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# IMPROVING PRIMARY HEALTH CARE ACCESS

Lessons from Canada and Scotland

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# Summary

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## Access to primary care varies by province, provider, and income

In 2024, one in five Canadians lacked access to a regular family doctor or nurse practitioner. The percentage of Canadians with a regular family doctor declined in seven out of 10 provinces between 2015 and 2024:

- Prince Edward Island (declined from 88 per cent to 53 per cent of Canadians 18 and over with a regular family doctor);
- Newfoundland and Labrador (declined from 86 to 67 per cent);
- Nova Scotia (declined from 86 to 72 per cent);
- New Brunswick (declined from 88 to 76 per cent);
- British Columbia (declined from 82 to 75 per cent);
- Ontario (declined from 87 to 85 per cent); and,
- Saskatchewan (declined from 78 to 77 per cent).

Between 2015 and 2024, the share of Canadians with access to a regular nurse practitioner (NP) increased from 0.8 per cent to 2.1 per cent. Although NPs represent a small share of primary care provision overall, their role in building a stronger primary care system is important and growing.

In 2024, 80 per cent of the lowest-income Canadians had a regular health provider (family doctors, nurse practitioner or other provider) compared to 86 per cent in the highest-income quintile (Figure 3). This gap did not improve between 2015 and 2024.

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## Primary care reforms have focused on physician payment, rather than structural change

In 2025, Health Workforce Canada reported that there were 193 primary care policy interventions in 2024 and 75 in 2025 across all provinces and territories. Changing and increasing physician compensation remains one of the most common interventions across the country. But it's not translating into increased access to primary care.

The lack of alternatives to the independent contractor model—where doctors and nurse practitioners are expected to own and operate a business—and investment in not-for-profit primary care infrastructure actively encourages the growth of investor-owned corporate chains. This privatization of primary care infrastructure has significant implications for care delivery, quality, and the commercialization of patient data.

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## Closing the primary care access gap requires strong federal leadership

Timely access to primary care remains a challenge across the country. Federal leadership is required to hold provinces accountable for addressing the primary care access gap:

- All federal funding, including the Canada Health Transfer, should have strings attached to hold provinces and territories accountable for closing the primary care access gap.
- The federal government should report annually on the progress of provinces and territories in achieving timely access to a primary care provider or team that also accounts for equity, including income, gender, age, and race and ethnicity.
- The federal and provincial governments should focus efforts on increasing access to primary care providers and teams by implementing the lessons from Scotland's reforms and the community health centre model.

# Introduction

Patients struggle to access primary care across Canada. While these challenges are not new, they have become acute in recent years.

Primary care is intended to serve as the foundation of the health care system. Globally, policy-makers face the challenge of improving population health while also containing health care spending. Evidence demonstrates that countries with a strong primary health care orientation have lower health care costs, better health outcomes, and reduced inequities.<sup>1</sup>

*Primary care* refers to services that are the first point of contact in the system (e.g., clinics and health centres). They are intended to prevent illness and they are where patients can be referred to specialized services. *Primary health care* refers to both a focus on interventions at the clinical level as well as improving population health by reducing health inequities that cause poor health in the first place (i.e., social and economic policies that reduce poverty and inequality). Effective primary care can help contain public spending by reducing the use of expensive hospital and emergency services.

Historically in Canada, primary care has been provided by individual or groups of family doctors who are independent contractors and operate leased or owned practices. They have significant autonomy as practitioners who are independent from government, and their practices have varying degrees of integration with the broader health care system.

These arrangements can be traced to the evolution of publicly funded health care in Canada. The medical profession reluctantly agreed to only bill government for its services and not patients. In exchange, the profession maintained business autonomy as independent contractors rather than publicly employed providers.<sup>2</sup>

Drawing on the Canadian Community Health Survey and the author's dissertation research, this report analyzes the growing primary care access gap in Canada and the provinces. It offers recommendations for closing the primary care access gap through lessons from Scottish primary care reforms and team-based non-profit primary care models that have a proven record of improving access and health outcomes.

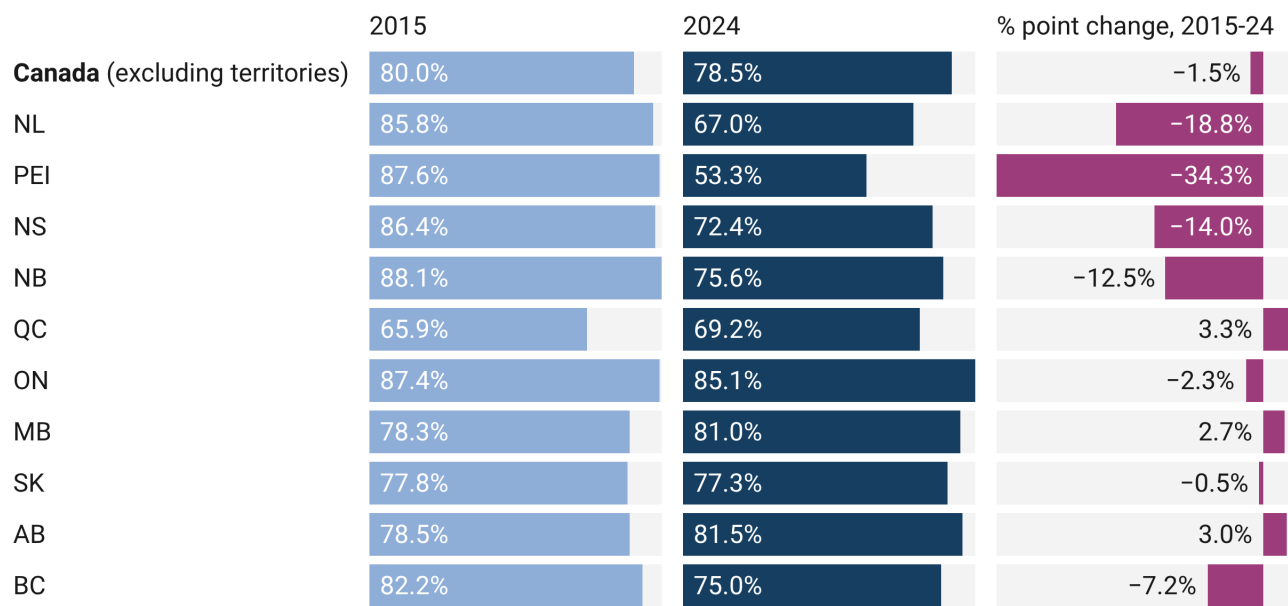
# Access to a regular family doctor declined in Canada and most provinces

In Canada, access to a regular family doctor declined from 80 per cent to 78.5 per cent of the population between 2015 and 2024—or by 1.5 percentage points (Figure 1).<sup>3</sup> Canadians' access to a regular family doctor declined in Canada and every province between 2015 and 2024, except Quebec, Manitoba, and Alberta:

- Prince Edward Island (declined from 88 per cent to 53 per cent of Canadians 18 and over with a regular family doctor);
- Newfoundland and Labrador (declined from 86 to 67 per cent);
- Nova Scotia (declined from 86 to 72 per cent);
- New Brunswick (declined from 88 to 76 per cent);
- British Columbia (declined from 82 to 75 per cent);
- Ontario (declined from 87 to 85 per cent); and,
- Saskatchewan (declined from 78 to 77 per cent).

**Figure 1 / How many Canadians have a regular family doctor, 2015-24**

Percentage of Canadians 18 and over



**Note** Beginning in 2023, the coverage of the Canadian Community Health Survey (CCHS) was changed to include adults aged 18 and older. Prior years included estimates of the population aged 12 and older.

**Source** Statistics Canada Canadian Community Health Survey custom request

In 2024, P.E.I., Newfoundland and Labrador, and Quebec had the lowest percentage of Canadians who had access to a regular doctor. Ontario, Alberta, and Manitoba had the highest.

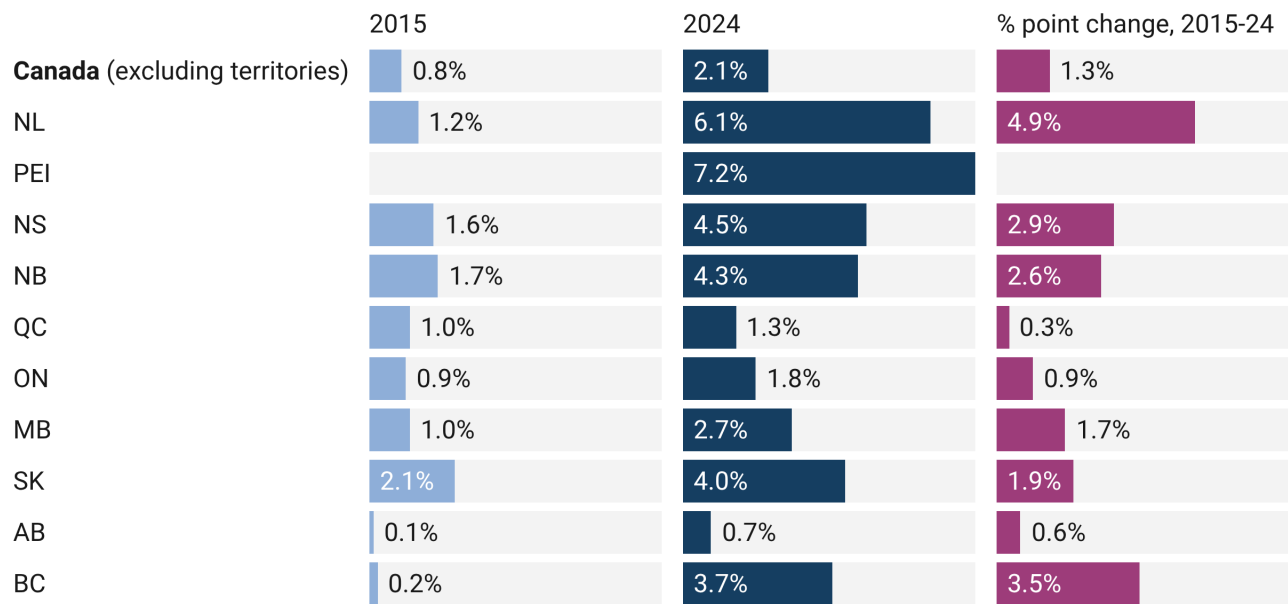
# Access to regular nurse practitioners increased in every province

First regulated in Alberta in 1996, nurse practitioners (NPs) are important primary care providers. They represent a growing share of regular primary provision. Although NPs represent a small share of primary care provision in Canada and the provinces, their contributions are important and growing.<sup>4</sup>

Between 2015 and 2024, the share of Canadians with access to a regular NP increased from 0.8 per cent to 2.1 per cent (Figure 2). Access increased in every province, with the largest increases in P.E.I. (7.2 percentage points), Newfoundland and Labrador (4.9 percentage points), B.C. (3.5 percentage points), and Nova Scotia (2.9 percentage point).

**Figure 2 / How many Canadians have a regular nurse practitioner, 2015-24**

Percentage of Canadians 18 and over



**Note** Beginning in 2023, the coverage of the Canadian Community Health Survey (CCHS) was changed to include adults aged 18 and older. Prior years included estimates of the population aged 12 and older. PEI data for 2015 are unavailable.

**Source** Statistics Canada Canadian Community Health Survey custom request

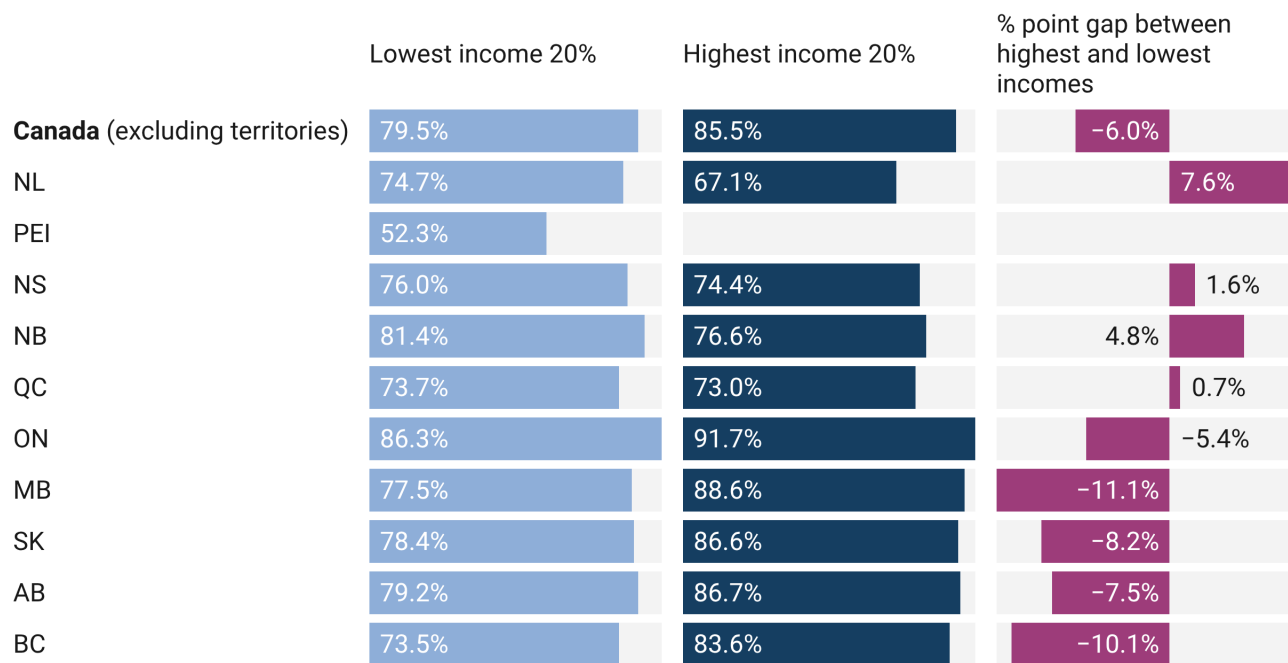
# Lowest-income Canadians have the worst access to a regular health provider

In 2024, 80 per cent of the lowest-income Canadians had a regular health provider (family doctors, nurse practitioner or other provider) compared to 86 per cent of the highest income (Figure 3). In fact, this gap has remained the same since 2015.<sup>5</sup>

In five out of nine provinces with data, the highest-income group had better access to a regular health provider than the lowest-income group, including Manitoba (11 percentage points), B.C. (10 percentage points), Saskatchewan (eight percentage points), Alberta (eight percentage points), and Ontario (five percentage points). These numbers demonstrate the importance that primary care reforms are designed to close income-based inequities in access.

### Figure 3 / How many Canadians have a regular health provider, by income, 2024

Percentage of Canadians 18 and over, by income quintile



**Note** PEI Q5 data are not available. All PEI data should be used with caution.

**Source** Statistics Canada Canadian Community Health Survey custom request

# Primary care policy interventions across Canada

**D**eclining access to family doctors remains one of the most significant public policy challenges facing provincial and federal governments. Policy interventions to address primary care access challenges fall into four main categories: increasing the supply of providers; increasing and reforming family physician payment models; introducing new governance structures and networks; and introducing new primary care providers and team-based care delivery models.<sup>6</sup>

In 2025, Health Workforce Canada—a new organization created with the support of Health Canada and CIHI—reported that there were 193 primary care policy interventions in 2024 and 75 in 2025 across all provinces and territories.<sup>7</sup> Despite the diversity of primary care policy interventions, changing and increasing family physician compensation—rather than structural reforms—remains one of the most common interventions across the country.

# New payment models increase compensation but aren't transforming primary care

**S**ignificant discontent with fee-for-service (FFS) payment has been building for many years in Canada, and family physicians have been frustrated with the lack of payment alternatives and the administrative workload. One of the main critiques is that FFS does not recognize (and compensate for) administrative work, including paperwork and patient follow-up on test results, which could not be billed under FFS.

Following British Columbia's new Longitudinal Family Physician (LFP) payment model in 2023, Alberta, Saskatchewan, Manitoba, Ontario, and Nova Scotia have also introduced new family physician payment models.<sup>8</sup> All models are a form of "blended payment" whereby doctors receive compensation for the time spent with patients and on administrative work, the volume of procedures or consultations performed, and for the medical complexity of their patient list (called a "panel").

The B.C. LFP payment model was developed by the B.C. Medical Association—the bargaining agent for doctors—with the explicit aim of

addressing this frustration with FFS and concerns of low pay relative to specialists and surgeons, despite generous pay for Canadian doctors compared to other high-income countries.<sup>9</sup>

B.C.'s LFP retains the basic premise of FFS payment: family physicians working in solo or group practice as independent contractors who are still responsible for administrative tasks. The significant increase in primary care expenditure predominately flows through individual physician compensation, rather than supporting the creation and development of non-profit primary care organizations with teams, administrative support, and physical infrastructure.

This practice of funding primary care infrastructure via individual physician payment—whereby they pay a portion of clinic overhead, including real estate (lease or mortgage), electronic medical record/IT systems, non-physician clinical and administrative staff—is no different than FFS. The biggest change is that LFP family physicians in B.C. are now compensated for time in addition to the specific procedures performed and panel.

The fact that both recent graduates and later career family physicians still do not have the option to practice outside of the independent contractor model is at odds with family physician practice preferences in Canada. A large and growing body of B.C. and Canadian research shows that family physicians, especially those who are new(er) to practice, are overwhelmingly unsatisfied with their independent contractor status and the lack of access to basic employment provisions, including parental leave and organizational support, that are standard in physician salaried employment relationships in other health systems in Canada and internationally. FFS also remains a significant barrier to team-based care because it disincentivizes collaboration.<sup>10</sup>

For example, a 2021 survey of 525 Lower Mainland family physicians found that 76 per cent indicated “a need for fundamental change to how primary care is delivered” and 44 per cent preferred to be salaried employees.<sup>11</sup> And while this body of research largely predates the inception of B.C.'s LFP—and similar models across Canada—these new payment models do not fundamentally shift family medicine practice away from owning and operating a business.

This continued reliance on the independent contractor business model, with physicians either owning the real estate or contributing to the lease payment, also means that provincial governments have not prioritized investment in public or non-profit-owned primary care infrastructure. Instead, provincial governments generally expect capital funding to flow from physician compensation into privately owned

primary care infrastructure. This provides governments with little ability to plan and guarantee primary health care services at the neighbourhood and community level.

Across the country, the lack of alternatives to the independent contractor model and investment in not-for-profit primary care infrastructure is actively encouraging the growth of investor-owned corporate chains in the primary care sector, with significant implications for care delivery and commercialization of patient data.<sup>12</sup>

Academic research and investigative reports have shown that corporate chains may pressure doctors to sell medically unnecessary services to patients. These corporate providers increasingly blur publicly funded services with private-pay services in order to increase profits. In British Columbia, for example, there are estimated to be 131 clinics owned by non-physician corporations—representing eight per cent of the total.<sup>13</sup> Many family physicians are attracted to corporate primary care clinics precisely because they provide a salary, administrative support, clinic infrastructure, and they do not require physicians to run a business.

# Learning from Scotland

## Shifting away from the business of general practice

Scotland offers promising lessons for how to shift primary care away from the independent contractor business model and into a more public primary care model as a strategy to improve recruitment and retention of family doctors and improve primary care access.

In Scotland, “general practice” refers to care provided by a general practitioner (GP) (typically called a family physician in Canada) and a multidisciplinary team including advanced nurse practitioners, nurses, pharmacists, physiotherapists, and other allied health professionals. “Primary care” is a broader term that refers to general practice, eye care, and dental care, which are often provided in other community settings.

Scotland takes a place-based approach to the organization and delivery of general practice. All Scottish residents have a right to access a general practice within their defined postal code-based boundary. Residents register by mail or online to be added to the practice nearest them, subject to availability.<sup>14</sup>

Traditionally, GPs have practised as “partners” who buy into the practice business using their own equity. As practice preferences have changed, the Scottish government has worked collaboratively with the

medical profession to shift away from the business model of general practice.

In the 2018 General Medical Services contract between the British Medical Association (BMA) Scotland and the Scottish government, the parties agreed to work towards a future where GPs are not presumed to be business owners and operators of their practices. The 2018 contract was a groundbreaking agreement because it offered a path forward to move away from the dominant independent contractor model. The 2018 contract was a collaborative effort to address some of the key reasons for declining interest in general practice, namely the financial cost, risk, and burden of running a business.<sup>15</sup>

The *National Code of Practice for GP Premises* establishes the Scottish government's approach to gradually shifting premises ownership over to NHS Scotland.<sup>16</sup> These policy directions offered GPs the option to have the local NHS health board take over their lease or buy the GP partners out at market value, if the practice real estate is owned. The Scottish government offers "GP Sustainability Loans" as a way to avoid the problem when retiring doctors leave the capital liabilities on the shoulders of the last GP in the practice. These interest-free loans allow GPs to release their equity in the property when a partner leaves, without having to sell the real estate or add unsustainable debt to the remaining partner(s).

These policy reforms also dovetail with efforts to build out the multidisciplinary team in primary care. Other providers, including physiotherapists, social workers, and nurses, are employed by NHS health boards, but work in community-based primary care practices. A senior NHS Scotland official describes this policy transformation as part of the strategy to bolster primary care at a time of declining interest in the independent contractor model:

We're seeing general practitioners...wanting to move away from partnerships because of the business model, the HR, and all of the bits and pieces that are attached to owning your own business, are not attractive to everybody and GPs that are coming out of training are telling us that they want a portfolio career, they don't want to be stuck... What the Scottish Government has done that England [hasn't] done is they've retained the locus of control in terms of multidisciplinary teams being employed by the NHS...and that... gives us control over how and what that workforce does, which is different. So, in essence, NHS Scotland can direct the outcomes of health through a multidisciplinary team, which has got much more control over it than if we were to negotiate the fee-for-service outcomes through a GP contract.<sup>17</sup>

Scotland's transformative reforms have not been without challenges. Taking the practice liabilities off the shoulders of family physicians can be complex legally and practically, but the Scottish Government remains committed to this policy direction. Early data show promising signs of the increasing GP workforce, but more research will be needed to show the effects of Scotland's reforms on access to care.<sup>18</sup>

Unlike Canadian provinces, Scotland has embraced the changing practice preferences among a new generation of family physicians who want reasonable work-life balance, reduced financial risk, and the ability to practice what is called a "portfolio career" in the UK. This means practising in a diversity of settings over one's career, which may include clinical work, academic research, and focusing in certain sub-specialties, rather than feeling constrained working only as a GP partner.

As one key informant put it, "we were willing to give up some of the profit-making elements and reduce the risks. As I said, we're moving more towards salaried practice and we're giving the government a way to eventually purchase the building stock."<sup>19</sup>

Closer to home, there are lessons to draw from Canada's community health centres.

# Learning from community health centres in Canada

An evidence-based model  
to scale nationally

Community health centres have been an effective but undervalued model for delivering primary health care in Canada. This non-profit, community-governed model allows physicians to practice medicine with a team and administrative support without the requirement to run a business. It is also a model with strong evidence behind its effectiveness.<sup>20</sup>

One of the unique features of the model is its strong focus on the socio-economic determinants of health, health equity, and preventing acute illness among groups who are more likely to experience poor health and suffer from chronic conditions, including those who are low-income, racialized, Indigenous, as well as frail seniors.

CHCs generally have the following characteristics:

1. CHCs provide team-based, interprofessional care from medical providers and social care providers, including family physicians, nurse

practitioners, pharmacists, social workers, occupational therapists, housing support and outreach workers, amongst others.

2. CHCs integrate medical care, mental health and substance user services, health promotion and chronic disease management. Many CHCs also integrate vision and dental care within the same organization.

3. CHCs are community-governed and responsive to the patients/ members they serve. They are legally established as non-profit societies or co-operatives and provide open membership to their patients, who are members and can serve on the board of directors.

4. CHCs actively address the social and economic determinants of health, including access to housing, food, and income supports.

5. CHCs demonstrate commitment to health equity and social justice, and recognize that disparities in health status are socially, economically, and institutionally produced—and that these disparities are avoidable and must be addressed through a community development and health equity approach.<sup>21</sup>

Today there are more than 300 CHCs represented by the Canadian Association of Community Health Centres. About a quarter of these are located in Ontario, where CHCs have a long history of growth and sustained funding by successive provincial governments, which totalled \$596 million in 2024-25.<sup>22</sup>

Ontario CHCs are composed of a diversity of health occupations,<sup>23</sup> including 447 nurse practitioners, 690 nurses, 468 family physicians, 519 community health and outreach workers, 209 social workers, 133 health promoters, hundreds of allied health professionals and administrative specialists who support clinical providers.<sup>24</sup>

Ontario CHCs serve more than 500,000 patients each year and another half a million through social and community programming, representing about six per cent of Ontario's population. CHC patients have an expected need for primary care that is 60 per cent greater than the average Ontarian. On average, one-third of CHC patients live in neighbourhoods from the lowest-income quintile and also disproportionately live with complex medical and social needs and may face barriers to accessing care in other settings.<sup>25</sup>

CHCs in Ontario have core funding (one funding envelope to cover all operating and staffing costs, including physician and NP salaries) by the Ontario Ministry of Health. The core funding model is critical to their success because it gives them considerable flexibility to hire staff

and develop services appropriate to the specific needs of their patient population and to also shift funding priorities in response to changes in community needs and demographics. It also opens up opportunities for them to develop novel funding partnerships to support new community initiatives, sector-wide improvement strategies, and needed infrastructure.

As part of the Primary Care Action Team's efforts led by Jane Philpott, CHCs have been on the forefront of connecting Ontarians to primary care who have not had a regular provider or team.<sup>26</sup> CHCs have helped attach additional patients, especially those who are low-income, racialized, and have faced barriers to access other primary care. The CHC sector has also played a significant role helping deliver Ontario's Primary Care Action Plan to close the primary care access gap by 2029 as a network hub for other primary care clinics in their communities.

However, Ontario's implementation of its blended payment model for physicians working as independent contractors risks undermining the positive role CHCs have played, especially if public funding is tilted in favour of increasing physician pay outside of CHCs.

# Conclusion

## Closing the primary care access gap requires strong federal leadership

The federal government has provided inconsistent leadership when it comes to improving primary health care. From 2000 to 2006, the Primary Health Care Transition Fund provided provinces, territories, and health care system stakeholders \$800 million. One of the aims of the fund was to facilitate the introduction of new models of team-based care that could improve access and outcomes. Among the provinces, Ontario used its funding in one of the more effective ways by expanding team-based primary care, including Family Health Teams and 22 new CHCs.<sup>27</sup>

In 2023, the federal government signed bilateral agreements with the provinces to provide \$46 billion in new funding for health care. As part of this funding, the federal government provided \$25 billion over 10 years to support shared priorities, including primary care, health workforce, backlogs, mental health and substance use, and information system modernization.<sup>28</sup>

The bilateral agreements establish indicators to report on provincial and territorial progress towards meeting the shared health priorities. For primary health care, the federal government and provinces and territories use the Canadian Community Health Survey indicator of the percentage of Canadians who report having access to a regular primary care provider, which is reported by the Canadian Institute for Health Information (CIHI) on its Shared Health Priorities website.

The federal government has a critical role to play—not only reporting on progress, but establishing primary care standards through federal transfers and also enforcing existing legislation.

The federal government's obligations under the *Canada Health Act*—to ensure that everyone has reasonable access to physician and physician-equivalent services without financial barriers—compels the federal government to ensure that the provinces and territories are working to close the primary care access gap. It also requires the federal government to crack down on provinces that allow corporate and virtual care providers that charge patients for publicly insured services.

The federal government needs to more effectively use federal transfers to effect change. This report makes the following recommendations:

1. All federal transfers payments, including the Canada Health Transfer, should have strings attached to hold provinces and territories accountable for closing the primary care access gap. Provinces should be given until 2030 to use existing bilateral agreements and CHT funds to ensure that the entire population has timely access to a regular primary care provider or team, based on Statistics Canada measures.
2. The federal government should report annually on the progress of provinces and territories in achieving timely access to a primary care provider or team that also accounts for equity, including income, gender, age, disability status, race and ethnicity, and Indigenous status.
3. The federal and provincial governments should focus efforts on increasing access to primary care providers and teams by implementing the lessons from Scotland's reforms and the community health centre model. Both of these approaches account for changing practice preferences among family doctors and nurse practitioners and the desire among providers to work in collaborative teams. By supporting alternatives to the independent contractor model, the lessons from Scotland and CHCs suggest that provincial and territorial governments must plan for a future where primary care providers are not expected to be business owners and operators. The federal government can provide policy direction and guidance to support the spread of team-based non-profit delivery models rooted in equity, including the community health centre model.

Access to a primary care provider or team remains a significant challenge for many across the country. In 2024, one in five Canadians lacked access to a regular family doctor or nurse practitioner. While

access to a family doctor declined from 2015 to 2024, the percentage of Canadians with access to a regular nurse practitioner increased.

Income is one of the key determinants of access to a primary care provider. The primary care gap between the highest-income and lowest-income Canadians did not improve from 2015 to 2024. Federal and provincial governments need to prioritize equity when implementing policy interventions.

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