

A letter, not a law: looming deadlines, provincial uncertainty, and Ottawa's push to reimagine Canada Health Act compliance

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Key Takeaways

- Starting April 1, 2026, patient charges for medically necessary services provided by nurse practitioners, pharmacists and midwives will count as extra-billing and user charges under the Canada Health Act Services Policy.
- Provinces face challenges in aligning the scope of their publicly funded health services with the policy due to its lack of statutory authority and clarity.
- Public hospitals, private healthcare providers and virtual healthcare providers should monitor changes to provincial rules applicable to publicly funded healthcare services and government health insurance plans in response to the policy to adapt their service delivery strategies and billing practices accordingly.

Background on the CHA services policy

The Canada Health Act Services Policy (policy) purports to expand the scope of publicly funded healthcare services in Canada. Since inception, the *Canada Health Act* (CHA) has required that provincial publicly funded health insurance regimes cover medically required services rendered by physicians, hospital services and certain surgical-dental services.

As of April 1, 2026, the policy takes effect, requiring that services provided by non-physician healthcare providers must also be publicly funded in certain contexts. In order to comply with the policy, provinces and territories would need to adopt laws providing for a provincial funding model for these additional health services and restricting healthcare providers from charging privately for such services. Provinces and territories that do not comply with the policy will be subject to deductions from their federal health transfer payments once the federal government starts enforcing the policy.

In particular, pursuant to the policy, the health minister will consider patient charges for medically necessary services provided by healthcare providers who provide "physician-equivalent services" as "extra-billing and user charges" pursuant to the CHA. The policy was announced in a letter to the provincial and territorial health ministers by former federal

Health Minister Mark Holland in January 2025, but there remains very little clarity regarding how provinces and territories will respond to it.

In a December 19, 2025, letter to provincial and territorial health ministers that was first reported by *The Globe and Mail* but has not been publicly released (the December 19 letter), federal Health Minister Marjorie Michel clarified that

- the policy only affects services provided by nurse practitioners, pharmacists and midwives
- the timeline for enforcement of the policy will be delayed, with penalties for not extending coverage being retroactive

For public hospitals and private healthcare providers, provincial and territorial efforts to comply with the policy may have a significant impact on their future operational decisions. Compliance with the policy also has the potential to disrupt established private healthcare and virtual care providers who have been operating under a fee-for-service model with nurse practitioners or other healthcare providers who are not legally prohibited from charging patients privately for their services under the CHA.

Despite the fast-approaching implementation date for the policy, provincial and territorial governments have not yet released legislation, regulations or policies outlining their respective responses that would allow them to comply with the new federal directive. As a result, healthcare providers do not yet have clarity on how they will be able to leverage or restructure their payment arrangements to comply with the federal directive.

Federal timelines: the implementation schedule

The policy's enforcement timeline is as follows:

Date	Stage	Details	Risk / implication
April 1, 2026	Effective date	The policy takes effect. Patient charges for physician-equivalent services are deemed extra-billing and user charges under the CHA.	Provincial and territorial governments are not compliant with the policy if they fail to curtail out-of-pocket payments by patients for physician-equivalent services but are not yet subject to enforcement action for non-compliance.
April 1, 2027 ^[1]	Enforcement date (conditional)	The policy will be enforced, unless provinces and territories are covering physician-equivalent services by the end of 2028.	Provinces and territories must take steps to cover physician-equivalent services or risk deductions from their federal health transfer payments.

December 2028 Coverage deadline

Provinces and territories must have begun covering medically necessary physician-equivalent services.

Provinces and territories that have enacted legislation but not yet implemented a funding mechanism may be found non-compliant and risk deductions from their federal health transfer payments.

Interpretation letter vs. legislative amendment: a challenge for provinces and territories

The policy is framed as a ministerial interpretation of the CHA. However, in our view it is a proposed *de facto* amendment to the CHA. This creates problems for provinces and territories seeking to avoid the consequences of non-compliance with the policy. Because the policy rests on a ministerial interpretation rather than a proper amendment to the CHA, there is no statutory standard against which provincial compliance can be measured. To date, the federal government has not publicly released supplementary guidance for provinces and territories on the policy, including to publicly clarify the healthcare providers and types of services considered to be “physician-equivalent” services. Furthermore, each province and territory must independently determine which medically necessary services are captured and the system by which non-physician healthcare providers are compensated by the provincial government. We anticipate that provincial interpretations will diverge, producing a patchwork system that undermines the national consistency the CHA was designed to encourage.

The federal government has not made any move to amend the CHA to align with Minister Holland’s stated objective in issuing the policy. The policy does not clarify an existing ambiguity in the CHA but instead introduces an irregular interpretation of “insured health services” which are defined in the CHA as “hospital services, physician services and surgical-dental services provided to insured persons.” Under the CHA, “physician services” are “medically required services rendered by medical practitioners” and “medical practitioners” are persons “lawfully entitled to practice medicine.” Other healthcare professionals, including nurse practitioners, pharmacists and midwives, are not medical practitioners capable of performing physician services for the purposes of the CHA. As a result, the policy, which is non-binding on provincial and territorial governments, introduces an interpretation of “physician services” that is incompatible with the text of the CHA.

Provinces and territories face an unfair choice: comply with a federal directive that lacks statutory authority or absorb Canada Health Transfer payment deductions. Although some provinces have adopted legislation acknowledging the policy without implementing any changes to the scope of insured services in the province (e.g., Ontario and Manitoba), no province or territory has enacted legislation that expands the scope of insured services in order to align with the policy. In addition, Alberta has called for the federal health minister to repeal the policy on jurisdictional grounds, stating that it is also unclear, difficult to apply and likely to lead to gaps in coverage. Ontario Health Minister Sylvia Jones has similarly expressed disappointment in the federal government’s lack of leadership related to the implementation of the policy by provinces and territories. Minister Jones stated that Ontario will comply with the policy by April 1, 2027, but criticized Ottawa for failing to create a national standard that

would ensure a consistent approach to funding medically necessary care by non-physicians in each province and territory.

Ontario hospital sector: significant opportunity for workforce expansion

Quick facts: primary care workforce impact in Ontario

Primary care in Ontario

Family physicians	17,304 ^[2]
Nurse practitioners	5,879 ^[3]
Ontarians without primary care	1.98 million ^[4]
Ontarians on the Health Care Connect waitlist	57,395 ^[5]

For many years in Ontario, the *Public Hospitals Act* (PHA) has allowed nurse practitioners to be appointed to a hospital's professional staff, with the ability to admit, discharge and act as the most responsible practitioner for hospital patients. To date, two barriers have blocked hospitals from relying upon these provisions to expand their workforce:

- There has been no provincial funding pathway for independently appointed nurse practitioners, forcing hospitals to fund nurse practitioners from the hospital's global operating budget. This has resulted in very few hospitals granting nurse practitioners privileges to work at their hospital as independent contractors.
- Direct hospital payment to nurse practitioners creates *de facto* employment and vicarious liability for the hospital for the nurse practitioners' actions.^[6] By contrast, this exposure is absent when services are provided by independently compensated physician appointees, since physicians are not paid as hospital employees and rather bill the Ontario Health Insurance Plan (OHIP) directly for their services.

The proposed provincial funding of medically necessary physician-equivalent services delivered by nurse practitioners, through a funding mechanism yet to be specified, could be the catalyst Ontario hospitals have been waiting for to credential and appoint nurse practitioners in public hospitals to provide physician equivalent services directly to the hospital's patients. Given current fiscal pressures and the severity of physician workforce shortages, public hospital boards in Ontario should immediately initiate a structured review of nurse practitioner credentialing opportunities within their institutions to seize this potentially transformational moment.

Private pay nurse practitioner, pharmacist and midwife primary care and virtual care providers: continue to monitor provincial and territorial response

The virtual care sector in Canada has evolved based on the premise that primary care delivered by non-physicians, such as nurse practitioners, falls outside the CHA's insured services definition, permitting private-pay billing through employer benefit plans and direct-pay models. The policy directly challenges that premise.

Healthcare providers offering the services of nurse practitioners, pharmacists or midwives that are charging patients for services, including virtual care providers, should continue to monitor changes in provincial and territorial rules to identify if the services they provide may become a service insured by the applicable government health insurance plan in response to the policy.

Similarly, organizations offering health services through business-to-business or B2B arrangements by way of employer group contracts or benefit plan arrangements may also require updates to their payment arrangements to ensure they are compliant with restrictions on private billing for physician-equivalent services that may be adopted by provinces in response to the policy.

The federal government had previously signaled that it might issue a directive on billing for virtual care. However, the December 19 letter stated that the federal Health Minister will not be issuing a virtual care policy interpretation letter. This does not necessarily mean that virtual care providers will not be impacted by the policy. Virtual care services provided by physicians are provincially insured services across Canada, subject to satisfying certain conditions in each jurisdiction, and provincial and territorial governments are responsible for determining the details of their provincial health insurance plans.

Conclusion

Compliance with the policy requires provincial and territorial action that is built on an uncertain federal foundation. The changes provincial and territorial governments are being asked to make stem from a ministerial letter and not from legislative amendments to the CHA. Covering medically necessary physician-equivalent services that have been excluded from public coverage to date introduces billions in new provincial fiscal obligations with no corresponding commitment from the federal government to boost health transfer payments.

There may be exciting opportunities for the Ontario public hospital sector to alleviate challenges caused by physician shortages. There are approximately 5,900 registered Ontario nurse practitioners, representing an immediately available talent pool. However, public hospital boards should act now because competition for nurse practitioner hospital professional staff talent may intensify once Ontario announces its funding mechanism.

By contrast, businesses charging privately for nurse practitioners, pharmacists and midwives to provide services that overlap with those provided by physicians will need to monitor provincial and territorial responses to the policy since changes in the provincial and territorial rules applicable to publicly funded health services could impact how they are providing and charging for healthcare services.

[1] ["Ottawa says provinces should pay for nurse practitioners, gives one-year grace before penalties," *The Globe and Mail* \(March 1, 2026\).](#)

[2] Canadian Institute for Health Information, [Health Workforce in Canada, 2024.](#)

[3] College of Nurses of Ontario, [Registrant Statistics.](#)

[4] [Ontario's Primary Care Action Plan: 1-year progress update](#), Government of Ontario (January 12, 2026).

[5] *Ibid.*

[6] *Yepremian v. Scarborough General Hospital*, 1980 CanLII 1906 (ON CA).