



January 27, 2026

From: Katherine Fierlbeck and Rosalie Wyonch
To: Healthcare Observers
Re: VIRTUAL CARE IS HERE TO STAY. PROVINCES MUST CLOSE THE GOVERNANCE GAPS NOW

Canada didn't just experiment with virtual care during the pandemic, it normalized it.

Patients and clinicians discovered what was always true: for a wide range of needs, seeing a provider by phone, video, or secure messaging is faster, more convenient, and often just as effective. Use has settled well above pre pandemic levels, with some provinces embracing virtual options and others retreating.

The resulting patchwork of rules, billing codes, and eligibility criteria make cross border delivery complex and continuity of care uncertain. If we don't modernize governance now, virtual care will harden inequities and fragment records instead of closing access gaps.

And because each province and territory has its own definition of "insured service" there is legal and economic space for a fast growing private, for profit virtual care market. Some fills real needs, such as unattached patients and after hours care.

But as employer sponsored and direct to consumer platforms expand across provincial lines, Canadians can face uneven access based on benefits, geography, or ability to pay, while their data are scattered across systems that don't talk to each other. Provinces risk losing visibility and leverage over how care is delivered to their own residents.

Provinces should lock in the benefits of virtual care by clarifying what's insured (regardless of mode or provider type), hard wiring continuity and data integration, and setting practical cross border rules that protect patients without stifling capacity.

Do this, and virtual care will reduce pressure on emergency departments, extend primary care into underserved communities, and support more team based, hybrid models. Fail, and we entrench a two track system that rewards simplicity and leaves complex patients behind.

We could start with these five things:

1. **Define insured services by task, not the mode of delivery.** If an assessment or prescription is publicly covered in person, it should be covered when delivered by phone or video (where medically appropriate). Similarly, a physician might be paid a different rate for the same service depending on virtual or in-person care, whether they have an ongoing established relationship with the patient, and whether they have seen the patient virtually before. When nurse practitioners (NPs), pharmacists or other regulated professional delivers services that substitute for physician care, whether or not those services are publicly insured varies by province. Provinces that already pay equally for comparable virtual visits should continue while using clinical appropriateness guidance and not billing codes to steer mode of care.
2. **Bake continuity into every virtual pathway.** Episodic, on demand care has value, but should never be a dead end. Any publicly funded virtual service (and any private service operating in the province) should be required to demonstrate continuity by design: Shared records, warm handoffs to in person providers when needed, and explicit responsibility for follow up and test coordination.
3. **Mandate interoperability and patient controlled data access.** Virtual care should improve integration, not fracture it. The rule of thumb: patients should be able to access their records and share relevant health data with providers, regardless of whether the health service is public or private. If the care involves a medically necessary service, the data should be in the provincial record accessible to patients, providers and in anonymized forms for research to guide evidence based policy making.
4. **Provincial reciprocity.** Canadians increasingly receive care across provincial lines. Provinces should adopt reciprocal or regional licensure models, virtual care licences with transparent complaint handling, and clear standards on prescribing, diagnostics, and referrals for non resident providers.. Publish annual data on cross border volumes, outcomes, and complaints to inform course corrections.
5. **Align incentives and guard against cream skimming – without strangling supply.** Don't let payment rules reward simple visits while making complex care a loss leader. Use blended models (capitation + fee for service + quality incentives) that support team based management, including virtual touchpoints, for high need patients. Where provinces contract private platforms, require service mix targets (e.g., chronic disease follow up, preventive care outreach), attach equity metrics, and forbid queue jumping for publicly insured services. At the same time, leverage virtual care to grow capacity with initiatives like flexible schedules that retain late career clinicians, after hours coverage across time zones, and NP led models.

Some have argued that virtual care adds costs and contributes to inequity, which could happen if it's just layered on the status quo. It can also improve access to primary and specialist care, prevent avoidable emergency department visits, and enable expansions to the care delivered at home and in the community.

Virtual care is neither a panacea nor a menace. It's a tool – and its ultimate value depends on the rules we set now. Provinces can let a fragmented market decide who gets timely, convenient care and where the data live. Or they can choose a modernized, mode neutral insurance design that integrates virtual care into the public health care system and leverages complementary private insurance services to extend comprehensive care to people, where they actually are.

Get those foundations right, and virtual care will do what Canadians expect it to do: make care faster, fairer, and more connected – without compromising the principles that define our system.

Katherine Fierlbeck is McCulloch Professor of Political Economy at Dalhousie University. Rosalie Wyonch is Associate Director of Research at the C.D. Howe Institute.

To send a comment or leave feedback, click [here](#).

The views expressed here are those of the authors. The C.D. Howe Institute does not take corporate positions on policy matters.