easily work three days a week within the public system in their home province, and two days a week providing virtual services as an unenrolled provider in another province. The reason that this is now problematic is that, if it is convenient and financially advantageous to provide simple and uncomplicated services virtually in another province, physicians and nurse practitioners may choose to limit their working hours in the public system, thereby reducing provider resources in the public system across the board. At the same time, virtual care increases the mobility of the limited provider workforce and could facilitate better access in rural locations and after-hours across time zones. Since virtual care does not require full-time hours, it has the potential to increase retention of the health provider labour force both young and old, by allowing the flexibility to reduce total workload or care for young children.

Another way in which the definition of "insured services" can affect the provision of virtual care is by stipulating whether a service is insured or uninsured depending on the longitudinal relationship with the patient. A physician may, for example, prescribe antibiotics to a patient (which is a medically necessary service), but if it is merely a one-off visit from a patient not on their roster, the service may be deemed "uninsured." The CHA allows each PT to determine what insured services are but, in the past, the mode of delivery has been neutral. If episodic care for in-person services is covered publicly (i.e., if in-person walk-in clinics can provide insured services), then the question arises why identical services provided virtually should not also be covered, on the grounds that the medically necessary service is being provided "on equal terms and conditions" (see Fierlbeck and Marchildon 2023, chapter 7). A slightly different case is that of synchronous versus asynchronous virtual care.

10 See Fierlbeck (2024) for details.

11 There are regulatory and insurance requirements for physicians to provide care in multiple jurisdictions. Medical licensure is a provincial domain, and (in most cases) providers would need to be licensed in multiple jurisdictions to provide care both in and out of the public system simultaneously. Regulations may also limit the provision of care to patients in that jurisdiction. However, the location of care remains somewhat technically undefined.

This distinction has become particularly notable in Ontario. In this case, a physician prescribing antibiotics virtually could be providing an insured service via a phone call, but an uninsured service via secure messaging. To reiterate, the definition of "insured services" has very little to do with whether the service is medically necessary, but rather how, to whom, and from where the service is provided.

The type of provider delivering the care also affects whether a service is publicly insured. Nurse practitioners, while able to diagnose, prescribe, and manage many conditions that overlap with primary care physicians' scope of practice, are not always classified as providing "physician services" under PT insurance plans. This allows private companies to charge fees for nurse practitioner and registered nurse consultations without violating either section 9 of the CHA, or the Act's prohibition on extra-billing or user charges for insured services. The overlap in scope is substantial – nurse practitioners in most jurisdictions can autonomously manage chronic diseases, order diagnostic tests, and prescribe medications, yet because these services may not be deemed "medically necessary physician services" in the strict regulatory sense, they can be delivered privately for a fee.

Provincial variations add complexity to this landscape. In provinces like British Columbia and Ontario, nurse practitioners have broad autonomous practice rights and can work in private clinics without the same restrictions that apply to physicians under the *Medicare Protection Act* or the *Commitment to the Future of Medicare Act*, respectively. Quebec has been more restrictive, historically limiting nurse practitioner autonomy and maintaining tighter integration with the public system, though this has been evolving. Saskatchewan and Alberta have embraced nurse practitioner-led clinics in both public and private models, while Atlantic provinces have varying degrees of nurse practitioner integration in primary care. The key issue across jurisdictions is that while nurse practitioners and physicians have overlapping scopes in primary care – both can be a patient's first point of contact and manage common conditions – the provincial definitions of what must be publicly insured generally focus on physician services specifically. This creates a situation where Canadians might pay out-of-pocket for a nurse practitioner consultation for the same condition that would be covered if seen by a physician, raising equity concerns about two-tiered access based on provider type rather than medical need.

The final category of private virtual care, employer benefit plans, also facilitate access to virtual care platforms, meaning those with private insurance coverage (the majority of Canadians) increasingly have access to private on-demand primary care services. How are these services CHA compliant? First, many of the services provided by these benefit plans are uninsured services (such as wellness coaching, mental health support, dietary advice, smoking cessation, sleep therapy, and so on). Second, for services that duplicate those that are publicly insured, private insurance providers can structure their virtual healthcare services to fit outside the technical definitions of public insurance coverage, making them entirely private and not subject to the CHA.[12] As noted above, this could include using non-physician professionals (often nurse practitioners), or licensed physicians not enrolled in the provincial plan where a patient is located, or providing "non-longitudinal episodic

12 It is the authors' understanding that employer-sponsored insurance coverage and access to virtual care currently occur entirely outside the public healthcare system. The only instance where fees might be incurred by the public insurance system is when the nurse practitioner or physician within the virtual care platform provides a reference for a service at a hospital/clinic or a prescription. The actual reference for the prescription or test is at no charge; however, when the prescription is filled at the pharmacy, or the test is conducted at the hospital, that is where it would be billed to public insurance or paid privately, depending on what type of private insurance (or not) is in place and what kind of residency the patient holds.

care" or asynchronous services where these are not included as insured services.

In the second case, the technical interpretation of the CHA seems to conflict with the spirit of the statute.[13] In 2023, the then-federal Minister of Health, Yves Duclos, declared that he would release an interpretation letter clarifying that "access of medically necessary services, whether provided in-person or virtually, remains based on medical need and free of charge." Yet when the letter was finally released in 2025, there was no attempt to ensure that virtual care services were (like "physician-equivalent services") to be included under the umbrella of publicly insured services. This would have been a difficult task, given that the Epp CHA interpretation letter clearly established that "provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary."

In sum, virtual care is rapidly changing the landscape of healthcare in Canada. As with other developments, the CHA could never have foreseen the dramatic shifts in the way healthcare is being provided. The advantages of virtual care are considerable, but the question remains: who will benefit the most from it? The ease and convenience of virtual care are raising all the documented issues associated with easy access to private for-profit care. These include the potential drift of healthcare professionals to a more lucrative private sphere, the fragmentation of continuity of care, and the diminishing ability of those with the least resources to access quality care in a timely manner. To these are added newer issues of how patient data are utilized and protected outside the public system, and the upselling of uninsured, and highly lucrative, "wellness services" (Spithoff, Vesely and McPhail et al. 2025). Wellness services can have significant value if they improve lifestyle factors that contribute to chronic disease and are preventative; however, the potential for supplier-induced demand for low-value services exists.

The expansion of virtual care means that governments will have to continue to think about fine-tuning their respective regulatory frameworks to ensure that virtual care pathways work as seamlessly as possible. One area PTs should carefully evaluate is the poorly defined and poorly enforced requirements supporting the continuity of care over time for patients in the system. Episodic care, requiring relatively simple treatments, should not be favoured over more demanding and complex patients requiring ongoing care. Preventing commercial enterprises or other providers from "cream-skimming" simple cases while sending more complex patients back into the public system can be achieved through regulation.[14] In practice, however, there is little evidence of "cream-skimming" affecting equitable access at the aggregate level. There is no significant difference in access to virtual or hybrid (in person and virtual care) by employment status, sexual orientation, immigration status, or ease of meeting household financial needs. Those with two or more chronic conditions were more likely to have virtual care appointments than those without (Frank and Bader 2025). In practice, virtual care providers generally do not actively choose patients based on acuity, particularly in employer-provided insurance or publicly covered virtual primary care. Requiring virtual care providers to have guaranteed in-person care providers responsible for navigating tests, referrals,

13 See Fierlbeck 2025 for an in-depth discussion of the history and implications of the CHA interpretation letter.

14 The exception would be specialized direct-to-consumer virtual care services such as those offering access to particular types of treatments such as those for ADHD, weight loss, erectile dysfunction, etc. These specialized services are generally entirely private and direct-to-consumer.

and more complicated conditions would provide a superior care pathway.[15] The model of a dedicated in-person clinic for those using VirtualCareNS is a useful proof of concept, and many provincial guidelines require providers to have the ability to refer to in-person care, or directly provide it themselves. In practice, virtual care can facilitate improved continuity of care through shared patient records, asynchronous communication, and hybrid treatment between virtual and in-person practices. Improved continuity and optimization between virtual and in-person delivery should be facilitated by regulatory and policy changes.

Another policy issue has been whether, and how, to standardize licensing across PTs to facilitate the ability of healthcare professionals to easily provide services across PT boundaries. Standardized licensure has not, to date, had considerable buy-in from the PTs. In a federal system where there are clear income differentials across provinces and between the public and private sectors, facilitating ease of movement could prove disadvantageous to provinces or individuals unable to offer more competitive remuneration. National licensure would improve provider mobility (both in-person and virtual) and would require its own set of guidelines and professional regulations governing participation (or not) in public insurance and provision of services outside PT of residence or for non-resident patients.

At the same time, provinces still have the capacity to exert some influence over provider mobility, independent of licensing, through micro-policy measures (such as restricted access to provincial IT networks or lab and other diagnostic services). However, while this could lessen the attractiveness to providers of working outside of their home provinces, it would also compromise the need to secure better continuity of care, as noted above. Policy choice, as ever, often requires a tradeoff between competing objectives.

As such, provinces would be well-advised to better articulate precisely what it is they wish to achieve with the potential that virtual care promises. Better access for unattached patients? More convenient access for discrete cohorts? A more longitudinally integrated system of care? Better equity? Or perhaps economic productivity gains independent of health outcomes? The advantages of virtual care can be considerable, but they are not without potential tradeoffs. Strategic plans should reach beyond technical and operational issues (regardless of how critical they may be) to ask what the effects of any specific virtual care pathway will have on the larger healthcare system, and all those who use it.

Virtual Care Meets Borders, Regulations and Prices

The governance structure of healthcare in Canada is largely grounded on a mid-twentieth-century model of healthcare delivery: in-person interface in real time. Virtual care adds additional dimensions of space (geographical distance becomes less relevant), time (asynchronous communication makes timing less important) and pay rates. Into this new expanse, healthcare can be offered in ways that are both advantageous (greater convenience for both patients and providers) and disadvantageous (skewing access opportunities or reduced provincial visibility of overall healthcare system). User satisfaction with online systems following pandemic implementation has been consistently strong (CMA 2022; CIHI 2023; Doraiswamy et al. 2020); virtual care has become an integral aspect of healthcare systems around the world. But the precise way in which it

15 This is a requirement in most provinces (excepting BC, ON, and PEI) although, as noted below, it is one that is often poorly enforced.. Similarly, most provinces have a requirement that patients must be adequately evaluated before being referred to specialists, ER, urgent care and in some cases for diagnostic testing/imaging (Table 3, A1, A2).

manifests will differ considerably, contingent upon the existing structures, institutions, and power dynamics of each jurisdiction. In Canada, the key question is how federal and PT legislation and regulatory requirements affect the provision of virtual care across provincial boundaries, and the consequences of these new pathways of delivery.

Discussion of provincial requirements and fees for physicians providing virtual care

Much virtual care is still an extension of existing provider relationships. Each province's regulatory college specifies the conditions under which existing provider relationships can be moved to online or telephone modes (appropriateness, informed consent, patient privacy, liability insurance, technical specifications for communication platforms, record keeping, expected standards of care; see previous section for details). Most provinces now set fee codes for virtual healthcare on par with comparable in-person services, although, as noted in Table 3, Saskatchewan sets fee codes for virtual services lower, while Newfoundland sets them higher, than in-person services. Different fees for different modes of delivery can create incentives for providers to prefer one mode over the other.

There are lower costs of contact associated with a virtual visit (reduced office overhead and use of supplies for providers and no travel costs for patients), which could in turn support slightly lower fees. On the other hand, higher fees for virtual appointments provide a direct incentive for physicians to prefer virtual provision and actively encourage the adoption and scale of virtual care. Enacting billing codes for virtual care during the pandemic and the immediate increase in provision illustrate how the (pre-pandemic) lack of compensation for virtual care within the public healthcare system was actively discouraging adoption and scale of technology that is now actively being used to address gaps in access to primary care in some PTs. Nonetheless, higher fees also increase public costs (assuming similar types and volumes of services).

Aside from fee-for-service payments for services and the differential rates for in-person compared to virtual care, other forms of provider compensation will affect the mix. For example, physicians and other providers might be paid hourly or a salary for time spent treating patients through a virtual care platform (as part of a public institutional program, or as a compensation agreement related to privately paid virtual care provision). In jurisdictions with capitation models (where providers are paid a standardized rate for patients in their "roster", and no or limited additional fees for services delivered), the choice of in-person or virtual care provision is less influenced by payments.

Complexity across provincial boundaries

The picture becomes slightly more complicated when considering providers offering virtual care services to patients outside of their province of residence. Again, the conditions under which these services can be provided are set out in the regulatory standards of each province rather than in provincial legislation. The respective Colleges of Physicians and Surgeons in each province have set out these terms and conditions. Nurse practitioners, pharmacists, and other regulated professions offering cross-border care may have practice guidelines set out by their own professions, or they may be subject to the terms set out in physician guidelines.

The most important condition is licensure. Most PTs require that a physician be licensed in the province in which they are providing virtual care. However, there are some exceptions (Table 3). Saskatchewan has a "virtual care licence" that is required for physicians in Saskatchewan to provide virtual care to patients outside the province, and for physicians located outside Saskatchewan but providing virtual care to Saskatchewan residents (licensing fees are related to patient volume).

This gives Saskatchewan a unique ability to track both the number of physicians providing care outside the province and the number of non-resident physicians providing care to Saskatchewan residents. Quebec also has a "special authorization" category for physicians who are fully licensed and in good standing in another jurisdiction, but these are generally given on an occasional or temporary basis to specified patients or groups only. The Atlantic provinces (Nova Scotia, New Brunswick, Newfoundland and Labrador, and Prince Edward Island) have a regional registry recognizing each other's licensure, and so they may practice virtually across these provinces if they are licensed in one of them. Similarly, Manitoba has an agreement with Nunavut, which allows physicians registered in Manitoba to provide virtual care in Nunavut. Manitoba has a similar agreement with Ontario related to the northwestern and remote region of the province. British Columbia allows out-of-province physicians to provide virtual care to BC patients but assumes no responsibility for regulation (complaints will be referred to the provider's governing body).

For other regulated health professions, the rules regarding licensure are more varied. As of 2025, for example, anyone providing virtual nursing care in Manitoba must have a certificate of practice from the College of Registered Nurses of Manitoba, while those providing virtual nursing care in Newfoundland only need to be licensed within the jurisdiction in which they are physically located (although nurse practitioners ordering diagnostic or lab tests for Newfoundland patients virtually must be licensed in Newfoundland).

While licensure is the most important requirement for cross-border virtual care, other provisions or requirements may also be embedded in professional regulatory guidelines or provincial policies. A requirement to offer patients an in-person option may mean that physicians offering virtual care must have an agreement with a physical clinic in close proximity to the patient, beyond walk-in clinics or emergency departments. Manitoba is the most restrictive – out-of-province physicians cannot provide virtual care to Manitoba patients, and physicians in Manitoba must be able to provide in-person visits to any patients they see virtually. British Columbia is the only province that explicitly prohibits charging for "insured services" in its virtual care practice standards, but it does allow out-of-province physicians to provide virtual care to BC residents and assumes no regulatory responsibility for out-of-province physicians (out-of-province physicians are also not eligible to access PharmaNet, so they are unable to view patients' prescription records). As noted above, private providers outside of Nova Scotia offering virtual care in that province cannot make requisitions for diagnostic services in the public system in that province; in most other provinces, labs and other diagnostic facilities will generally accept requisitions from any provider registered in that province, regardless of where the requisition was issued. Some provinces do not allow the prescribing or authorization of certain substances (such as cannabis or psychotropic medication) in the absence of an in-person examination or longitudinal patient relationship.

The provision of private virtual care

The terms and conditions that set out the provision of private virtual care become even more complicated due to provincial statutes governing insured services, especially when virtual services are provided from outside of the province. Neither provincial statutes nor the CHA explicitly state that "all medically necessary healthcare services must be publicly insured"; rather, these documents specify that all *insured* services must be covered publicly, and so much rests in the way in which "insured services" are defined in these documents (Fierlbeck 2024; Fierlbeck 2025). Similarly, no jurisdiction has a document which specifies that "medically necessary virtual healthcare services must be

publicly insured," and, once again, the definition of "insured services" becomes crucial in understanding the provision of virtual care.

In addition, it is important to specify what, precisely, constitutes "private" virtual care. Both individual physicians and commercial virtual-care companies are technically "private" entities, and healthcare providers in both categories (depending on the legislation of any specific province) can provide virtual care to a patient in exchange for direct payment. Generally, individual physicians work within a provincial health insurance plan and therefore are reimbursed by provincial insurers when they provide insured services virtually. They may also provide uninsured services virtually (including services that are normally publicly insured). Non-participating physicians can provide medically necessary services in-person or virtually (except in Ontario), as the services they provide are not considered to be insured. As noted above, the growth of commercial virtual-care companies has been remarkable over the past 10 years, and it is worth breaking down in more detail the ways in which they provide care. Generally, there are three categories of provision, and large providers may be involved in all three areas. It is also crucial to remember that provincial legislation and professional guidelines will influence the exact instantiation of each category from province to province.

Private platforms for public healthcare delivery

The first category of work for commercial virtual-care companies is in a contractual relationship with a provincial insurer. This is an example of a private company platform facilitating the delivery of public services. Patients using the platforms do so through their health card. From a user perspective, this is the digital equivalent of going to see a care provider in person, and the service is covered by public insurance (meaning that users are unlikely to consider it "private" healthcare, since it is publicly paid). As Table 2 notes, all four Atlantic provinces have contracted with corporate entities to provide virtual care. These services were established largely to secure access to primary care for individuals who were unable to find a regular primary care provider. However, there is generally also some provision for people with primary care providers who are nonetheless unable to access timely care (in Nova Scotia, for example, those registered with healthcare providers can still access two free virtual-care consultations annually through the province's public virtual care service, which utilizes the Maple platform).

In all four Atlantic provinces, those on a registry for individuals without a primary care provider can register for the publicly insured pathway (VirtualCareNS in Nova Scotia, eVisitNB in New Brunswick, the Unaffiliated Virtual Care Program in PEI, and PatientConnectNL in Newfoundland). Once their status is verified, prospective patients can access primary care providers via the contracted company's platform (Teladoc in Newfoundland; Maple in the Maritime provinces). VirtualCareNS has established a primary care clinic specifically for those requiring further in-person treatment; the clinic is staffed by both physicians and nurse practitioners, and patients must have referrals from the virtual provider before they can access in-person services. They can receive follow-up in-person care for the specific condition for which they accessed the virtual system, but must return to the virtual platform for any unrelated conditions. There is thus some, albeit limited, continuity of care via the virtual system. Having a shared platform and health record across virtual and in-person care allows for continuous patient records, helps facilitate communication between providers and provides transparency for patients.

Initial evaluation has found that this model of delivery has been generally positive (Tomblin Murphy et al. 2025; New Brunswick Health Council 2022-2023), although there were negative experiences with wait times and limited access when the program was first set up (Willick 2023).

More thorough evaluation remains to be done (Lavergne et al. 2025). Nova Scotia has also integrated this platform into some of its urgent care pathways. This virtual urgent care service is available to all those with a health card and is designed for individuals with minor urgent care needs. It can be accessed either within an emergency department (where a patient is placed in a private room and is seen virtually by a physician or nurse practitioner, supported by an in-person triage nurse) or from a patient's phone via the urgent care hotline. A patient using the virtual urgent care pathway may receive a prescription or treatment instructions, or they may remain in (or be directed to) the hospital system for further treatment.[16]

Where the supply of these online services is sufficient to give unattached patients appointments in a timely manner, the satisfaction level seems strong, even where patients remain unattached to a regular primary care provider. Where the supply of online services covered by provincial insurers is not adequate, unattached patients unable to access the insured services may choose faster access to the for-profit platform of the same company for the same care (NUPGE 2021; Armstrong 2022). At this point in time, the contracting of commercial virtual-care companies to supply insured services is seen by all jurisdictions using this modality as a temporary measure lasting only as long as there is a critical mass of patients who are unable to find a primary care provider. However, given their popularity and the combined pressures of an ageing population, ageing physician workforce and population growth, commercial virtual-care companies could be a more permanent solution to primary care access challenges.

Direct-to-consumer virtual care

Another discrete pathway is that of private virtual walk-in services. As with in-person services, patients can receive an appointment with a primary care provider on an ad hoc basis. These services are often provided by large commercial providers (such as Maple, TELUS Health, MD Connected, Eden Telemed, Rocket Doctor, WELL Health VirtualClinics+, Tia Health, and Gotodoctor.ca). However, there are also smaller commercial virtual health providers that are limited to a single province (such as Medicuro in Newfoundland or Lumeca in Saskatchewan). The extent to which these services are covered publicly depends on the province and, again, it depends most critically on the articulation of what constitutes "insured services." In this case, what is relevant is not the service provided, but the mode of provision. A general practitioner consultation may be identical both in-person and online, but if it is a virtual "episodic on-demand visit" rather than part of an existing patient-physician relationship, then it is often categorized as uninsured rather than insured. As an uninsured service, a single episodic appointment can then be offered as a direct for-profit service. Similarly, if the same service is offered by a provider who is not enrolled in a provincial insurance program, then (depending on the PT) the service is not insured and can also be offered directly to the patient for-profit. This is particularly relevant in Quebec, with almost 900 physicians working outside of the provincial insurance plan.

As with in-person walk-in clinics, one problematic aspect virtual episodic care is the lack of continuity. Many provinces require those offering virtual care services to have an

16 There are other examples of temporary or pilot initiatives related to virtual triage, preventing unnecessary hospital transfers, and facilitating consultation with specialists without hospital admission. For example, during the pandemic Trillium Health Partners (using Maple) had a two-year program with long-term care facilities in Ontario to enable immediate virtual care consultations. 70 percent of virtual consultations prevented a hospital visit or ED transfer. The program was discontinued after 2022 due to lack of ongoing program funding (Wyonch 2025).

arrangement, through agreement or policy, with another regulated healthcare provider or health authority, which allows the patient the ability to access in-person care from a regulated healthcare provider. However, this "policy" in practice is often no more than simply directing the patient to an in-person walk-in clinic, an emergency department, or their own healthcare provider, so this "continuity of care" stipulation seems rather weak. There are some virtual care clinics (such as WELL Health) which have a network of in-person clinics that are more integrated with their virtual care clinics. Nonetheless, these in-person visits are not guaranteed; they are simply offered "when available". There is significant variation across provinces. Manitoba is the most restricted – physicians providing virtual care must be able to personally see any patients that require in-person examination. Meanwhile, Ontario only requires physicians to "assist or advise" patients where and how to seek in-person care.

Direct-to-consumer virtual primary care creates an access pathway for people who do not have public insurance coverage (such as recent immigrants or temporary workers who face a waiting period before they are covered publicly). It also fills a gap for patients who do not have a primary care provider in PTs that do not cover virtual care for unattached patients. Both are important and meaningful gaps in public primary care coverage.

Private insurance and virtual primary care

The third category in which commercial virtual-care companies play a major role is employer benefit plans. Where employees enjoy private health insurance (such as Sun Life), the insurer will support a platform hosting a suite of virtual healthcare services (e.g., Sun Life uses Lumino) provided by a commercial virtual care company (such as Dialogue). Similarly, Manulife uses the Healthcare Online platform with TELUS Health providing the services, while GreenShield uses Telemedicine Solution with services supplied by Teladoc Health. Employees access services through dedicated portals. Services are focused on primary care (advice on minor conditions, prescription renewal, and referrals). The services themselves are generally outside the scope of public coverage (often because of the nature of the services themselves, but also due to the type of provider that delivers them). However, the results of an insurer-provided virtual care visit can lead to publicly covered services (associated tests, referrals to specialists in the public system, etc.). These services are on-demand (usually on the same day) and are available on a 24/7 basis. Platforms also normally offer a suite of uninsured "wellness" services (such as nutrition, smoking cessation, sleep quality, and mental health consultations) which are often covered by the employer, although the provider service may offer additional wellness services for which they can pay directly. Except for these discretionary services, employees pay nothing directly to providers; rather, employers pay a per-member/per-month fee or flat subscription to the platform they utilize (the insurance premium associated with the inclusion of virtual care services in employee coverage).

The growth of employer benefit plan virtual care services has been quite dramatic. Prior to the COVID-19 pandemic, less than 9 percent of Canadians had access to these programs (TELUS Health 2020); by 2024, the Chamber of Commerce stated that a quarter of all Canadians had access to virtual care through employer benefit plans (CCoC 2024). This has led to increased concerns that the expansion of virtual care could lead to serious issues with both continuity of care and equity in access (College of Family Physicians of Canada). At the same time, benefit plan sponsors are concerned that the current model of virtual care provision through these plans may be contrary to provisions set out in the CHA (Smith 2025).

Policy Implications

The current landscape of virtual care in Canada is characterized by significant PT variation and considerable regulatory complexity. PTs have taken different approaches to contracting with commercial providers, defining insured services, setting billing codes, and regulating cross-border provision. While some variation is inevitable and even appropriate in a federal system, the ease with which virtual care crosses jurisdictional boundaries means that PT policy choices have spillover effects that complicate governance for all jurisdictions. The sheer volume of laws, regulations, professional standards and licensing requirements – and the inconsistencies arising from their interaction – means that coordination between PTs and ongoing adaptation of policy will be required as virtual care evolves.

Many of the concerns related to continuity of care, rapid access to treatment, and integrated patient records affect both public and private channels. Virtual care both complicates and facilitates these goals: virtual delivery goes hand-in-hand with digital patient records and enables multi-provider coordination and asynchronous communication. However, the potential for both public and private providers to treat a patient, along with the potential for data fragmentation if records are not shared across channels, complicates integration and continuity and raises privacy concerns about other potential uses of patient medical information. Policy should encourage complete integration of information across providers while limiting the use of individual or identifiable patient data to appropriate and relevant uses. Further, guidelines for the provision of virtual care should require the ability to refer to in-person primary care, with clear pathways for continuity of care (particularly for provinces that do not currently have a robust continuity of care requirement as part of virtual care practice standards).

Fundamentally, private for-profit virtual care has significant legal space to operate, and there is clear market demand for access to primary care services. The space is outside provincial public insurance systems and therefore is outside the scope of the CHA. PTs have full discretion to amend policies to prohibit private physician practice (or ensure equivalent fees and reduce the economic incentive to practice privately), to include other professionals in the scope of publicly funded healthcare, to include all virtual modes of delivery, and to otherwise expand or contract the scope of insured services. Conversely, they have significant scope to allow private virtual care services, as the CHA is not explicit about the mode of delivery, the inclusion of other professions delivering "physician-equivalent" services (outside of hospitals), or the definition of "medically necessary." Beyond individual PTs, there is also space for virtual care platforms and providers to operate between provincial boundaries. In the current complex legal and regulatory landscape, there is significant scope for the growth of private virtual care, and the landscape is not likely to simplify anytime soon.

Provinces should approach virtual care as a useful tool to fill gaps in care and improve access. Regardless of who pays, virtual care has significant potential to reduce inappropriate hospital visits and fill gaps in access to primary care. About 17 percent of Canadian adults do not have a regular healthcare provider and more than three-quarters cannot access same- or next-day appointments and find it difficult to access care outside regular business hours. One in seven emergency department visits could be managed in primary care settings, and over half of those could potentially be managed virtually (CIHI 2024). There are potential trade-offs that should be monitored and managed where necessary. These trade-offs include:

- **Access and equity:** equitable but relatively slow (and incomplete) access compared to more rapid but potentially less equitable access, facilitated by a mix of public and private virtual care provision. The key question is whether the overall effect improves or worsens access for vulnerable populations.

- **Labour market dynamics:** while private care might compete for human resources with the public system, it could *expand* the labour force of providers by providing a part-time or more flexible option, particularly for physicians near retirement or with young children and caregiver responsibilities. It could also *diminish* the labour force by allowing physicians who are currently obliged to work 50 or more hours a week the opportunity to work far fewer hours for similar pay. At the same time, if this makes general practice less stressful, it could attract more people to become family practitioners. The point is that labour market dynamics are neither simple nor predictable, and numerous variables will influence the movement of the labour market in this field. Virtual care also increases provider mobility, potentially improving access in rural and remote areas. Similarly, where virtual care reduces unnecessary hospitalizations and emergency department visits, affording downstream labour-saving effects.
- **Cost management:** the public healthcare system is resource-constrained, and employers and individuals are taking on the cost of some primary care through private virtual care options. While this might increase the volume of downstream care in the public system, more rapid access to treatment could also reduce total costs and improve patient outcomes by preventing conditions from worsening, for those able with access to private care. Similarly, it can prevent many unnecessary hospital and emergency department visits for this same cohort.
- **Connected care and interoperability:** virtual delivery goes hand-in-hand with digital patient records and enables multi-provider coordination and asynchronous communication. PTs should take steps to ensure that the added complexity of mixed in-person and digital health services does not fragment health records and instead enables more complete and accessible medical records for patients and providers.[17]

The evidence from existing research shows that equity dimensions (race, immigration, gender, age, employment status) have a negligible impact on access to virtual-only or mixed virtual and in-person appointments (including public and private access channels, Frank and Bader 2025). There are, however, significant differences in access to virtual care by province: those in Newfoundland and Labrador, Nova Scotia, New Brunswick, and British Columbia were more likely to have virtual appointments, while those in Quebec and Alberta were less likely to have had virtual appointments than those in Ontario. There is minimal research and information available about the impact of virtual care on the overall labour market, or the effect on the accessibility of patient medical records. Where pilot projects have been evaluated – and in NS where virtual care is integrated into primary care and expanding to acute and urgent care – the potential for virtual care to improve access to primary care and reduce unnecessary hospital visits is clear.

Different provinces will weigh these trade-offs differently, reflecting their distinct political contexts, fiscal situations, and health system priorities. Some may choose to expand public virtual care services substantially, while others may rely more heavily on private provision within a well-regulated framework. The key is that these choices should be made deliberately and strategically, with clear attention to how different models affect access, equity, continuity of care, and system sustainability.

Conclusion

This *Commentary* has aimed to clarify the complex landscape of virtual care provision and governance in Canada. The analysis presented here captures only a moment in an ongoing evolution. What is clear is that virtual care has net

17 See the Competition Bureau's recommendations in "Unlocking the power of health data" (Digital Health Care Market Study).

benefits for Canadians – it is a valuable addition to the healthcare system that can improve access, convenience and efficiency when appropriately integrated and governed. The challenge for policymakers is not to resist the growth of virtual care or to choose definitively between public and private models, but rather to ensure that virtual care, in whatever mix of public and private provision emerges, serves the goal of affordable and equitable access to quality healthcare for all Canadians.

Canada's healthcare system has always evolved in response to technological, demographic and social change. The challenge posed by virtual care is significant, but it is not unprecedented. What is required is ongoing policy innovation, interprovincial cooperation, systematic evaluation, and a willingness to adapt regulatory frameworks as evidence and experience accumulate. Virtual care is neither a panacea that will solve all access problems nor a threat that will inevitably undermine the medicare system. It is a tool – and like any tool, its ultimate value depends on how skillfully and thoughtfully it is used. The policy choices made in the coming years will shape whether virtual care becomes an integral component of a modernized, accessible healthcare system or a source of fragmentation and inequity. The evidence to date suggests that, with appropriate governance and ongoing attention to equity and quality, virtual care can continue to make a positive contribution to healthcare in Canada.

APPENDIX:

Table A1: The Legislative and Regulatory Framework Setting Out Virtual Care Provisions, by Province

	Legislative authority	Professional regulation
AB	*Alberta Health Care Insurance Act*	College of Physicians and Surgeons of Alberta. *Standards of Practice: Virtual Care* College of Registered Nurses of Alberta *Virtual Care Standards* (draft only) Alberta College of Pharmacy. *Standards of Practice for Virtual Care* (January 2025).
BC	*BC Medicare Protection Act*	College of Physicians and Surgeons of British Columbia. *Practice Standard: Virtual Care* (2023) College of Health and Care Professionals of BC. *Virtual Care Guide* (March 2025) The British Columbia College of Nurses and Midwives (BCCNM) does not have a stand-alone practice standard devoted solely to virtual care. When nurses provide care virtually (by phone, video, messaging, or other technology), they are expected to meet the same professional standards as for in-person care.
MB	*Manitoba Health Services Insurance Act*	College of Physicians and Surgeons of Manitoba. *Standard of Practice: Virtual Care* and *Information on Virtual Medicine across Provincial and International Borders* College of Registered Nurses of *Manitoba Virtual Nursing Care Guidelines*
NB	*Health Services Act Medical Services Payment Act**	• College of Physicians and Surgeons of New Brunswick, *Professional Standards/Virtual Care* New Brunswick College of Pharmacists, *Virtual Pharmacy Practice* 2021 • Nurses Association of New Brunswick, *Guidelines for Telenursing Practice 2024*
NF	*Medical Care and Hospital Insurance Act*	• College of Physicians and Surgeons of Newfoundland and Labrador. *Standard of Practice: Virtual Care* • College of Registered Nurses of Newfoundland and Labrador, *Virtual Nursing Practice*, 2020 and *Virtual Nursing Licensure Requirements*
NS	*Health Services and Insurance Act* (as amended in 2021 under Bill 102), effective June 1, 2024.	• NS College of Physicians and Surgeons, *Professional Standards Regarding Virtual Care* (last revision 24 May 2024) • *NS College of Nursing, Practice Guidelines for Nurses/Telenursing 2023* • Pharmacists practicing in Nova Scotia must adhere to the broader guidelines for virtual care set by the College of Physicians and Surgeons of Nova Scotia
ON	*Ontario Health Insurance Act** *Ontario Commitment to the Future of Medicare Act 2004**	• College of Physicians and Surgeons of Ontario. *Policies: Virtual Care* (2022) • College of Physicians and Surgeons of Ontario. Advice to the Profession: *Virtual Care* (2022) • College of Nurses of Ontario *Virtual Care Practice Guideline*. 2025. • Ontario College of Pharmacists. *Virtual Care Policy*. 2021.

Table A1: Continued

	Legislative authority	Professional regulation
PEI	*Health Services Payment Act** **Bill 51* ("The Medical and Hospital Services Insurance Act") *was introduced in the Legislative Assembly in February 2024. As of July 2025, it has not been proclaimed in force.*	The College of Physicians and Surgeons of Prince Edward Island *Standard of Practice: Virtual Care* College of Registered Nurses and Midwives of Prince Edward Island, *Delivery of Care Through Technology* PEI College of Pharmacy, Practice Directive: Practice Directive, Prescribing of Drugs by Pharmacists
QC	*Health Insurance Act*	*Collège des médecins du Québec. Telemedicine*. Collège des médecins du Québec. *Special authorization to practice in Quebec*. The Ordre des infirmières et infirmiers du Québec (OIIQ) does not have a single, stand-alone "virtual care practice standard" document equivalent to those found in some other Canadian jurisdictions. Instead, OIIQ regulates virtual care by requiring that all existing professional standards, ethical codes, and regulatory guidelines for nursing practice apply equally in virtual settings. This approach aligns with broader Quebec health system rules that treat telehealth as an extension of in-person care.
SK	*Saskatchewan Medical Care Insurance Act**	College of Physicians and Surgeons of Saskatchewan. *Policy: Virtual Care* and *Policy: The Practice of Telemedicine* College of Registered Nurses of Saskatchewan, *Telehealth Nursing Practice, 2019* College of Licensed Practical Nurses of Saskatchewan, *Virtual Practice*

Table A2: Guidance Documents, Evaluation Frameworks, Strategic Plans, and Formal Policies Governing Virtual Care, by Province

	Guidance documents, policies, position papers, and evaluation frameworks	Strategic plans
AB	• AHS Healthcare Professional Considerations in Virtual Care • AHS Virtual Care Evaluation Framework	• Optimizing Virtual Care in Alberta: Recommendations from the Alberta Virtual Care Working Group • Alberta Health Virtual Care Action Plan
BC	• Doctors of BC Policy Statement on Virtual Care • BC Family Doctors, The Future of Virtual Care	• BC Digital Health Strategy • British Columbia Virtual Care Action Plan
MB	• Information on Virtual Medicine across Provincial and International Borders	• Manitoba Virtual Care Action Plan
NB	New Brunswick Medical Society, Healthcare in New Brunswick: Physicians' Vision for Success	• New Brunswick Virtual Care Action Plan • *Stabilizing Health Care: An Urgent Call to Action* (November 2021)
NF	Newfoundland and Labrador Medical Association, Virtual Care Strategy 2019	• NL Health Services, Strategic Plan 2024-26 • Canada-Newfoundland and Labrador Virtual Care Bilateral Agreement: Action plan 1
NS	*Provision of Publicly Funded Virtual Health Services Policy* Effective January 1, 2021 (Version 3: November 1, 2023) Authorized prescriber policy	• Action for Health • Integrated Digital Health Strategy • NS Virtual Care Action Plan
ON	Ontario Health. Adopting and Integrating Virtual Visits into Care: Draft Clinical Guidance For Health Care Providers in Ontario. 2021.	• Ontarios' Virtual Care Streamlined Action Plan
PEI	Health-Care Providers' Guide to Virtual Care, 24 January 2023	• Health PEI, 2025: Setting the Stage • Health PEI, Digital Health Strategy 2024-2029 • Advancing virtual care in PEI: A plan to improve access and safeguard public health
QC	Framework for Evaluating the Performance of Virtual Care in Quebec (2023)	• 2023–2027 Ministry of Health and Social Services Strategic Plan • Canada-Quebec Agreement on Virtual Care in Response to COVID-19 • Réseau québécois de la télésanté, Telehealth governance and Orientations Telesante
SK	Saskatchewan Health Authority, Clinical Documentation and Communication	

Table A3: Are Billing Codes for Virtual Services at Parity with, Lower, or Higher than Similar In-person Services?

AB	parity	
BC	parity	
MB	parity	
NB	parity	
NL	higher	The standard in-person visit (office) is $37; while a virtual visit (telephone or video) is $47 (daily cap of 40 virtual visits per physician)
NS	parity	
ON	parity/ lower	Publicly-insured virtual physician services are generally paid at the same rate as equivalent in-person services, but only when a physician has an ongoing or recent in-person relationship with the patient. When there is no such relationship, a much lower fee applies for virtual visits.
PEI	parity	For most services, physicians use the same billing codes as they would for in-person care, and they add a modifier or indicate the service was provided virtually.
QC	parity	The exact same fee codes and nomenclature are used for virtual (phone or video) visits and for in-person consultations. The only notable restriction is that, generally, both the physician and the patient need to be located in Quebec for the service to be publicly insured.
SK	lower	Most virtual visits are reimbursed at 90 percent of the rate for the equivalent in-person service under the provincial health insurance plan. For episodic care at "virtual-only" clinics, the fee is set at 70 percent of the in-person rate (typically applied to encounters without an ongoing care relationship).

Source: Authors' compilation from publicly accessible information.

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