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## Examining Policy Conditions Influencing the Adoption of Virtual Primary Care: A Comparative Analysis of Ontario and British Columbia

Stefaniia MARTSYNKEVYCH, *University of Toronto, Toronto, Ontario, Canada*

Lindsay HEDDEN, *Faculty of Health Sciences, Simon Fraser University, Vancouver,  
British Columbia, Canada*

Rachelle ASHCROFT, *Factor-Inwentash Faculty of Social Work, University of Toronto,  
Toronto, Ontario, Canada*

Sara ALLIN, *Institute of Health Policy, Management and Evaluation, University of  
Toronto, Toronto, Ontario, Canada*

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### A Comparative Health Reform Analysis

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## Abstract

Virtual health care has existed for decades, but the COVID-19 pandemic significantly accelerated its adoption. In response to the pandemic, all Canadian provinces swiftly implemented virtual care and adjusted remuneration fee codes to ensure health care access. However, as the pandemic subsided, provinces faced the decision to either retain or reverse these changes. In Ontario, the provincial government introduced barriers that limited access to virtual primary care, while in British Columbia, the government maintained and expanded its virtual care services. This paper presents a comparative analysis of Ontario and British Columbia, applying John Kingdon's Multiple Streams Framework to uncover the political and policy contexts shaping their post-pandemic approaches. The findings highlight key factors influencing policy divergence, including how virtual care is framed — either as a tool for accessibility or a disruption to patient-provider relationships. Additionally, the study underscores the role of unified advocacy and strong political commitment in sustaining virtual care beyond emergency measures. By comparing these two provinces, this analysis suggests the need for long-term policy strategies that prioritize accessibility and integration rather than short-term cost-cutting measures. Establishing virtual care as a permanent component of the primary health care system requires sustained political will and a policy framework that views virtual care as a means of improving health care access.

*Les soins de santé virtuels existent depuis des décennies, mais la pandémie de COVID-19 a considérablement accéléré leur adoption. En réponse à la pandémie, toutes les provinces canadiennes ont rapidement mis en place des soins virtuels et ajusté les codes de rémunération afin de garantir l'accès aux soins de santé. Cependant, à mesure que la pandémie s'est atténuée, les provinces ont dû décider de maintenir ou d'annuler ces changements. En Ontario, le gouvernement provincial a mis en place des restrictions à l'accès aux soins primaires virtuels, tandis qu'en Colombie-Britannique, le gouvernement a maintenu et élargi ses services de soins virtuels. Cet article présente une analyse comparative de l'Ontario et de la Colombie-Britannique, en appliquant le cadre des courants multiples de John Kingdon afin de mettre en lumière les contextes politiques et stratégiques qui ont façonné leurs approches post-pandémiques. Les résultats mettent en évidence les principaux facteurs qui influencent la divergence des politiques, notamment la manière dont les soins virtuels sont présentés : soit comme un outil favorisant l'accessibilité, soit comme une perturbation des relations entre les patients et les prestataires. En outre, l'étude souligne le rôle d'un plaidoyer unifié et d'un engagement politique fort dans le maintien des soins virtuels au-delà des mesures d'urgence. En comparant ces deux provinces, cette analyse suggère la nécessité de stratégies politiques à long terme qui privilégient l'accessibilité et l'intégration plutôt que des mesures*

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*de réduction des coûts à court terme. Pour faire des soins virtuels une composante permanente du système de soins de santé primaires, il faut une volonté politique soutenue et un cadre politique qui considère les soins virtuels comme un moyen d'améliorer l'accès aux soins de santé.*

### Key Messages

- Since the onset of the COVID-19 pandemic, virtual primary care has gained strong patient support and shown many benefits, yet not all Canadian provinces have fully adopted it into their health care systems.
- This comparative analysis identifies political conditions that help explain why British Columbia has chosen to maintain the virtual care changes introduced during the pandemic, while Ontario has opted to roll back the introduced changes.
- The study reveals that the adoption of virtual care seems to depend on how it is framed and highlights that unified advocacy, along with strong political commitment, is essential to sustaining virtual care beyond the pandemic emergency.

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### Messages-clés

- *Depuis le début de la pandémie de COVID-19, les soins primaires virtuels ont conquis de nombreux patients et ont fait preuve de nombreux avantages, mais toutes les provinces canadiennes ne les ont pas encore pleinement intégrés à leurs systèmes de santé.*
- *Cette analyse comparative identifie les conditions politiques qui expliquent pourquoi la Colombie-Britannique a choisi de maintenir les changements apportés aux soins virtuels pendant la pandémie, tandis que l'Ontario a choisi de revenir sur les changements introduits.*
- *L'étude révèle que l'adoption des soins virtuels semble dépendre de la manière dont ils sont présentés et souligne qu'un plaidoyer unifié, associé à un engagement politique fort, est essentiel pour maintenir les soins virtuels au-delà de l'urgence pandémique.*

## 1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORMS

Virtual synchronous health care is a broad term that refers to remote, technology-driven health care solutions that facilitate interactions between patients and health care professionals. These interactions can occur through video calls and telephone consultations (Ashcroft et al. 2021; Donnelly et al. 2021; Ontario Chamber of Commerce 2020). The adoption of virtual primary care grew significantly during the COVID-19 pandemic, both in Canada and globally, as in-person appointments were restricted or unavailable (Latifi and Doarn 2020). This shift to virtual primary care enabled individuals to connect with their primary care providers using digital tools like phone consultations and online platforms (Ontario Health 2023). Across Canada, the demand for synchronous virtual care increased during lockdowns, as people were required to stay home to prevent the spread of the virus. In 2019, only 10% to 20% of primary care and specialist appointments were conducted virtually on average. This number increased to 60% in 2020 during the pandemic, as virtual health care became a tool for maintaining access to medical services (Canada Health Infoway 2022a). According to a population-based study conducted by Glazier et al. (2021), the increase in virtual primary care visits in Ontario was particularly pronounced, with virtual visits accounting for 71.1% of all primary care appointments during the early stages of the pandemic.

During the pandemic, the federal government played a critical role in supporting virtual health care initiatives, including a \$240.5 million investment announced on 3 May 2020, to accelerate the adoption and use of virtual care (Prime Minister of Canada 2020). In response to the need for remote health care services, all Canadian provinces swiftly adapted by revising their physician compensation models shortly after the pandemic began, enabling the widespread delivery of virtual health care (Canadian Medical Association 2022). Surveys indicate that many Canadians value the convenience of virtual health care, with 59% of respondents expressing a desire for ongoing access to these services (Canada Health Infoway 2022b; Zhang 2025).

Virtual health care has emerged as an important tool for improving access to care, particularly in rural and underserved communities where health care services are often limited (Canadian Institute for Health Information [CIHI] 2024a). It allows patients to save time and money by avoiding travel and minimizing disruptions to work or daily responsibilities. According to Canada Health Infoway, Canadians saved 11.5 million hours and \$595 million in travel costs through virtual appointments, while also preventing 120,000 metric tonnes of CO<sub>2</sub> emissions (Canada Health Infoway 2020). Virtual care also offers a potential solution to some issues of access to primary care providers by enabling timely access to physicians and nurse practitioners without the need for travel (CIHI 2024b). Moreover, it can empower individuals to take a more active role in managing their health, promoting greater flexibility and engagement in their well-being (Burton et al. 2022a).

Physicians generally expressed positive attitudes toward virtual care, recognizing its potential to enhance access to services (Braund et al. 2023; Li et al. 2022). However, many cautioned that its usefulness may be limited to specific types of appointments, particularly those that do not require physical examination (Li et al. 2022). Additionally, concerns were raised about access barriers for marginalized populations (Guetterman et al. 2025). Evidence from a systematic review indicates that virtual care is more frequently used by individuals who are young to middle-aged, female, white, from higher socioeconomic backgrounds, and living in urban areas (Hatef et al. 2023). In contrast, populations already facing systemic barriers — such as older adults, racialized communities, newcomers, refugees, and those with lower incomes — have experienced greater challenges in accessing virtual services during the pandemic (Hatef et al. 2023). For instance, many older adults reported discomfort with digital platforms due to limited digital health literacy (Shahid et al. 2023; Xu et al. 2022), while newcomers and refugees often encountered language barriers and unfamiliarity with the health care system (Bagchi et al. 2022; Bhatti et al. 2022; Public Health Ontario 2023).

These mixed benefits and limitations have fuelled an ongoing policy debate over how physicians should be remunerated for virtual care services. Some provinces, such as British Columbia (BC), have continued to support physician remuneration for virtual visits at the same rate as in-person care (Government of British Columbia 2024b; Government of British Columbia 2019). Others, such as Ontario, have introduced new barriers to accessing virtual primary care by changing physician payment models (Kfrerer et al. 2024). This paper compares the political and policy contexts of these provinces to identify the factors contributing to the divergence in adoption of virtual primary care post-pandemic.

## 2 HISTORY AND CONTEXT

Virtual health care has been in use for decades. In 1977, Dr. Arthur Maxwell House established the Telemedicine Centre at Memorial University in Newfoundland, pioneering the use of telephones for physician consultations and improving access to medical advice for people in rural areas (Halliday 2020). Since then, virtual health care has evolved significantly, incorporating video conferencing, remote monitoring, digital health records, and other advanced technologies to enhance patient care and accessibility (Li et al. 2021).

Table 1 provides a descriptive overview of Ontario and BC; both provinces have a relatively long history of attempting to implement virtual health care (Patterson et al. 2022). However, before the COVID-19 pandemic, its use remained low in both provinces, accounting for 1% of all medical visits in Ontario and 3% in BC (CIHI 2022a).

Table 1: Comparative Descriptive Table of Ontario and British Columbia

Category	Ontario	British Columbia
<b>Population</b>	Approximately 16 million <sup>a</sup>	Approximately 5.7 million <sup>b</sup>
<b>Local health care governance</b>	58 Ontario Health Teams <sup>c</sup>	Five regional health authorities <sup>d</sup>
<b>Main models of primary care delivery</b>	Family Health Groups, Family Health Networks, Family Health Organizations, Family Health Teams, walk-in clinics, community health centres, nurse practitioner-led clinics, Aboriginal Health Centres <sup>e</sup>	Primary Care Networks (family practice clinics, primary care centres, First Nations primary care centres, Foundry centres), walk-in clinics, community health centres <sup>f</sup>
<b>Physician compensation in 2022–2023<sup>g,*</sup></b>	45.7% fee-for-service and 54.3% alternative payment models (e.g., salary, capitation, etc.)	76.8% fee-for-service and 23.2% alternative payment programs (salary, capitation, etc.)
<b>% patients who accessed virtual care pre-pandemic<sup>i</sup></b>	1%	3%
<b>% virtual primary care visits post-pandemic (2023)<sup>j</sup></b>	36.1%	46.5%

*Note:* <sup>a</sup>Government of Ontario 2024a; <sup>b</sup>Government of British Columbia 2024a; <sup>c</sup>Government of Ontario 2024b; <sup>d</sup>Government of British Columbia 2025a; <sup>e</sup>Government of Ontario 2024c; <sup>f</sup>Government of British Columbia 2025b; <sup>g</sup>CIHI 2023; <sup>i</sup>CIHI 2022a; <sup>j</sup>CIHI 2024c. \*The figures represent the distribution of total clinical payments to primary care physicians.

Before the pandemic, both provinces worked to integrate virtual care into existing fee-for-service payment models, but their approaches differed (Patterson et al. 2022). BC has covered virtual care visits since October 2012, extending coverage to all residents without restrictions on online platforms (McGrail et al. 2017). BC was among the first provinces to compensate doctors for video- or text-based consultations (Patterson et al. 2022). In contrast, Ontario imposed restrictions on platform use and coverage from 2006 until the onset of the pandemic. Physicians were required to use a specific telemedicine platform to receive compensation for video consultations (Patterson et al. 2022). The Ontario Telemedicine Network (OTN), established in 2006, was initially designed to serve rural and remote communities (Ontario Chamber of Commerce 2020). Patients were required to travel to specific locations equipped with video technology to access specialist consultations. In 2014, OTN expanded its services by launching a pilot program that allowed patients to connect from their preferred locations, such as their homes, eliminating the need to visit designated OTN sites. However, the program faced limitations, as it only supported video calls made through OTN-approved systems (Ontario Chamber of Commerce 2020).

In the early weeks of COVID-19, all provinces in Canada modified their fee schedules under their respective provincial health care coverage. BC expanded its definition of virtual care to include telephone visits and allowed the claiming of in-person fee codes in cases where no existing fee codes are applicable, further broadening access (Doctors of BC 2020). In Ontario, a policy change allowed all physicians to bill for virtual care visits, regardless of whether they used OTN, enabling the use of a wider variety of platforms (Canadian Medical Association [CMA] 2022). However, the percentage of primary care services delivered virtually varied between provinces in the period April 2020 to March 2021, with Ontario providing 38% of services virtually and BC 53% (CIHI 2022b). Consequently, the use of virtual health care services varied between the two provinces during the pandemic and in the period immediately after. Data from Statistics Canada (2023) showed that between April 2021 and August 2022, 73.8% of patients in BC accessed virtual care, compared to 64.7% in Ontario. Additionally, the 2023 Commonwealth Fund reported that 46.5% of people aged 18 and older in BC received care from their primary care provider via telehealth, compared to only 36.1% in Ontario (CIHI 2024c).

After the pandemic, the provinces diverged in their approaches to reimburse virtual care. BC continued to reimburse virtual health care, based on the most recent Medical Services Commission Payment Schedule provided by the Ministry of Health in 2024, maintaining the changes introduced during COVID-19 (Government of British Columbia 2024b; Government of British Columbia 2019). The restriction on the number of complex virtual counselling sessions, which existed prior to the pandemic, has remained in place. Specifically, physicians can bill the public health insurance plan for up to four virtual counselling sessions longer than 20 minutes per year and per patient (Government of British Columbia 2024b; Government of British Columbia 2019). Ontario’s updated virtual health care billing system as of 17 June 2025, reimburses video visits at the same rate as in-person consultations, provided the patient has been seen in person within the past 24 months. Phone consultations are reimbursed at 85% of the in-person rate under the same condition. However, walk-in clinics receive significantly lower payments — just \$15 for phone consultations and \$20 for video visits (Vermes 2023). Previous fees were set at \$37 for minor assessments and \$67 or more for longer sessions. Compared to the \$37 fee, this represents a 59.5% reduction for phone consultations and a 45.9% reduction for video visits. Compared to the \$67 fee, the reductions are even steeper — 77.6% for phone consultations and 70.1% for video visits (Abi-Nakhoul 2023; Canadian Healthcare Technology 2022; Griffin 2022; Lee-Shanok 2022; Ontario Health 2025). It is important to note that these changes primarily impact primary care providers working under the fee-for-service model.

Both BC and Ontario are facing an issue of access to primary care providers, with the issue being more pronounced in BC. Eighteen percent of BC residents aged 18 and older lack a primary care provider, compared to 12% in Ontario (CIHI 2024d). While Ontario’s access issue appears less dire, it remains a pressing concern. This issue is expected to worsen, as a survey of 1,300 Ontario physicians suggests that 65% are planning to retire, leave the profession, or reduce hours within the next five years (i.e., 2024-29) (Ontario College of

Family Physicians 2024). In BC, 40% of family doctors are expected to retire or reduce their work hours within the next five years (i.e., 2024-29) (Lazenby 2025). Additionally, both provinces are grappling with significant health care inequities (Lavergne et al. 2023; Sanford et al. 2024). Ontario’s new virtual care billing structure has worsened challenges for individuals without a dedicated primary care provider, as they increasingly depend on walk-in clinics for medical services, further deepening health inequities (Vermees 2023).

Ontario and British Columbia are suitable comparators because both health care systems are grounded in the foundational principles of the *Canada Health Act* (Department of Justice Canada 1985). They face similar challenges in primary care and operate within the same national context, which minimizes cultural differences. Additionally, their history with virtual health care shows similarities — both had low adoption before the pandemic and had previously attempted to implement virtual health care. However, it is important to acknowledge key differences. Ontario has approximately 16 million residents (Government of Ontario 2024a), while BC has around 5.7 million, creating a significant demographic disparity (Government of British Columbia 2024). The other crucial difference is that BC relies more heavily on the fee-for-service payment model, with 76.8% in 2022-23, compared to Ontario’s 45.7% (CIHI 2023). On 1 February 2023, BC introduced the Longitudinal Family Physician Payment Model as an alternative to the fee-for-service system (Government of British Columbia 2026). However, because its implementation occurred in 2023, it lies outside the scope of the comparison period examined in this article. These differences could introduce limitations in analysis. Nevertheless, the commonalities provide a strong foundation for making comparisons and seeking to uncover factors that explain why different approaches to retaining virtual primary health care have emerged post-pandemic.

### 3 THE POLICY-MAKING PROCESS

The objective of this paper is to examine policy outcomes in two Canadian provinces, BC and Ontario, concerning the maintenance and expansion of virtual care. By analyzing the political and policy conditions that have influenced their divergent approaches to adopting virtual primary care in the post-pandemic era, this study aims to identify key driving factors behind these differences. John Kingdon’s Multiple Streams Framework serves as a useful tool for this analysis. This framework helps explain how certain issues gain traction on governmental agendas while others do not (Kingdon 2011). It highlights three distinct but interrelated streams: the problem stream, the policy stream, and the politics stream. According to this framework, for an issue to reach the governmental agenda, at least two of these streams must converge, or be “coupled” by policy entrepreneurs during specific moments known as “policy windows.” These windows represent opportunities when an issue gain heightened attention, creating a favourable environment for policy change and the introduction of new initiatives (Kingdon 2011).

### 3.1 Problem stream

Problems often gain the attention of government decision-makers when systematic indicators reveal their existence and significance (Kingdon 2011). The issue of inadequate access to primary care, particularly in rural and remote communities, has been well documented across both provinces (Wilson et al. 2020). Timely access to primary care has been declining across Canada. In 2023, only 26% of Canadians were able to see a health care provider on the same or next day, a significant decrease from 46% in 2016 (CIHI 2024f). The situation is even more severe in Ontario and BC, where only 21.6% and 19.6% of respondents, respectively, reported same-day or next-day access to care (CIHI 2024c). This worsening trend has prompted provincial medical associations and advocacy organizations to act, drawing public and governmental attention to the growing crisis in primary care. In addition, emerging evidence suggests that virtual care may help alleviate some of the pressures contributing to physician dissatisfaction and burnout. Studies have found that physicians who incorporate virtual care into their practice report improved work-life balance, higher provider satisfaction, and greater flexibility, without experiencing an increase in overall workload and while benefitting from shorter visit lengths (Butzner and Cuffee 2021; Burton et al. 2022b; Li et al. 2020). These perceived advantages may have contributed to policymakers’ and professional organizations’ interest in virtual care as a potential strategy to support provider sustainability in rural and remote communities.

The Ontario College of Family Physicians (2023) called on the government to better support family medicine, highlighting the urgent need for every Ontarian to have access to a family doctor, warning that one in four Ontarians could be without a primary care provider by 2026. The president of the Ontario College of Family Physicians at that time, Dr. Mekalai Kumanan, stated: “It is clear that millions more Ontarians will go without a family doctor unless immediate changes are made to provide supports for family doctors” (Ontario College of Family Physicians 2023). Similarly, in British Columbia, the organization BC Health Care Matters initiated a campaign in 2022 aimed at improving timely access to health care, noting that one in five British Columbians currently lack a primary care provider (BC Health Care Matters n.d.). Furthermore, it was not only physician associations that highlighted this issue; extensive media coverage has also brought attention to it, driven by people’s experiences of poor access in both provinces (CBC News 2022a; Daflos 2023; Lavery 2022; Wright 2022).

Limited access to primary care not only directly affects Canadians’ ability to find family physicians, but it also creates ripple effects throughout the health care system. For example, emergency departments have seen a rise in visits from individuals unable to secure timely primary care appointments. In 2023, 24% of emergency department visits in rural and remote areas were for conditions that could have been treated in a primary care setting — more than double the 11% rate observed in urban areas across Canada (CIHI 2024e). Rural advocacy organizations in both provinces have consistently underscored this issue in their reports. The Rural Ontario Municipal Association (2024) notes that “rural Ontario is losing

access to primary care at four times the rate of urban residents,” highlighting the magnitude of the problem. Likewise, Kornelsen et al. (2021) identify limited access to primary care as the most significant health care gap for rural communities in British Columbia. In response, the BC Rural Health Network outlined a list of health care challenges specific to rural settings, including the recruitment and retention of family doctors, the high costs associated with travel, and the relocation of health care services to urban centres (BC Rural Health Network 2023). As Dr. Maryam Zeineddin, president of BC Family Doctors, explained, “Family doctors and their specialist colleagues in BC’s rural areas are under immense pressure for numerous reasons, which in turn impacts the rest of the health care system, especially the emergency departments, which have seen frequent closures” (BC Rural Health Network 2025).

Although both provinces saw a rise in difficulties accessing health care, Multiple Stream Theory emphasizes that the presence of indicators does not necessarily make problems clear (Kingdon 2011). For the issue to be addressed by the government, a focusing event captures attention and highlight the problem’s importance (Kingdon 2011). The COVID-19 pandemic served as a focusing event that brought virtual care to the forefront of health care delivery in Canada. It triggered a rapid and widespread adoption of virtual care solutions. This moment also provided an opportunity to evaluate the effectiveness of virtual care and its impact on patient outcomes. As a result, it set the stage for reassessing the role of virtual care post-pandemic — raising important questions about its long-term integration and the extent to which it should be embedded in routine care.

According to the Multiple Streams Framework, whether a focusing event influences the government’s agenda depends on how the problem is framed (Kingdon 2011). Both provinces recognized the issue; however, they diverged in how they framed and communicated virtual care as a response to inadequate access to primary care. While the problem itself was already well established, the key distinction lay in how each government positioned virtual care — either as a central solution to access challenges or as a supplementary measure within a broader strategy. The Ministry of Health BC, in its review and report on patients’ experiences with virtual care since the beginning of the pandemic, outlined its next steps regarding virtual care. They emphasized that “moving forward, the Ministry of Health, in partnership with health-care providers, will be identifying ways to sustain the benefits of virtual care. With the appropriate provincial policies and infrastructure in place, the combination of in-person and virtual care is enabling more accessible care to British Columbians where and when they need it” (BC Ministry of Health 2021). Virtual care was framed as a solution to accessibility challenges.

Ontario framed virtual care differently, positioning it as “not urgent” while emphasizing the importance of strengthening patient-provider relationships. In an interview with CBC, Ontario’s Health Minister, Sylvia Jones, stated: “The worst of the pandemic is over, the need for virtual care is not urgent.” She further highlighted the value of in-person care, adding: “We need family physicians to be seeing patients in person. When that parent is concerned, when that caregiver has questions, the first place they need to be able to go and

have access to is their primary care physician” (Lee-Shanok 2022). This was also reiterated by Hannah Jensen, spokeswoman for the Minister of Health, who indicated that virtual care is intended to complement — not replace — in-person care. She emphasized that relying solely on virtual care is insufficient for maintaining a strong patient-provider relationship (Canadian Healthcare Technology 2022).

### 3.2 Policy stream

In the Multiple Streams Framework, the policy stream focuses on developing solutions to a problem, with policy advocates supporting the identification and promotion of potential solutions. (Kingdon 2011). Both provinces have strong advocacy systems from health care providers, research and advocacy groups. The strongest advocacy came from provincial physicians’ associations, which played a crucial role in the outcome regarding the retention of virtual care. The Ontario Medical Association (OMA) struggled to secure the continuation of virtual care at pandemic levels in its negotiations with the provincial government (Canadian Healthcare Technology 2022). Although the OMA opposed the government’s push to reduce virtual care remuneration to pre-COVID levels, the negotiations resulted in a compromise: some virtual care coverage was retained, but with barriers, as described above (Canadian Healthcare Technology 2022).

The OMA’s stance on virtual care appeared divided, which may have weakened its negotiating position. The OMA was not prepared to endorse virtual care as a solution to the problem of access to primary care. As Dr. Rose Zacharias, OMA president at the time, noted in an interview with CBC, “We have now pulled back, looked at how we can best leverage virtual care, and prioritize the patient-doctor relationship. We don’t have enough doctors for everyone to have that relationship... We need more doctors in the system to provide patients with comprehensive care.” Further, the OMA president emphasized that the priority should be licensing more doctors to ensure people can receive in-person care, rather than focusing on virtual care (Lee-Shanok 2022). The OMA also cited a report suggesting that direct-to-consumer virtual care platforms increase pressure on the health care system by disrupting continuity of care, often leading patients to seek emergency room visits after virtual consultations (Lapointe-Shaw et al. 2023; Lee-Shanok 2022).

In contrast, in BC, Doctors of BC and the Ministry of Health maintained temporary virtual care fees and created an independent Virtual Care Clinical Reference Group to guide clinical practices (Doctors of BC 2022; Government of British Columbia 2024b). Advocacy groups in BC appeared to be more unified in their support for integrating virtual care, emphasizing its potential benefits while maintaining the importance of in-person visits. For instance, BC Family Doctors, an association representing family physicians in the province, released a statement highlighting their priorities for further integrating virtual primary care post-pandemic (BC Family Doctors 2022). Their focus included equity, improving both patient and physician experiences, modality-neutral remuneration, and ensuring quality and safety. They also acknowledged the limitations of virtual care, stating, “Though no tech-

nology can fully replace in-person care, BC Family Doctors recognizes that the appropriate use of telemedicine can enhance patient access to care and strengthen the doctor-patient relationship” (BC Family Doctors 2020).

### 3.3 Political stream

The political stream operates independently of the problem and policy streams, influenced by public sentiment, elections, and government ideology (Kingdon 2011). Here, we focus on public attitudes toward virtual care in both provinces and party ideologies on health care. In Ontario, the June 2022 election resulted in no government change, with the Progressive Conservative (PC) Party securing a second consecutive term (CBC News 2022b). The new remuneration policy took effect in December 2022, six months after the election (Government of Ontario 2022). Furthermore, virtual care was not included in any of the Ontario political parties’ campaign platforms (Ontario Health Coalition 2022). In BC, the last election was in 2020 (Election BC n.d.), meaning that virtual care policy changes post-COVID occurred under the same government. Thus, changes of government are not a salient factor to consider in this comparison.

One key distinction between Ontario and British Columbia is the ideological orientation of their governing parties, which influences their respective approaches to health care. Ontario’s PC Party is right of centre, typically favouring fiscal restraint and privatization (Blake 2024; Canadian Health Coalition 2021). In contrast, BC’s New Democratic Party (NDP), which has been in power since 2020, is left of centre, emphasizing stronger government involvement and public investment in health services (Blake 2024; Canadian Health Coalition 2021). While it is unclear whether virtual care aligns more closely with right- or left-of-centre principles, these ideological differences have clearly shaped how virtual care has been implemented in each province.

Virtual care has been shown to decrease overall health care costs by reducing hospital admissions, minimizing travel expenses, and improving system efficiency (Hafner et al. 2022). However, because the implementation of virtual care requires short-term investment in technology and infrastructure (Hafner et al. 2022), its expansion depends largely on the government’s fiscal priorities. The Ontario PC Party’s approach to health care has consistently emphasized cost containment in the short-term rather than large-scale spending increases. This focus is evident in the Annual Business Plan 2022-2023, which prioritizes “identifying efficiencies, savings, and value creation” while also seeking to “quantify value-add opportunities within the health system” (Ontario Health 2022). Similarly, the previous year’s business plan underscored the importance of developing “performance measures focused on operational excellence, including cost savings, patient outcomes, cycle time, spending per full-time equivalent (FTE), quality, and provider satisfaction” (Ontario Health 2021). In the 2022-2023 Business Plan, the emphasis on virtual care was directed toward rural and remote communities, rather than the general population (Ontario Health 2022).

Another political decision reflecting the Ontario PC Party’s commitment to cost-saving health care initiatives was Bill 124: *The Protecting a Sustainable Public Sector for Future Generations Act*. Introduced in 2019, this legislation capped annual compensation increases for public sector workers at 1%, covering salary, benefits, perquisites, and all forms of discretionary and non-discretionary payments (Legislative Assembly of Ontario 2019). While legal pushback eventually led to its repeal (Canadian Union of Public Employees 2024), the bill remained in effect during key decision-making moments regarding virtual care, significantly impacting health care workers.

The NDP in BC has been shaping health care policies with a focus on system expansion rather than cost-cutting measures. Their approach prioritized improving physician compensation models, hiring and training more nurses, increasing incentives for health care workers, and expanding the number of paid sick days (BC NDP 2023). However, while these measures were intended to strengthen the health care system, challenges such as long wait times, physician shortages, and system inefficiencies persisted.

Public sentiment can be assessed through advocacy campaigns, which often engage media outlets to amplify their messages (Kingdon 2011). Following changes to physician reimbursement for virtual visits in Ontario, media coverage of the issue increased significantly. Many outlets highlighted growing public concern about reduced access to virtual care, emphasizing the risk of diminished treatment options and heightened health inequities (D’Mello 2022; Griffin 2022; Lee-Shanok 2022; Vermes 2023). Notably, one virtual gender-affirming clinic was forced to close due to the new billing structure and later reopened under a pay-for-service model, sparking strong backlash and concern among advocates for trans and non-binary communities across Ontario (Abi-Nakhoul 2023; Alberga 2023; Winsa 2022). We were not able to uncover any media coverage in BC on this issue, suggesting a lack of controversy or division among the public and political parties. The absence of significant media attention in BC indicates that virtual care was not a polarizing topic in the province.

## 4 IMPLEMENTATION AND EVALUATION

To our knowledge, no formal evaluations have been conducted in either Ontario or BC to assess the impacts of their respective virtual care policy decisions or the divergence between them. However, available evidence suggests that Ontario’s approach led to reduced access to care for some individuals. For example, direct-to-consumer virtual care platforms such as Rocket Doctor were forced to significantly scale back their services (Griffin 2022). In contrast, BC has seen sustained growth in virtual care, with visits increasing at an average annual rate of 14% from 2020 to 2023 (Provincial Digital Health and Information Services 2023).

## 5 CONCLUSION

While research on virtual care delivery in Canada has grown in recent years — focusing on areas such as patient satisfaction (Hardcastle and Ogbogu 2020; Mangalji et al. 2022), pilot programs (Desveaux et al. 2021), quality of care (Mangalamoorthy et al. 2023), and impacts on patient-provider relationships (Lapointe-Shaw et al. 2023; Wu et al. 2023) — there is limited literature examining the political and policy factors that influence the adoption and implementation of virtual care. This study addresses that gap by analyzing how differences in problem framing, advocacy efforts, governmental priorities, and historical health care structures shaped provincial responses.

The comparison between BC and Ontario provides a valuable case study in understanding why virtual care was retained in one province while access to it was restricted in the other. In both provinces, the policy window opened due to the urgent need to navigate the post-pandemic landscape and restore a sense of normalcy. However, Ontario used this opportunity to modify policies and introduce barriers to virtual care, whereas BC chose to maintain existing policies. A key factor in this divergence is how virtual care was framed in each province. In BC, virtual care was defined in terms of accessibility and integration within the health care system. In contrast, policymakers in Ontario viewed virtual care as a potential obstacle to patient-provider relationships, leading to policies that discouraged its widespread use. Unified advocacy played a crucial role in shaping virtual care policies. While public support for virtual care was strong, professional associations were not fully aligned with this perspective. Their statements emphasized the importance of patient-provider relationships, a stance that closely mirrored the Ontario government’s position. Additionally, reports highlighting increased pressure on emergency rooms following virtual visits may have further weakened advocacy efforts (Lapointe-Shaw et al. 2023; Lee-Shanok 2022). Government priorities significantly influenced the implementation and retention of virtual care. Neither government made specific political promises regarding virtual care, but their broader health care stances offer insight into their decision-making. The Ontario government prioritized cost-cutting and reducing health care expenditures, making it less likely to invest in a relatively new and potentially costly initiative like virtual care. In contrast, the BC government focused on expanding and improving health care services, making it more willing to integrate and sustain virtual care as part of its broader health care strategy.

Beyond these immediate policy considerations, historical factors also played a role in BC’s policy stability. The structure of physician compensation in BC likely contributed to a more unified advocacy effort, as 76.8% of doctors in the province relied on a fee-for-service model at the time of COVID pandemic compared to 45.7% in Ontario (CIHI 2023). This difference may have influenced how strongly physicians supported the continuation of virtual care. Additionally, the initial introduction of virtual care varied between the two provinces. BC implemented virtual care broadly for the entire population, albeit with certain limitations on delivery methods, while Ontario restricted virtual care to specific

areas and technologies. These early policy choices likely shaped public and professional perceptions, contributing to a less controversial and more stable approach in BC, which ultimately allowed for the continued expansion of virtual care.

Ultimately, these factors help explain why virtual care remained accessible in BC, while Ontario introduced barriers. Although the policy window opened for both provinces, their distinct policy landscapes led to starkly different outcomes. This contrast highlights how local context and governance priorities can shape the trajectory of health care innovation, even under similar health care challenges.

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