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Primary Care Accessible to All is Better Medicare

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Countries that invest in primary care have better population outcomes. Canadian Doctors for Medicare urges governments to enhance publicly funded primary care by ensuring that everyone in Canada has guaranteed access to a neighbourhood/geographically based interprofessional care team. Doing so will, over time, reduce the need for emergency and hospital care, improve equity and health, and lower system costs.

Accessible, reliable primary care is the essential foundation of an efficient, effective healthcare system, with proven lower overall costs, improved health outcomes, and reduced health inequities. A single visit to a family doctor costs $54 on average, compared to $304 on average for a single emergency department visit, demonstrating the substantial cost savings associated with primary care.[1] Timely access to a regular primary care team is not only better for patients, but also a more efficient use of public healthcare resources. When timely primary care is inaccessible, patients may turn to emergency departments for conditions that could otherwise be managed in the community, increasing costs and placing additional pressure on already strained hospitals. However, according to a 2025 survey, 5.9 million adults, or 17.6% of Canadians, do not have a family doctor, nurse practitioner, or primary care team. For Canadians who make less than $20,000 per year, this number rises to 30.4%.[2] Additionally, the gap between Black and white individuals having regular access to care is 23%.[3] In Canada, the share of respondents who can access same-day or next-day appointments (45.8%) is significantly lower than the OECD average (59.2%).[4] These statistics are especially worrying, given the significantly higher mortality risk in individuals who are unattached or not stably attached to a primary care provider, compared to those with a stable attachment.[5] The serious inequity and lack of access to primary care in Canada and serve as a call to action to strengthen primary care from coast to coast to coast.

Canadian Doctors for Medicare strongly supports implementation of geographic catchment with the Patient Medical Home Model (PMH) across the country.[6] PMHs can be geographically based hubs or networks that connect comprehensive primary care, community health, and social services. Every patient is associated with a team of healthcare providers, such as family physicians, nurses, social workers, and dietitians, with the specific community needs and resources determining the exact makeup of the healthcare team. The geographic catchment aspect of this model would be similar to that of public schools—the area in which an individual or family lives automatically links them to a given PMH.[7]

The OurCare Standard provides a framework to implement and evaluate the geographic catchment PMH model against six elements of a sustainable, high-quality, and equitable primary care system that could address the significant number of Canadians who currently lack a regular primary care provider.[2]

First, everyone should have a relationship with a primary care clinician who works with other health professionals in a publicly funded team. The PMH framework directly addresses this goal by automatically connecting residents within a geographic catchment area to an interprofessional team. Rather than requiring individuals to independently find a provider accepting new patients, residents would develop an ongoing relationship with a primary care team that could include family physicians, nurse practitioners, nurses, social workers, dietitians, and other health professionals. In diagnosis and treatment, these relationships are vital as good rapport supports patients to share important information, become partners in treatment planning, and ultimately adhere to treatment.[8]

Second, patients should receive ongoing care and be able to access their team in a timely manner. Although attachment to a primary care provider is important, it does not guarantee timely access. Less than half of Canadians can currently obtain a same- or next-day appointment.[4] Team-based PMHs could improve timely access by distributing care across professionals according to patient needs. For example, patients requiring medication management or nutritional support could see a pharmacist or dietitian rather than a physician, preserving physician capacity for more complex needs. This could improve both access and continuity while reducing reliance on emergency departments for non-emergency care.

Third, primary care should be connected to community and social services that support physical, mental, and social well-being. These connections are often fragmented in the current system, leaving patients to navigate services independently.[9] PMHs would integrate allied health professionals and community navigators into primary care, supporting referrals to services such as housing, legal assistance, tax support, food programs, and mental health care. This approach is particularly important for lower-income patients, for whom social conditions can have a significant impact on health.

Fourth, patients should be able to access and share their health records online. Although electronic medical records are widely used by physicians, information remains siloed across providers and organizations.[10] PMHs should therefore use interoperable electronic medical record software, which has been introduced in some provinces, such as CorCare in Newfoundland and Labrador, allowing patients and authorized members of their care team to access relevant information on a province-wide basis ("one patient, one record").[11] This would reduce duplication, improve coordination, and allow patients to play a greater role in managing their care.

Fifth, care should be culturally safe and responsive to the communities being served. Many racialized and Indigenous patients continue to experience racism and discrimination within the health-care system.[10] PMHs could address these inequities by tailoring teams and services to the populations they serve, including through culturally safe practices, language-concordant care, and community representation among staff and leadership.[12, 13] Importantly, this should include support for Indigenous-led and community-led models where appropriate rather than imposing a single model of care.

Finally, primary care systems should be accountable to the communities they serve. PMHs should therefore involve patients and community members in governance and regularly report on measures such as access, continuity, patient experience, equity, and health outcomes.

Ontario's primary care key performance indicators could provide a foundation for developing a broader national accountability framework.[15] This would ensure that success is measured not only by the number of people attached to primary care, but by whether they receive the quality of care envisioned by the OurCare Standard.

Two in five family physicians in Canada report experiencing symptoms of burnout, often due to overwhelming administrative burdens, high patient complexity, and lack of adequate time off.[16] The PMH model helps to address these issues by allowing each member of the care team to share responsibility for administrative tasks and patients while playing to their individual strengths to help those with multiple morbidities. This has the potential to reduce burnout by redistributing workload and administrative responsibilities across the team, thereby better supporting family physicians and addressing the primary care crisis.[17, 18]

Primary care is foundational to Canada's healthcare system, and to high functioning universal healthcare. To achieve a more equitable and effective health system Canada must strengthen the organization and delivery of primary care. The PMH geographic catchment model provides a pathway that prioritizes effective navigation, connecting patients to specialists and other health-care services while facilitating access to the broader community and social supports that shape their health. It also centres equity-oriented care, which will mitigate the disproportionate burden of poor health outcomes and primary care unattachment experienced by racialized and low-income populations. Ultimately, realizing this vision will require federal, provincial, and territorial governments to work collaboratively to establish shared standards for team-based primary care while allowing jurisdictions and communities the flexibility to adapt the PMH model to their local needs.

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