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Canadians Are Seeing Fewer Doctors as Emergency Rooms Handle the Overflow

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This study was commissioned by the Centre for Civic Engagement. The CCE is a non-partisan Canadian charity dedicated to conducting original research on public policy issues related to Canadian prosperity, productivity, and national flourishing. The CCE's research informs an active program of policy seminars, events, conferences, and lectures all aimed at providing the policy making community with actionable insights that encourage informed decision making on issues that matter to Canadians.

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Introduction

At a time when Canadians are experiencing increasingly crowded emergency departments (EDs) and longer and longer wait times, new research from the Canadian Institute for Health Information (CIHI) puts concrete numbers behind the frustrating phenomenon.

For example, an April 2026 release reported that ED visits grew to 16.1 million in 2024–2025, up from almost 15.5 million in 2023–2024 for an increase of nearly 4 percent.[1]

A June 2026 release noted increased ED crowding because of growing pressures on Canada's health-care systems resulting from limited primary care access, a shortage of long-term care beds, and acute care hospital beds, as well as older patients with more complex needs.[2]

Moreover, wait times in EDs have increased, with the number of patients waiting 10 hours or more for emergency services increasing by 28 percent since 2018/19.

A key reason for increased use of EDs is limited access to primary care—nearly one in five Canadian adults report that they do not have a regular health-care provider.[3] Meanwhile, even those with a regular provider report significant delays in same- or next-day access as well as an inability to get care on evenings or weekends. This is despite the supply of Canadian physicians increasing steadily over the last decade, with the supply now being the highest it has ever been, both in absolute and per capita terms.[4]

At the same time, evidence suggests that physicians are in pursuit of better work-life balance and are working less. A recent study shows that average weekly hours by physicians declined by 6.9 hours from 1987–91 to 2017–21.[5]

Another study found that from 2005/06 to 2017/18, the number of family physicians increased by 35.3 percent in Ontario and 48.7 percent in Alberta; however, annual average service days per physician declined by 10.6 percent in Ontario and 5.9 percent in Alberta.[6]

1 Canadian Institute for Health Information, "NACRS Emergency Department Visits and Lengths of Stay," accessed September 15, 2026, https://www.cihi.ca/en/nacrs-emergency-department-visits-and-lengths-of-stay.

2 Canadian Institute for Health Information, "Emergency Department Waits Reflect Access to Care across the System," June 25, 2026, https://www.cihi.ca/en/emergency-department-wait-times-in-canada-insights-from-a-health-system-perspective/emergency-department-waits-reflect-access-to-care-across-the-system.

3 Canadian Institute for Health Information, "Canadians with a Regular Health Provider," accessed September 15, 2026, https://www.cihi.ca/en/indicators/canadians-with-a-regular-health-provider.

4 Livio Di Matteo, "Canada Has More Doctors than Ever Before. Here's Why It Doesn't Feel like It: DeepDive," *The Hub*, August 5, 2024, https://thehub.ca/2024/08/05/deepdive-canada-has-more-doctors-than-ever-before-heres-why-it-doesnt-feel-like-it/; Gregory P. Marchildon and Livio Di Matteo, "Physician Workforce Planning and Boom–Bust Economic Cycles: A Retrospective on the Barer–Stoddart Report," *CMAJ* 195, no. 4 (2023): E162–E166, https://www.cmaj.ca/content/195/4/e162.full.

5 Boris Kralj, Rabiul Islam, and Arthur Sweetman, "Long-Term Trends in the Work Hours of Physicians in Canada," *CMAJ* 196, no. 11 (2024): E369–E376, https://www.cmaj.ca/content/196/11/E369.

6 Terrence McDonald et al., "Family Physician Count and Service Provision in Ontario and Alberta between 2005/06 and 2017/18: A Cross-Sectional Study," *CMAJ Open* 11, no. 6 (2023): E1102–E1109, https://www.cmajopen.ca/content/11/6/E1102.

Yet, as documented by the CIHI National Health Expenditure Database (NHEX), both total spending on physicians as well as spending per physician continue to rise; physicians are working less and earning more.

This should not come as a surprise—international comparisons reveal that our health system has been characterized by greater spending on lesser outcomes for some time.[7]

In the end, why we face increased spending and less access is a complicated question that may have answers in the way physicians are compensated for their work.

[7] Livio Di Matteo, "How Can We Spend So Much on Health yet Still Fail So Badly?," *The Hub*, April 23, 2021, https://thehub.ca/2021/04/23/livio-di-matteo-how-can-we-spend-so-much-on-health-yet-still-fail-so-badly/.

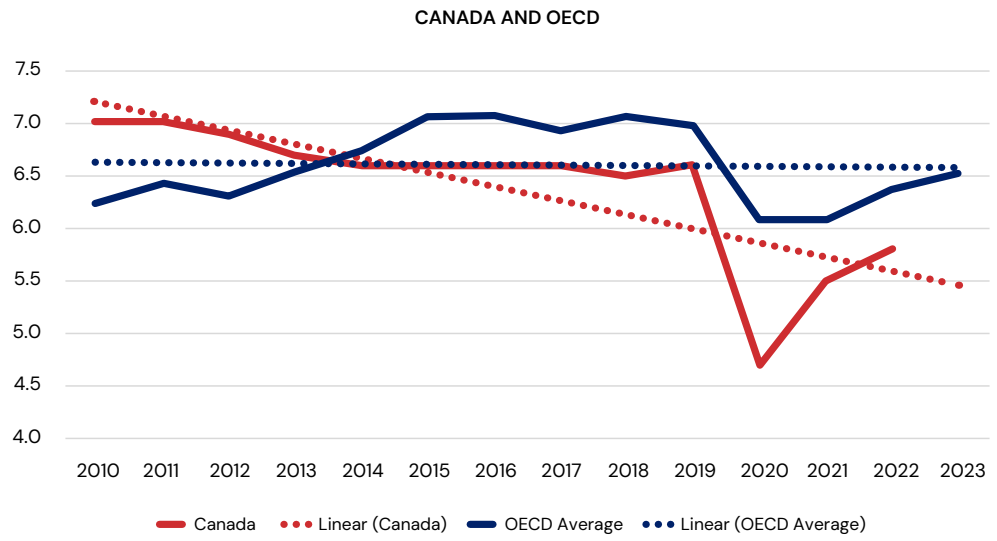
Access to Doctors

To start although historically Canadians have had fewer physicians per capita than other OECD countries, the evidence is that they actually had relatively more access to physicians than the OECD average, as seen in **Figure 1**. Two noteworthy observations can be made.

Until 2014, Canadians had more consultations per capita than the OECD average, but then fell below. Canadian consultations declined from 2010 to 2014, then levelled off until the pandemic, declined sharply, and have since grown.

However, the overall trend since 2010 is one of decline. OECD consultations per person rose from 2010 to 2015, levelled off, and then declined sharply during the pandemic, but have since rebounded, with the overall trend being flat over the entire period.

Figure 1: In Person Consultations with Medical Doctors per Person



Source: OECD Health Statistics and author's calculations

The decline in per-person consultations has occurred alongside the increase in physicians per capita and rising total billed services. Yet, there is also a decline in billed services received per capita as well as a decline in services provided per billing physician.

The distinction here is an important one. The National Physicians Data Base (NPDB) maintained by the CIHI provides detailed historical and current data not only on the total number of physicians but also on physicians who are providing services via fee-for-service, with details on the number and types of services and payments.[8]

[8] Canadian Institute for Health Information, "National Physician Database (NPDB) Metadata," accessed September 15, 2026, https://www.cihi.ca/en/national-physician-database-npdb-metadata.

Compensation

Physicians are compensated through a variety of approaches, but the predominant approach covering about 70 percent of physicians' payments is from fee-for-service (billing of health ministries), with 96 percent of physicians in Canada receiving some payments from this source.[9]

Other payment methods that are available to both billing and non-billing physicians are known as alternative payment plans (APPs) and include salaries, capitation, and other contracts. While physicians working in hospitals and EDs are often on contracts or salaries, physicians have increasingly participated in capitation methods, which involve rostering patients and receiving a per-person payment from provincial health ministries that is usually graduated according to age, gender, and patient complexity.[10] This payment is provided independently of seeing a patient and providing services that are still billed for.

The logic behind capitation schemes is that it allows physicians to cover fixed costs of having a practice as well as improve the quality of care by being able to spend more time per patient rather than churning them through to obtain fees.[11]

At the same time, as any economist would tell you, people respond to incentives, and if one can earn the same income stream by rostering patients and seeing them less, then one might expect to see a decline in consultations per physician as well as a decrease in billed services per physician.

Figure 2 plots two series using data from the National Physician Database.[12] First, there is the total number of services billed by physicians for fiscal years 1996/97 to 2023/24, and second, there is the number of billed services per 100,000 population. The first point is that physicians have indeed provided more billable services over time, with the annual average growth rate at just under 1 percent annually.

However, those services have not kept pace with population growth, and the billed services per 100,000 population have declined at an average annual rate of one-third of 1 percent.

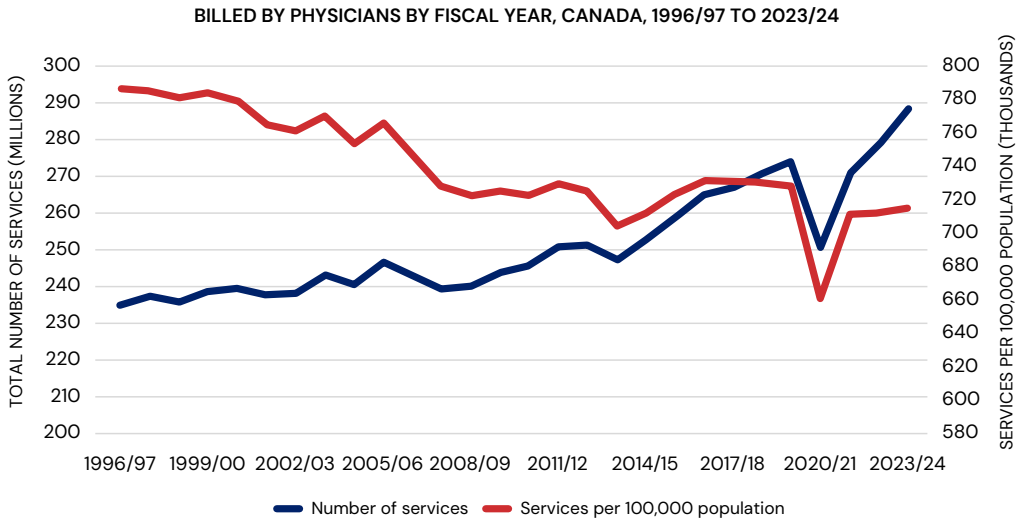
9 Canadian Medical Association, "How Do Doctors Get Paid in Canada?," March 23, 2026, https://www.cma.ca/healthcare-for-real/how-do-doctors-get-paid-canada.

10 Ontario Medical Association, "FHO Capitation and CCM Rates," 2022, https://www.oma.org/siteassets/oma/media/pagetree/pps/starting/primary-care-models/fho_capitation_and_ccm_rates_final.pdf; "New Capitation Rates for FHO Physicians and FHN Physicians," Stewart Medicine, 2024, https://stewartmedicine.com/wp-content/uploads/2024/04/new-capitation-rates-for-fho-physicians-and-fhn-physicians.pdf.

11 Roger Collier, "Shift toward Capitation in Ontario," *CMAJ* 181, no. 10 (2009): E237–E238, https://www.cmaj.ca/content/181/10/668.

12 "Ontario Building Permit Cost Calculator," Builders Ontario, accessed September 15, 2026, https://buildersontario.com/ontario-building-permit-cost-calculator/.

Figure 2: Total Number of Services and Services per 100,000 Population

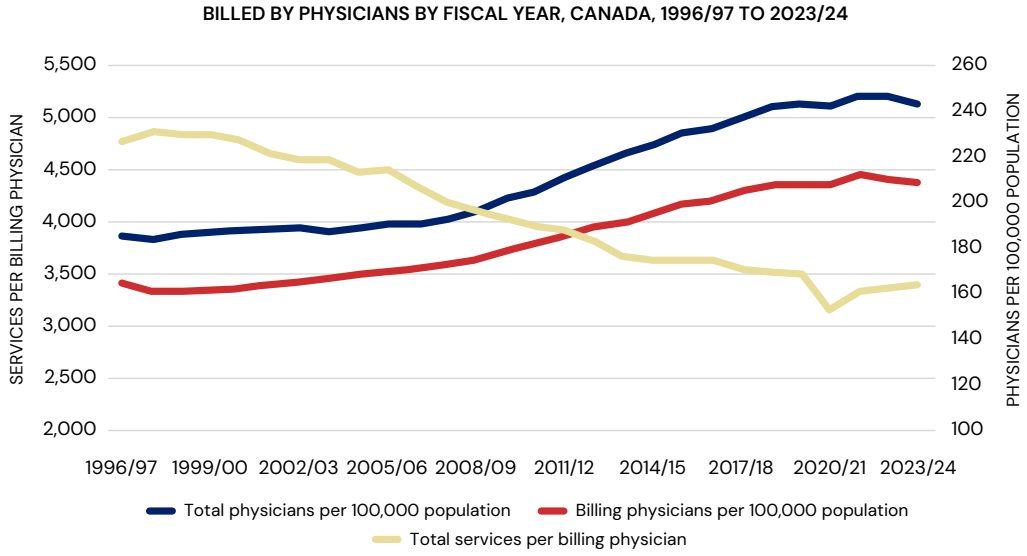


Source: NPDB and author's calculations

This situation is not the result of a falling number of physicians per capita, as **Figure 3** illustrates. **Figure 3** plots the total number of physicians per 100,000 as well as the number of billing physicians per 100,000. This is an important distinction as some physicians are paid by salary or some type of alternate contract for their services and consultations—for example, in hospital settings or working for a public health unit.

As **Figure 3** illustrates, the number of physicians per 100,000 population has grown. From 1996/97 to 2023/24, the total number of physicians per 100,000 population grew from 186.5 to 243.0 for an increase of 30 percent, while the number of billing physicians went from 164.7 to 208.7 per 100,000 for an increase of 27 percent. However, the services per billing physician declined by 28 percent—going from 4,775 to 3,426.

Figure 3: Physicians per 100,000 and Total Services per Billing Physicians



Source: NPDB and author's calculations

Physicians Are Earning More and Doing Less

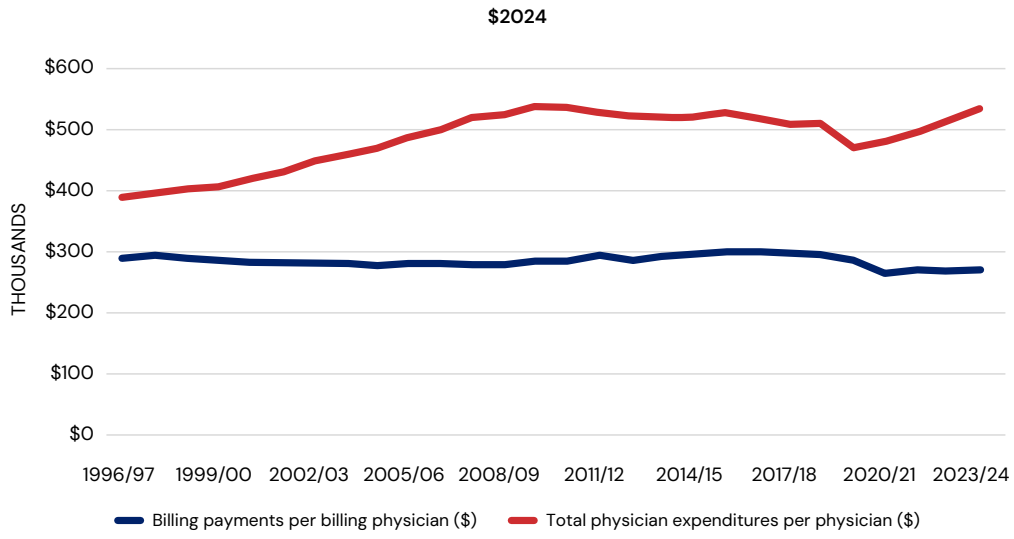
Despite the decline in services billed, physicians have managed to maintain their revenue flow. **Figure 4** presents two ways of looking at physician incomes. The first is real per capita total spending on physicians as provided in the CIHI-NHEX. The second is the real value of billings per billing physician. Since 1996/97, total spending per physician adjusted for inflation has grown and stands at $535,515 (in 2024 dollars)—an increase of 37 percent over nearly 20 years or an average of 1.4 percent annually.

This is hardly a lavish growth rate, and one must also remember that spending of $535,515 per physician annually in 2024 is before whatever physicians need to deduct for the costs of their practices.

The second way is looking at the total value of billings per billing physician, and these, after adjusting for inflation, have stayed relatively stable. However, as a share of total spending per physician, since 1996/97, they have declined from 75 percent of total spending per physician to 50 percent.

In other words, the gap in revenues between billing and alternate payment revenues has grown, and while physicians who bill have the same billing revenues in real terms as they did nearly 20 years ago, they are providing fewer services.

Figure 4: Real Billings per Billing Physician & Real Physician Spending per Physician



Source: NPDBand CIHI-NHEX and author's calculations

This suggests that, on average, physicians are indeed earning more but probably doing less. Indeed, **Figure 5** plots the total services per billing physician against the billing payments per billing physician for the 1996/96 to 2023/24 period, and the result reveals a hump-shaped curve.

That is, as real payments per physician rise from just under $265,000 to about $285,000, services billed per billing physician rise from approximately 3,000 to about 4,500.

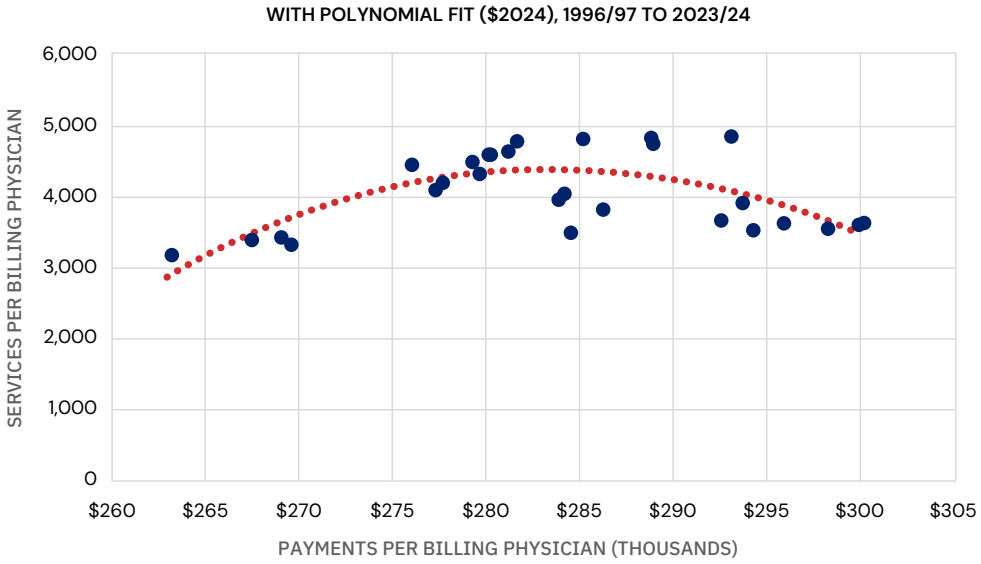
However, as the payments per physician continue to rise past $285,000, billed services per billing physician fall to about 3,500. Labour economists might describe this as an example of a backward-bending labour supply curve—that is, as income rises, there is ultimately a substitution of leisure (read work-life balance, for lack of a better term) for more money.

We have a situation where doctors, for very legitimate reasons, want work-life balance. They are essentially opting for alternate payment systems that allow them to earn the incomes that physicians are accustomed to, but often with smaller practices in terms of patients, both registered and visiting.

Emergency Departments Fill the Gap

The bottom line remains, though: there are more Canadians without a family physician now than there were 20 years ago, and even those who do have a physician appear to have difficulties in timely access. As a result, EDs are taking the overflow, providing a lot of primary care in an emergency services setting. This increased demand in turn is also fuelling burnout of ED physician resources.[13] And, Canadians in general are paying more for all this as measured by the rising total health expenditure to GDP ratio, which was 12.7 percent in 2025 as opposed to 8.7 percent in 1996.

Figure 5: Total Services per Billing Physician vs. Total Payments per Billing Physician



So, what is to be done? The goal of a public health-care system is to provide insured services that are available and accessible to the public. If we are unable or unwilling to allow more private providers and out-of-pocket payments to enter the system to fill the gap, then we need to address the institutional mechanisms whereby we have more physicians earning more and providing fewer services, with an ever-larger number of Canadians forced to rely on emergency departments for care.

[13] Kyla de Wit et al., "Emergency Physician Burnout and Attrition in Canada: A Longitudinal Study," *CMAJ* 198, no. 27 (2026): E1055–E1063, https://www.cmaj.ca/content/198/27/E1055.

Solutions

One can think of two solutions.

First, overhaul the entire payment system for physicians by eliminating capitation and alternate payments and returning to a completely fee-for-service system. It is true that some aspects of such a complete return to fee-for-service will affect aspects of quality of care, but at the same time, physicians will have an incentive to see more patients because that is how they will have to earn their incomes.

Such a system, however, will certainly encounter resistance from the many physicians who like the work-life balance they've now become accustomed to.

Second, if we are instead to retain the current system mixing fee for service with alternate payment systems like capitation because it provides more intensive patient experiences for those with a doctor and better work-life balance for physicians, but off-loads the remaining patients to emergency departments, then those emergency departments should receive the resources they need.

That is, every emergency department needs to have a staffed primary care clinic alongside the ED departments that takes patients who have come to the emergency but have been triaged as non-urgent.

The physician staff at these Hospital Primary Care Centres would be salaried physicians and can be staffed with the thousands of international medical graduates who want to work as physicians but are currently enmeshed in a lengthy accreditation process that seems designed to restrict supply rather than approve physicians. It's not a stretch to assume that many of these international medical graduates would be quite happy to provide their services and use their training in a hospital-based clinic setting for a salary.

The assorted memberships of Canadian medical associations will likely raise numerous caveats and cautions to such a move. But it is ungracious, to say the least, to want to see fewer patients but then prevent others from seeing them.

Will more salaried physicians cost more money? Certainly. But it is worth trying to see if, for once, we can design a solution in which spending more on health actually solves the primary care access problem that millions of Canadians face.

What is there to lose at this point?

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