Recent Stresses and Underlying System Causes of the Primary Care Crisis Point Toward Policy Solutions

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Abstract

Across Canada, millions of people are struggling to find a family doctor, nurse practitioner or primary care clinic and millions more are attached to a clinician who is over the age of 65. Research led by INSPIRE-PHC and analyzed at ICES has demonstrated the growing number of unattached people and their higher likelihood of being of lower income, racialized and having newly arrived in Ontario. Recent stresses include population growth, declining volume of services per physician and decreased attractiveness of comprehensive primary care, while underlying system causes point to the need for organized accountable systems designed to look after the entire population.

Introduction

Primary care is the first point of contact with the health system and the most important health system determinant of better population health and greater equity at lower cost (Macinko et al. 2003; Shi et al. 2002). In Canada, a maldistributed and aging workforce has been further stressed by the COVID-19 pandemic, high inflation and growing patient and administrative complexity and demands (Glazier 2024). Millions of Canadians cannot access healthcare without going to a walk-in clinic or emergency department and those who can access care often face long wait times. While these are global issues, Canada continues to fall farther behind peer countries in performance (CIHI 2023).

Most primary care in Canada is still being delivered as it was 50 years ago, by independent family doctors running small businesses supported by public fee-for-service payments negotiated by provincial/territorial medical associations. These arrangements lack support and capacity for improving population health; meeting community needs; improving quality of care; implementing digital health tools; connecting electronic health data; and effectively coordinating care across health, social and community sectors.

Signs of Distress

The first steps to addressing a crisis are to recognize its root causes and to consider a range of appropriate policy responses. The signs of system distress are everywhere: people not being able to find a family doctor, nurse practitioner or clinic; emergency departments being understaffed or closed, with increasing wait times; growing numbers of admitted patients waiting for appropriate supports to be discharged; hospitals running large deficits; workforce shortages in every sector; and a rapidly growing private for-pay sector filling in major gaps in care (Bechard and Boan 2024; Matthewman et al. 2021). While all of these issues require attention, the imbalance between enormous investments in institutions such as hospitals and long-term care homes and meagre investments in community-based services such as primary care and home care lies at the heart of many of these challenges. Hospitals will always be overwhelmed if people cannot receive timely and appropriate care in the community to prevent emergency department use and to be discharged to supportive environments.

Why it is so hard to find a family doctor: proximal causes

There are different approaches to measuring the size, nature and trajectory of the problem with access to a family doctor, nurse practitioner or clinic. Self-report through population-based surveys shows a large and growing number of Canadians without access to a regular healthcare provider. Statistics Canada's Canadian Community Health Survey found that 83% of adults had access to a regular healthcare provider in 2023, leaving 5.4 million individuals without access (Statistics Canada 2021). Notably, only 71.3% had access to a family physician or nurse practitioner, with others identifying a medical specialist (5.3%) or other type of provider (6.2%) as their regular health provider. Access varied widely across provinces, from 73% in Prince Edward Island (PEI) to 88% in Ontario, and even more widely across territories, from 44% in Nunavut to 78% in Yukon. The OurCare survey conducted in

2022 found that only 77% of Canadians had a family doctor or nurse practitioner, estimating that there were more than 6 million Canadians without access (OurCare Survey 2022).

A deeper dive into the Ontario health administrative data, led by INSPIRE-PHC investigators and conducted at ICES, found that 84% of those eligible for healthcare in Ontario had some form of primary care attachment in 2023 compared with 88% in 2020 (Jaakkimainen et al. 2021). In 2023, those considered "uncertainly attached" included 735,461 people whose only primary care was with a walk-in style or a straight fee-for-service doctor and 1,786,165 people with no attachment and no primary care contact in the previous two years (INSPIRE-PHC 2023). Between 2020 and 2023, 2.6% more people were attached, but this increase fell behind the population growth of over a million people, with the largest change comprising an increased 35.8% with no primary care contact (Table 1).

TABLE 1.
Primary care attachment in Ontario, 2020 and 2023*

	2020	2023	Increase
Total population	14,632,575	15,717,487	6.9%
Attached	12,854,553	13,195,861	2.6%
Uncertainly attached	1,778,022	2,521,626	29.5%
Walk-in only	631,553	735,461	14.1%
No contact	1,146,469	1,786,165	35.8%

* Data can be found at https://www.ontariohealthprofiles.ca/ontarioHealthTeam.php.

Compared with those who were attached, people with no primary care were younger (mean age 37.5 years vs. 41.9 years) and more likely to be a male (59.8% vs. 48.0%), to be in the lowest-income quintile (25.4% vs. 18.3%), to live in racialized neighbourhoods (34.% vs. 29.4%) and to have arrived in Ontario in the previous 10 years (31.5% vs. 13.8%). They were also less likely to have a chronic illness or use healthcare services. This profile is likely associated with high concentrations of recent immigrants in urban neighbourhoods, some with low availability of primary care clinicians. Meeting these needs will require clinicians and clinics with language skills, cultural humility and the ability to effectively engage local communities to help address barriers to care. Younger male patients may have lower perceived healthcare needs and may prefer to access episodic rather than ongoing care.

While population growth appeared to be an important driver of increasing numbers of Ontarians being unattached, changes in primary care supply also played a role and may provide insight into future trends. The number of Ontario family physicians grew by 42% from 2005–2006 to 2022–2023 (Kim et al. 2024), but the number of hours worked and the number of patients seen declined (Kralj et al. 2024), as did the proportion of comprehensive office practice (Premji et al. 2023). In 2019, close to 15% of Ontarians were attached to a comprehensive family doctor over the age of 65, putting 1.7 million people at risk when their family doctor retires (Premji et al. 2023). Net growth of all family physicians in Ontario was 324 physicians in 2020, 382 in 2021, 490 in 2022 and 153 in 2023 (OPRC 2023), barely enough to manage population growth even with a full-time and comprehensive practice.

New medical schools and residency positions will help boost these numbers but will take many years and could fail to attract graduates to comprehensive primary care if reimbursement, supports and working conditions continue to be less attractive than other options. Recently, Ontario announced tuition coverage for medical students committing to a full-scope family practice (Stone and Grant 2024). Given the dire shortage of capacity in family medicine, many provinces and territories are expanding team-based care, a necessary and constructive direction. Ontario has also committed to attaching everyone to primary care within five years and has appointed a primary care action team to enable those connections (Ontario Health 2024).

How we ended up here: underlying system causes

For years, demographers have been warning about the rapidly aging population and corresponding increased need for healthcare, but little consideration has been given to the aging of the family physician workforce and the impact of physician retirements. More fundamental to that issue are planning challenges, given the workforce comprises independent contractors largely paid by fee for service who can readily change or limit their scope of practice. Many high-performing countries have primary care clinicians on contracts with established expectations for the size of their practice and scope of their work, together with appropriate supports such as interprofessional staff, well-organized specialist referral systems and well-connected digital systems (Shahaed et al. 2023). Those countries also plan for and achieve access to primary care for close to 100% of their population, often through automatic or mandated attachment. The goal of primary care for all is now gaining traction in Canada (Philpott 2024; Price et al. 2015), with policy commitments from some provinces, notably PEI and Ontario (Stone and Grant 2024). Fundamentally, Canada lacks the population-based strategy, investment, supports and accountability for primary care that would establish it as a high-performing health system rather than as one at high risk for further fragmentation, privatization and two-tiered primary care.

Conclusions

Canada's primary care crisis is being driven in part by population growth, the highest in the G7. Those being left out are more likely to be new Canadians who are, of lower income and racialized. Many newcomers are relatively young and healthy but the extent of their unmet needs in areas such as preventive care, early detection of chronic disease and mental health require further investigation. Recent stresses include post-pandemic burnout; an aging workforce; and the increased demand of running a small business with challenging information technology systems, lack of connectivity, growing practice complexity, increasing administrative burden and high inflation. Faced with the choice of running a difficult small business in the community or working in a hospital with no overhead, many family medicine graduates are choosing the latter. Underlying system causes of the crisis are largely historical, with a 1970s health system struggling to provide 21st-century care. As other countries have done, establishing a goal of universal access to local primary care is needed, along with the governance, accountability, digital connectivity and support structures required to achieve that goal. Given population and clinician aging, and the lack of appeal of comprehensive primary care among trainees, the primary care crisis will undoubtedly worsen in the next few years. A timely, robust and transformative response is urgently needed. HQ

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