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The Quebec Primary Care Conundrum: Good Intentions, Persistent Problems

Quebec has spent two decades reforming primary care, but access remains among the worst in Canada. This report shows how coercive policies, misaligned incentives, and underused team-based care have deepened the crisis. It outlines a roadmap to improve existing capacity and rebuild timely, patient-centred care.

Tingting Zhang

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ABOUT THE AUTHOR

TINGTING ZHANG
is a Policy Analyst at the
C.D. Howe Institute.

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THE QUEBEC PRIMARY CARE CONUNDRUM: GOOD INTENTIONS, PERSISTENT PROBLEMS

by Tingting Zhang

- Despite increased physician supply, substantial investment, and multiple structural changes, Quebec's primary care reforms over the past two decades have yielded limited improvements in access. Over one-quarter of Quebecers still lack a regular provider, and emergency rooms remain heavily burdened by primary-care-treatable cases.
- Coercive policies such as regional medical staffing plans, mandatory hospital work, and recent legislation like Bills 83 and 2 have made family medicine less attractive, driving new graduates away and reducing the clinical time family doctors spend on comprehensive primary care.
- Team-based care, introduced through family medicine groups, has not reached its potential due to misaligned incentives, limited task-sharing, and a fee-for-service payment model. As a result, physician capacity is underused and non-physician professionals remain insufficiently integrated.
- Sustainable improvement requires coordinated, structural reform. This includes transitioning to risk-adjusted capitation payment models, fully integrating nurse practitioners and pharmacists into care teams, mandating patient enrollment with clear accountability, and establishing robust performance measurement systems with transparent public reporting.

INTRODUCTION

Millions of Canadians are without a primary care provider – a reality that has dominated headlines for the past three years. This public concern has created momentum for reform, and federal, provincial and territorial governments have invested billions to address the issue. Yet tangible progress has been limited.

Quebec stands out as a case study. Despite more than two decades of primary care reforms, it continues to rank among the lowest in Canada for access. Nearly 26 percent of residents lack a regular healthcare provider¹ – significantly higher than the national average – and three-quarters report difficulty accessing

1 A regular healthcare provider is defined as a health professional that a person sees or talks to when they need care or advice about their health. This can include a family doctor or general practitioner, medical specialist, nurse practitioner, or other.

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same-day or next-day appointments and after-hours care. However, Quebec has more family physicians per capita than most Canadian provinces. Quebec is also the only province that allows physicians to completely withdraw from the public insurance system and permits non-participating doctors to be paid via private insurance (Fierlbeck 2025). With more choices for its residents, high physician density, and a long history of reforms, why does Quebec still struggle so much to provide timely access to care?

This paper examines Quebec's primary care reforms over the last two decades and finds that, despite significant changes to governance, funding and service delivery, these efforts have achieved limited success in improving access to primary care. Several reforms, most notably penalty-based measures such as Bill 20, remain unique to Quebec. Evidence shows that these "stick-based" approaches have little demonstrable impact on access. Family physicians in Quebec also tend to work fewer hours on comprehensive care than in other provinces, partly because the mandatory hospital shifts divert their time to secondary care. With more restrictive working conditions, physicians are increasingly opting out of the public system. All of this contributes to its existing access crisis. As the population ages and healthcare demand increases, patients are seeking alternative forms of care, such as private virtual care and walk-in clinics.

Quebec's recent legislative efforts highlight the urgency for change, but they also carry potential missteps. Bill 2, which proposed an overhaul of the payment model, was passed through legislative closure to limit debate, sparking significant controversy. Although the government's commitment to improving access appears genuine, many elements of Bill 2 fail to incentivize physicians, do not support team-based care or patient outcomes and, in some cases, actively discourage them. The bill continues to rely on a "stick" approach which, based on the results of previous reforms, is unlikely to succeed. Implementation continues to evolve amid resistance

from the province's two medical professional organizations (the *Fédération des médecins omnipraticiens du Québec*, FMOQ and *Fédération des médecins spécialistes du Québec*, FMSQ), with several measures already partially suspended.

The status quo is indeed failing and maintaining the current trajectory will only increase costs while worsening outcomes. Training more family physicians or simply increasing their pay will not resolve the crisis. Addressing Quebec's primary care challenges requires coordinated, structural reform that establishes a central allocation architecture to define responsibility, funding, equity and outcomes, while leaving the design of the care model to local teams. Quebec has repeatedly inverted this structure: it centralizes model design while leaving allocation fragmented and reactive. This is why reforms fail even when intentions are good.

Apart from this, the transformation also needs to encompass:

- optimizing family physicians' time allocation toward direct patient care;
- building effective team-based care models through payment reform, better integration of other healthcare professionals and mandatory patient enrollment; and
- establishing robust monitoring and evaluation systems that enable continuous improvement based on emerging evidence.

Provinces across Canada face similar challenges in access and staffing, and many are implementing innovative initiatives to improve primary care. As they adapt their systems, lessons from two decades of reforms in Quebec can help avoid repeating past mistakes, refine policies for greater effectiveness, and minimize unintended consequences. Provinces considering Quebec-style structures should be mindful of its cautionary tale: highly centralized systems do not automatically improve access. Expanding interdisciplinary teams may seem progressive, but without mandatory patient enrollment and clear accountability mechanisms, it merely adds costs without creating incentives for coordinated, cost-effective care. Likewise,

expanding the scopes of practice of other primary care providers has minimal impact when the system continues to only reward physicians for billable services and fails to integrate them into teams.

The most impactful reforms are often the most difficult to implement. Yet Quebec's two-decade experience offers a clear lesson: avoiding these structural changes only ensures further deterioration of the system. Incremental adjustments may provide temporary relief, but they cannot resolve the access crisis without tackling its root causes: a poorly designed system that discourages integrated care and squanders limited physician capacity.

CURRENT STATE OF CARE

The significance of primary care is well established. As the foundation of the Canadian health system, primary care providers act as gatekeepers – diagnosing and treating illnesses, managing chronic conditions, delivering preventive care, and coordinating with specialists to support patients holistically. Extensive evidence indicates that a robust primary care system enhances care quality, reduces costs and lowers mortality rates (Zhang 2024).

Yet, primary care is in crisis in Canada. In 2024, 17.4 percent of Canadians reported having no regular healthcare provider – slightly higher than in 2015 (16.8 percent) (CCHS 2015 and 2024). Under medicare, patients expect access to a primary care provider and the insured services that accompany that care. However, the fact that nearly six million Canadians lack a regular healthcare provider suggests that most provinces are failing to meet their residents' expectations.

Quebec performs the worst among provinces on this measure, with residents consistently reporting the highest rates of not having a regular healthcare provider between 2015 and 2021. In 2023 and

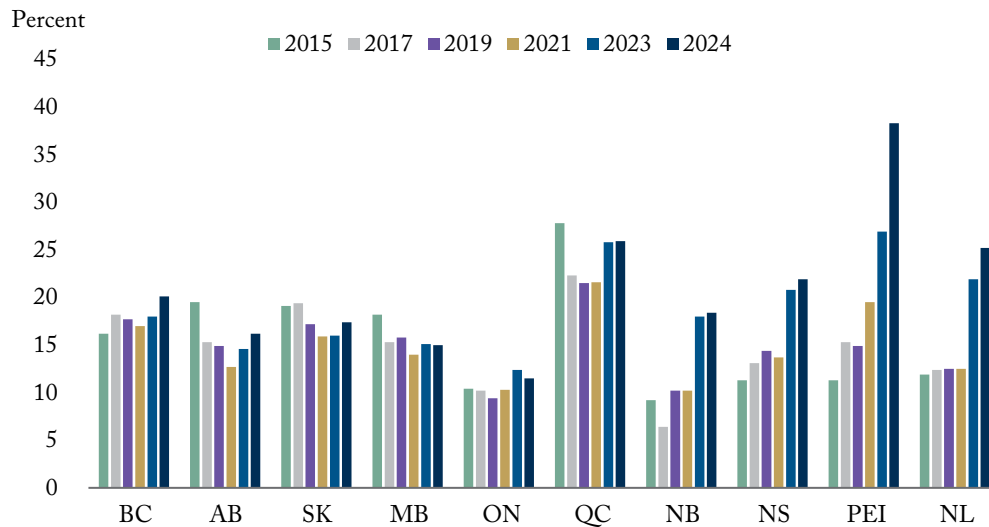
2024, Prince Edward Island surpassed Quebec in this measure. Quebec's access issue, however, has been chronic and persistent for over a decade. In 2024, more than one-quarter of Quebecers were without a provider – a rate significantly above the national average – despite the province's relatively high health spending of 13.3 percent of GDP (Arpin, Gautier, and Quesnel-Vallée 2025a). In contrast, Ontario² has reported the lowest share of residents without regular healthcare providers, while its health spending is below the national average.

In 2022–2023, about 2.1 million Quebecers were not registered with a family doctor (Plé et al. 2024). Nearly half a million had moderate to significant health conditions requiring ongoing care, yet their access was limited to walk-in or semi-urgent clinics. Those with multimorbidity among this group are particularly vulnerable, experiencing significantly higher mortality rates than those with long-term attachment (15+ years) to a family physician (Fitzsimon et al. 2025). Fitzsimon et al. (2025) estimated that if all unattached Ontarians had long-term attachment, approximately 8,200 deaths could have been prevented. Given that Quebec has an even larger share of unattached residents, thousands of deaths could similarly be avoided if long-term attachment were achieved.

Unsurprisingly, those without a family doctor turned to emergency departments (ERs) more often than registered patients (Plé et al. 2024). The reliance on ERs for conditions that could be treated in primary care carries significant cost implications. The Canadian Institute for Health Information (CIHI 2024) estimates that one in seven ER visits nationwide were for minor conditions, such as colds, ear infections or antibiotic prescriptions that could have been managed in primary care. In 2024/25, Quebec hospitals recorded 1.5 million of these lower-acuity cases, representing 41 percent of all ER visits – well above the national average

2 Ontario is chosen as a comparator because it is the best-performing province in this regard and has undergone recent reforms to further improve primary care access.

Figure 1: Proportion of Residents Aged 12 and Older Without a Regular Healthcare Provider



Note: According to CIHI, the 2023 and 2024 data distinguish adults (aged 18 and over) from youth, meaning individuals aged 12-17 are not included. However, this is unlikely to significantly affect the overall access rate given the relatively small size of this age group.

Source: Canadian Community Health Survey, 2015, 2017, 2019, 2021, and 2023. Canadian Institute for Health Information.

(28 percent) and Ontario's rate (21 percent). With a primary care visit costing about \$56 compared to \$387³ for an ER visit in Quebec, redirecting such cases to primary care or community clinics could save Quebec's system millions of dollars while easing pressure on hospitals. However, ERs have remained the default option for many patients for immediate access to care, and this pattern has persisted for decades (Forget 2014).

TWO DECADES OF PRIMARY CARE REFORM

Quebec's challenges with primary care access predate the early 2000s. At the time, only 10 percent of patients could see their regular doctor within a day, and one in four Montreal

residents lacked a family physician (Haggerty et al. 2007). Since 2000, the province has implemented several major reforms to improve access (Table 1). In 2002, the family medicine groups (*Groupes de médecine de famille* or GMFs) were introduced to improve accessibility and continuity of care through interdisciplinary teams (Levesque et al. 2010). GMFs typically consist of six to ten family physicians (FPs), two nurses, and two administrative assistants, serving approximately 15,000 rostered patients (Breton et al. 2011). The goal of GMFs is to provide timely care to their patients through extended after-hours care and an on-call system specifically designed for patients with complex, chronic conditions (Levesque et al. 2010). Participation is voluntary; physicians are primarily paid on a fee-for-service (FFS) basis, with

3 For more information, see <https://www.ciuss-ouestmtl.gouv.qc.ca/en/visitors/fees-and-payments/hospitalization-fees>

additional operational funding, a small per-patient bonus, and contractual obligations to meet after-hours coverage targets.

Although early evaluations reported some positive effects (Beaulieu et al. 2006; Pineault et al. 2009), later studies suggest that GMFs fell short of their expectations in improving access. Research found no significant gains in reported access or unmet needs compared with other primary care models (Dunkley-Hickin 2013; Levesque et al. 2012a; Strumpf 2014), even as GMFs reported better continuity and after-hours care (Tourigny et al. 2010; Aubin and Quesnel-Vallée 2016). Pineault et al. (2016) concluded that GMFs may have slowed, but not reversed, the ongoing decline in access, with little measurable impact on care outcomes or service use.

The Auditor General of Quebec (2015) also found that GMFs and network clinics had not fully met ministry objectives, primarily due to unclear rules, insufficient guidelines and incentives, and a lack of oversight by the ministry and regional agencies during implementation. The original GMF target of 1,200 to 1,500 patients per FP fell well short, averaging only 837 patients per physician (Forget 2014; Peckham, Ho, and Marchildon 2018). Patient registration barely increased, leaving the share of Quebecers with a regular doctor essentially unchanged. Between 2009 and 2014, the number of physicians participating in GMFs increased by 41.5 percent, yet registered patients rose by only 5.9 percent (VGQ 2015). While extended hours were often the only feature distinguishing GMFs from other clinics, many GMFs failed to meet their after-hours access obligations (Dunkley-Hickin 2013; Forget 2014; VGQ 2015; Aubin and Quesnel-Vallée 2016). Yet, the ministry and regional agencies continued funding GMFs without evaluating whether their regulations or agreements were improving access, leaving GMFs and network clinics with wide latitude but limited accountability (VGQ 2015, 2020).

The initially proposed capitation model was replaced by a mixed system, still dominated by

fee-for-service but supplemented with bonuses for specific services and patient registration.

Later, however, the patient registration bonus was extended to physicians outside GMFs, thereby weakening the distinct financial incentives associated with GMFs (Pomey, Martin, and Forest 2013). By broadening the remuneration structure, non-GMF clinics could operate much like GMFs – enjoying higher pay but without the GMF label or its associated accountability framework. As a result, the GMF reform had only marginal effects.

In 2003, Quebec passed Bill 25, restructuring its healthcare system by replacing eighteen regional health boards with a three-tiered structure: the Ministry of Health and Social Services at the top, fifteen new intermediary administrative agencies in the middle, and ninety-five health and social services centers (CSSSs) at the local level (Bourque and Quesnel-Vallée 2014). The agencies served as administrative intermediaries between frontline care and the ministry, monitoring population health, allocating funds, and reporting on performance, while CSSSs provided an administrative umbrella for local health and social institutions that delivered direct patient care.

In effect, assigning the agencies significant managerial authority shifted greater decision-making power to the provincial level (Pomey, Martin, and Forest 2013). The new public management principles driving the reform, particularly accountability and performance reporting requirements, created excessive centralization incompatible with patient-centred care (Bourque and Quesnel-Vallée 2014). Problems with accessibility persisted and many Quebecers still lacked access to a family doctor. Although the reform was intended to advance regionalization, its structure and implementation may have inadvertently enabled the centralization efforts that led to the system's overhaul through the 2015 reform (Pomey, Martin, and Forest 2013; Arpin, Gautier, and Quesnel-Vallée 2025b).

Table 1: Major Primary Healthcare Reforms in Quebec since 2000

Year	Major Reforms	Results
2002	Family medicine groups (<i>groupes de médecins de famille</i> or GMFs) were established to improve access to and continuity of primary care, reduce emergency visits, and promote team-based models of care.	362 GMFs* were created as of August 2022. Little to no improvement in access.
2003	The Act Respecting Local Health and Social Services Network Development Agencies (Bill 25) was passed; the act overhauled the organization of the healthcare system by assigning population health responsibilities to health administrative regions.	A three-tier administrative system was created, with a 10-year lifespan; did not lead to meaningful improvements in access.
2013	An Act to Amend the Pharmacy Act (Bill 41) was passed, allowing pharmacists to adjust medication dosages, renew existing prescriptions, prescribe medication for minor conditions, and order lab tests.	Effective.
2015	The Act to Enact the Act to Promote Access to Family Medicine and Specialized Medicine Services and to Amend Various Legislative Provisions Relating to Assisted Procreation (Bill 20) was introduced to address persistent gaps in access, orphan patients, and challenges with after-hours care.	Attachment and continuity of care temporarily improved, but not with access.
2015	The Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies (Bill 10) was passed; the act overhauled the organization of the healthcare system by merging health establishments and centralizing power to the Ministry of Health and Social Services.	Moving toward more centralization; no evidence on improvement in access.
2020	An Act to Amend Mainly the Pharmacy Act to Facilitate Access to Certain Services (Bill 31) was passed to further expand the scope of practice of pharmacists to administer vaccines.	Effective.
2020	The Act to Amend the Nurses Act and Other Provisions in Order to Facilitate Access to Health Services (Bill 43) was passed to further expand the scope of practice of nurse practitioners.	Effective.
2022	An Act to Increase the Supply of Primary Care Services and to Improve the Management of that Supply (Bill 11) was passed to change how general practitioners can add to their caseloads through the Quebec Family Doctor Finder (the GAMF).	Unclear.
2025	The Act Mainly to Establish Collective Responsibility with Respect to Improvement of Access to Medical Services and to Ensure Continuity of Provision of Those Services (Bill 2) was passed to improve access by holding physician groups collectively responsible, centralizing patient registration, and imposing performance targets.	Early stage of development; unclear.

* For more information, see <https://patientsmedicalhome.ca/pmh-in-canada/pmh-quebec/>.

Source: Author's compilation with adoption from Arpin, Gautier, and Quesnel-Vallée (2025b).

In 2015, Quebec passed Bill 10 to further centralize decision-making and reduce administrative layers, mirroring similar reforms in Alberta and Nova Scotia, which had consolidated multiple regional health authorities into single provincial bodies during this period. The reform abolished the fifteen agencies established in 2003, moving from a three-tiered to a two-tiered system, while merging 182 facilities into 34 integrated health and social services centers (CISSSs/CIUSSSs) responsible for both oversight and care delivery (Quesnel-Vallée and Carter 2018). Proponents argued that the restructuring would reduce bureaucracy, increase direct accountability to the ministry, enhance transparency, and improve service integration (Arpin, Gautier, and Quesnel-Vallée 2025b). However, experts noted that the reform lacked evidence on achievable economies of scale, optimal organizational size, or whether vertically integrated structures could respond to diverse population needs (Béland et al. 2014; Quesnel-Vallée and Carter 2018). Evidence supporting administrative mergers to improve access or service quality is limited (Béland et al. 2014). The governance model – where each CISSS/CIUSSS board of directors is appointed directly by the ministry and reports to it – was also criticized as increasingly political rather than evidence-based (Quesnel-Vallée and Carter 2018). Over time, this highly centralized structure created significant challenges for public health governance and health human resource management, issues that became

particularly visible and were amplified during the COVID-19 pandemic (Arpin, Gautier, and Quesnel-Vallée 2025b).⁴

In 2015, in response to persistent access issues, Quebec also passed Bill 20 to expand primary care availability. The legislation⁵ required FPs to register a minimum number of patients, with non-compliance resulting in a 30 percent fee reduction (Young 2015).⁶ This reform marked a departure from previous reforms, adopting a “stick” rather than a “carrot” approach to influence physician behaviour. Within three years, both patient registration and continuity of care improved: by December 31st, 2018, 81 percent of the Quebecers were registered with a primary care physician – up from 68 percent before the reform, though short of the 85 percent target – and continuity of care rose from 68 percent to 84.4 percent (Laberge and Gaudreault 2019). While coercive measures can provoke strong opposition, Bill 20 nonetheless produced measurable gains, even without the complete application of penalties. At the same time, the bill generated unintended consequences. Its coercive and punitive nature made family medicine less attractive to new medical graduates, thereby increasing the difficulty of attracting and retaining physicians in the field. Over the past decade, the pay gap between FPs and specialists has also widened, further undermining the appeal of family practice (Laberge and Gaudreault 2019).⁷

4 In 2024, Santé Québec was created as the government corporation responsible for health and social services across the province.

5 The bill also requires FPs to work a minimum number of hours in a hospital setting. It revises the distribution of medical staff between the hospital and the medical clinic by adjusting the AMP.

6 Gore, Brian. 2017. “Opinion: Two Years in, Quebec Health Reforms have Brought Malaise.” *Montreal Gazette*. <https://montrealgazette.com/opinion/columnists/opinion-two-years-in-quebec-health-reforms-have-brought-malaise>

7 Unlike other provinces, Quebec has two separate medical associations, one for family physicians and one for specialists. As a result, the province must negotiate with each group individually rather than through a single organization such as the Ontario Medical Association. This dual-negotiation structure limits the Ministry of Health’s ability to influence compensation across different types of physicians.

Since 2013, Quebec has expanded the prescribing and diagnostic powers of other health professionals, such as pharmacists and nurse practitioners, to improve access to care and free up physicians' time to manage more complex cases (Table 1). This approach has been adopted in other provinces, such as Alberta and the Atlantic provinces, with demonstrated efficiency and relatively low-cost gains in improved access to primary care (Richards 2024).

Quebec's recent legislation, Bill 106 and Bill 2, represents a significant attempt to use "stick" again to change physician behaviour. Introduced in May 2025, Bill 106 proposed shifting family physicians from FFS to a blended model combining capitation, hourly rates, and performance-based compensation.⁸ The bill tied 10 percent of physician pay (initially 25 percent) to meeting government-set targets for patient volumes, particularly those with vulnerability codes, while automatically registering all Quebecers to clinics regardless of capacity. Physician groups are collectively responsible for meeting access goals. If targets are not met, everyone in the group faces pay reductions, regardless of individual effort or patient complexity.

When contract negotiations with medical professional organizations stalled, the government passed Bill 2 in October, aiming to end the labour dispute. The law incorporates most Bill 106 proposals but adds strict penalties for "concerted action" by physicians, prohibiting collective withdrawal from activities or teaching stoppages to challenge government policies. The move sparked widespread outrage. At the time of writing, the situation remains volatile: at least 125 doctors have completed processes to practice in Ontario, with 200 more

in progress.⁹ The medical directors of regional departments of family medicine have also refused to comply with parts of Bill 2, stating they will not assign 1.5 million orphan patients to already overburdened physicians and clinics.¹⁰ Given past failures and ongoing physician resistance, this approach seems unlikely to succeed in improving access.

Quebec has been active in pursuing health reforms over the past two decades, along with other organizational innovations (Box 1), yet these efforts have had limited impact on improving access to care. Despite many attempts to influence physician behavior, Quebec continues to report the highest proportion of residents without a regular healthcare provider among Canadian provinces. Several reforms, most notably coercive quota and penalty-based measures such as Bill 20 and Bill 2, remain unique to Quebec. To date, evidence shows that these approaches have strained physician morale and relationships, with little demonstrable improvement in access.

Like other provinces, Quebec has also shifted away from earlier regionalization initiatives toward increasingly centralized governance structures since the early 2000s (Arpin, Gautier, and Quesnel-Vallée 2025b). Despite differing approaches across jurisdictions, Canada as a whole continues to lag its international peers in timely access to primary care (Zhang 2025). This suggests that provincial strategies, including Quebec's, have failed to address the fundamental structural barriers undermining access across the country.

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- 8 Lofaro, Joe. 2025. "What's in Quebec's controversial doctors' bill?" CTV News. <https://www.ctvnews.ca/montreal/article/whats-in-quebecs-controversial-doctors-bill/>
- 9 The Canadian Press. 2025. "10 days after gag order adoption of Bill 2, Santé Québec remains silent." <https://www.ctvnews.ca/montreal/article/10-days-after-gag-order-adoption-of-bill-2-sante-quebec-remains-silent/>
- 10 Hanes, Allison. 2025. "Update: Dubé pleads for time as family medicine directors vow to defy Bill 2". <https://montrealgazette.com/news/local-news/family-medicine-directors-across-quebec-vow-to-defy-bill-2>

Box 1: Central Waiting List and Primary Care Access Point

Since 2008, the Quebec government has established the *Guichet d'Accès aux Clientèles Orphelines* (GACO), a centralized waiting list to connect patients without an FP to one. The program's primary objective – boosting the number of residents enrolled with an FP – has largely been met since its launch, with about 10.9 percent of Quebec's population gaining a regular doctor (Breton, Gagne, and Gankpe 2014). This attachment improved both access to and continuity of primary care (Smithman et al. 2022). However, most of the growth came from non-vulnerable patients, while enrollment of vulnerable patients remained stagnant. Despite repeated adjustments to financial incentives for physicians to accept patients with rare and complex conditions, recruiting doctors to care for the most vulnerable remained a challenge (Breton, Gagne, and Gankpe 2014).

While the province's centralized waiting list has connected over a million patients with FPs since its implementation, both the number of unattached patients and the waiting time to be attached have continued to climb in recent years (Breton et al. 2024a). To help unattached patients access care while waiting for attachment, the Quebec government introduced primary care access points (*Guichets d'accès à la première ligne* or GAPS) in 2022. GAPS have improved short-term access to primary care services; however, they are less suited for older adults with chronic conditions who require ongoing, continuous care (Breton et al. 2024a).

Quebec's Unique Context

Health reforms often face two opposing forces – facilitators and barriers – that, in some ways, are two sides of the same coin. Facilitators include a strong financial commitment, active involvement of professional associations, gradual decentralization, and flexibility to adapt reforms to local needs (Levesque et al. 2012b). Barriers arise when funding is insufficient, professional associations resist, reform models are overly prescriptive, or governance is too centralized (Levesque et al. 2012b).

Since the inception of medicare, physicians have retained a high degree of professional autonomy, making large-scale changes difficult to implement. FPs in Canada have been reluctant to adopt organizational or payment models perceived as threatening their autonomy, especially when linked to cost containment (Hutchison et al. 2011; Aggarwal 2009; Aggarwal et al. 2023; Aggarwal and Williams 2019). Given this history,

most provinces have pursued incremental reforms that engage physicians voluntarily and link new initiatives to tangible benefits such as higher income, improved working conditions, or greater professional satisfaction (Strumpf et al. 2012; Hutchison et al. 2011). Provinces have typically negotiated reforms with medical associations and offered multiple organizational and remuneration models. This approach reflects the reality that system-level innovation in Canadian primary care is only possible with the support – or at least the acquiescence – of organized medicine (Hutchison et al. 2011).

In Quebec, however, a strong regulatory framework has led to many top-down and mandatory reforms being implemented (Levesque et al. 2012b and 2015). Family physicians in Quebec face many structural constraints. In 2004, Quebec's Health and Social Services Ministry (MSSS) and Quebec's federation of family doctors

(FMOQ) introduced regional medical workforce plans, known as *plans régionaux d'effectifs médicaux* (PREMs), to ensure equitable distribution of FPs across regions. Under the PREMs, newly licensed FPs must obtain a compliance notice from the regional departments of family medicine (DRMG)¹¹ before establishing a practice, or face a 30 percent cut in clinical service fees. Compliance notices are granted only if regional staffing targets have not yet been met.

By 2015, the PREMs became more restrictive. Physicians could no longer avoid penalties by choosing to work in hospitals rather than offices or homes (Fortin et al. 2025a), and the 30 percent cut was extended to all income billed through Quebec's public health insurer, the *Régie de l'assurance-maladie du Québec* (RAMQ). FPs with a compliance notice were also required to ensure that at least 55 percent of their billing days came from within their assigned region (or sub-region after 2015), or risk quarterly income penalties.¹²

In practice, PREMs cap the number of FPs in each Quebec region, with targets revised annually based on staffing gaps. When calculating new PREM allocations, the MSSS uses the total number of active physician licenses in a region as the denominator. This approach inflates the numbers, as it includes retired and semiretired physicians, family medicine teachers, researchers, and hospitalists (DeMore 2017). Patient mobility

further skews the numbers, since many individuals travel to Montreal or other cities for care. While PREMs regulate the geographic distribution of physicians, they do not control the type or volume of work physicians perform once assigned to a region. However, the distribution set out in PREMs is determined by each region's assessed needs for medical resources and the types of services FPs can provide. Thus, a discrepancy exists between the planned and actual provision of primary care services in a region. Restrictions on activity volume within establishments are instead guided by local staffing plans approved by the DRMG. As a result, a region could allocate most of its FPs to hospital-based activities without jeopardizing the medical resources it will receive in the following year's PREM allocation (VGQ 2015).¹³

However, this regional staffing policy has indeed been effective in redistributing physicians. Following PREMs, the proportion of new doctors practicing in university regions declined, while placements in peripheral areas and intermediate regions increased significantly (Fortin et al. 2025a). Between 1975 and 2021, the number of FPs per 100,000 residents increased from 47 to 191 in remote regions and from 69 to 146 in university regions (Fortin et al. 2025b). While PREMs helped address geographic disparities, they may contribute to physician shortages in urban areas, as the number of physicians who can work in

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- 11 To better coordinate primary care supply and planning, Quebec established DRMG, which works closely with regional health authorities and local health centers to control the placement of new FPs and decide whether they will fulfill their medical staffing obligations (Hutchison et al. 2011). On December 1, 2024, DRMG was renamed the Territorial Department of Family Medicine (DTMF). The department is made up of all family physicians in a given health region who receive remuneration from the RAMQ and practice in that region, including those who practice in a private professional office.
 - 12 A day is considered as soon as the physician has billed at least \$523 in the area. A half day is considered as soon as the physician has billed at least \$261.50, but less than \$523. A doctor may therefore devote up to 45 percent of their billing days to practising outside the area where they hold their compliance notice, either in another local services network in the same region, in one of Quebec's 17 other regions, or on part-time locums. For more information, see <https://fmrq.qc.ca/en/pems-prems/family-medicine/prem-process/your-obligations/#55-45-rule>
 - 13 Anecdotally, regional hospitals may overstate their demand for FPs, knowing they will receive only a portion of their request. This can create a gap between the number of FPs requested and the actual need for FPs for patient care, potentially inflating perceived demand and complicating broader workforce planning and projections at the provincial level.

Montreal has decreased over the years. Restrictions on practice location may also make family medicine less attractive relative to specialties, or push new doctors toward focused or private practice. For example, from 2000 to 2020, only a third of Quebec physicians claimed 90 percent or more of their billings from family medicine.¹⁴ Moreover, financial incentives intended to attract physicians to work in remote areas can risk encouraging physicians to reduce their working hours (Fortin et al. 2025a).

Unlike most provinces, Quebec also requires FPs to spend certain hours per week in institutional settings to provide secondary care. This is a policy dating back to 1991, when specific medical activities (AMPs) were introduced following an emergency department closure. Over time, regional authorities began setting the type and volume of physician services required, obligating FPs with less than 15 years of practice to commit 12 hours of AMPs per week or equivalent and cover activities such as emergency, hospital, or long-term care work. Those with more than 15 years of practice have reduced or flexible commitments based on billing volume.

All FPs practising under Quebec's public health insurance plan are required to devote part of their practice to AMPs. Non-compliance with this requirement results in a 30 percent cutback on physicians' total billings to the RAMQ. The DRMG determines the list of eligible AMPs in each region, grouped into six categories. Regional authorities identify their needs for physicians for each type of activity within the categories, and physicians are obligated to work on them. In addition to these priority activities, FPs may voluntarily perform other hospital-based duties. Because FPs receive the same fees as specialists for common medical procedures, hospital work offers

both professional and financial advantages (Forget 2014).

According to Forget (2014), the AMPs mechanism has succeeded to the point that community hospitals are now largely staffed and operated by FPs. The FMOQ reports that Quebec FPs spend about 35 percent of their time in provincial healthcare facilities, compared with just over 20 percent in the rest of Canada (FMOQ 2022).¹⁵ Slightly over half of FPs in Quebec work in two or more settings. While intended to address hospital staffing needs, the AMPs policy has had the unintended effect of diverting physician time away from community-based primary care (Forget 2014).

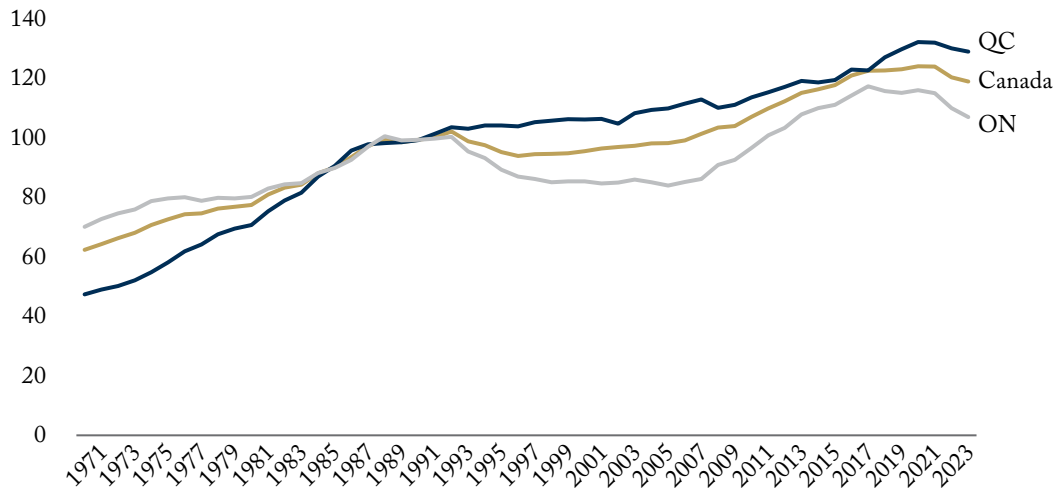
PREMs and AMPs distinguish Quebec's strategy for addressing geographic disparities in physician distribution. The mandatory obligations and penalties associated with these programs further reflect Quebec's "stick" approach to physician remuneration and distribution. In contrast, most other Canadian provinces, including Ontario, have favoured a "carrot" approach, using financial incentives to attract and redistribute health professionals across their jurisdictions. Quebec's approach may help explain the province's apparent paradox: despite having high family physician density per capita, access to primary care remains among the lowest in Canada.

Quebec has many assets to support a successful transformation, including its long-standing integration of health and social services, as well as numerous innovative projects and programs that have been tested across the health system (Vedel et al. 2011). However, significant challenges remain. Primary care reorganization, integration between primary and secondary care, and more effective governance and change management are

14 Ha, Tu Thanh. 2022. "Why Quebec's Family Doctor Crisis is the Worst in Canada." *The Globe and Mail*. <https://www.theglobeandmail.com/canada/article-quebec-family-doctors-shortage/>

15 In 2024-25, the FMOQ identified 9,907 practising family physicians in Quebec. Of these, 40 percent practise exclusively in front-line care, 20 percent do not practise in front-line settings at all, and the remaining 40 percent split their time between the first- and second-line care.

Figure 2: Family Physicians per 100,000 Population, since 1971



Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2024 – Historical Data.

still needed (Vedel et al. 2011). Silos persist at the clinical level, particularly between secondary and primary care, acute and long-term care, and social and medical care, hindering the delivery of comprehensive, coordinated care for patients with multiple chronic conditions. Equally concerning is the lack of accountability for GMFs and independent family physicians who fail to improve patient access. As Contandriopoulos and Brousselle (2010) argue, reforming primary care is less a matter of programs than of governance level.

INEFFICIENT USE OF EXISTING PHYSICIANS

Starting from a relatively low physician density in the 1970s, Quebec surpassed both the national average and Ontario's ratio by 1992 and maintained

a higher-than-average family physician per capita ratio ever since (Figure 2). In 2024, Quebec had 129 family physicians per 100,000 residents, compared to 107 per 100,000 in Ontario.¹⁶ Yet this has not translated into better access to care. Policies such as PREMs and AMPs have unintentionally limited physicians' availability to provide comprehensive care. Young FPs are often required to cover 24-hour on-call shifts, elder care, and obstetric and emergency services; in practice, few hospitals permit physicians to work fewer than 25 hours a week (Gladu 2007). Even in the early 2000s, the minister of health acknowledged that the imposition of AMPs had the perverse effect of reducing the number of medical practices and limiting patients' access to family physicians (Gladu 2007). Yet, these measures remain in place today.

16 Similarly, the Collège des médecins du Québec reported 10,695 family physicians in the province as of December 31, 2024, equivalent to 125.8 family physicians per 100,000 population. According to CIHI, only British Columbia and New Brunswick have a higher family physician per capita than Quebec.

Quebec physicians also work fewer hours on average than their Ontario counterparts (Forget 2014). Between 1987 and 1991, physicians in Quebec logged the fewest weekly hours in Canada. Over time, other provinces gradually converged toward Quebec's level, narrowing interprovincial differences (Kralj, Islam, and Sweetman 2024). This reflects a broader shift in work preferences: male physicians increasingly seek better work-life balance, while younger cohorts also place greater value on quality of life and often choose to work fewer hours.

An increasing number of FPs are also shifting into narrower scopes of practice, such as palliative care or sports medicine, which reduces their availability for comprehensive primary care. Ansari et al. (2025) estimate that nearly 40 percent of the growth in Canada's FP workforce over the past two decades has been concentrated in focused practice areas, with emergency, hospitalist care, and addiction medicine being the most common. These roles often offer higher remuneration, greater flexibility, stronger team support, and freedom from the overhead and administrative burdens associated with running a small business, all of which contribute to a better quality of life (Ansari et al.).

Recent RAMQ data reinforces this trend. In 2021, Quebec FPs reached a minimum billing threshold during only 37 weeks on average, implying that one in four weeks worked was not dedicated to FFS medical care (Benatia et al. 2025). Fewer than one in five physicians billed at least five days per week on average, while about one-third did so only three days or fewer. Benatia et al. (2025) also document a notable decline in the average number of patients seen per day between 2011 and 2023 – 17 percent among FPs compared to 8 percent among specialists. These figures indicate

a significant amount of unused capacity in the delivery of medical services in Quebec.

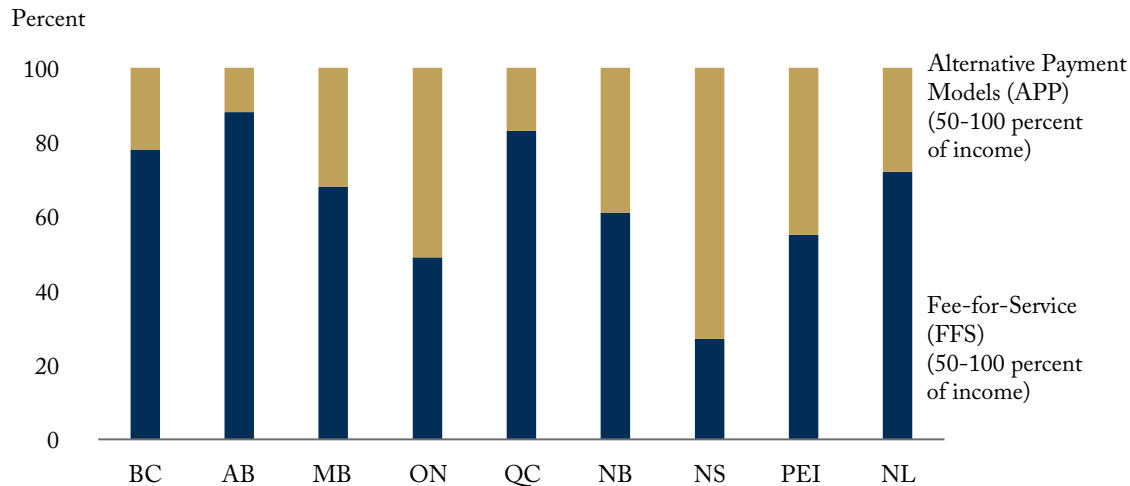
Comparing physician headcounts with full-time equivalent (FTE)¹⁷ shows that Quebec has a higher ratio than Ontario (Appendix Figure A). In Ontario, FPs generally work the equivalent of full-time clinical hours, making it the only province where this is consistently the case (Wyonch 2021; Zhang 2024). Although Quebec has more FPs per capita than Ontario, its FTE rate remains significantly lower – 88 per capita compared to 110 in Ontario. Between 2014 and 2023, the number of FPs in Quebec increased by 12 percent, while FTEs rose by 9 percent. This discrepancy suggests that, on average, fewer clinical services were being delivered as reduced practice intensity has offset the benefits of training new doctors (Benatia et al. 2025). As a result, improving patient access to primary care requires increasing clinical hours among existing physicians and reducing time spent on non-patient care and secondary services.

MISALIGNMENT BETWEEN REMUNERATION AND TEAM-BASED CARE

Quebec has more interprofessional primary care teams than any other province, yet it remains among those struggling the most with access. As of 2024, Quebec has 362 GMFs, with 65 percent of the population registered with a participating FP (Breton et al. 2024b; Corriveau et al. 2023). However, the full potential of team-based care has yet to be realized. Physicians and other healthcare professionals continue to struggle with collaboration and task-sharing within GMFs (Forget 2014), which creates risks of mis- or under-utilization of providers (Wankah et al. 2022). Ideally, tasks should be delegated to the practitioner with the lowest

17 As many family physicians work part-time, focus on research or hold administrative positions, a more meaningful measurement of physician supply is using the concept of full-time equivalent, where gross income per physician is used as a measure of output to model the full-time equivalent number of physicians.

Figure 3: Payment Models for Family Physicians by Province, 2023–2024



Source: Adapted from Peckham, Ho, and Marchildon (2018), with data from CIHI. National Physician Database – Payments Data, 2023–2024. Table A5. The author's calculation.

opportunity cost of time and greatest comparative advantage – for example, nurse practitioners (NPs) managing less complex cases. However, the predominance of FFS discourages physicians from delegating tasks to others, undermining team collaboration and the optimal use of nurses, nurse practitioners, and other providers within the teams.

In Quebec, FFS remains the dominant payment model for FPs and has changed little since 2007. FFS accounts for more than two-thirds of total clinical payments in the province (Appendix Figure B). By contrast, Ontario expanded alternative payment models between 2007 and 2012 through the rollout of family health teams and, since then, these models have accounted for more than half of total payments. In 2023 to 2024, the majority of

Quebec FPs reported that 50–100 percent of their income came from FFS, a pattern similar to that of British Columbia and Alberta (Figure 3). Only 17 percent relied primarily on alternative payment, one of the lowest shares in Canada.¹⁸

Between 2007 and 2023, total clinical compensation for Quebec FPs grew by 120 percent, among the highest increases nationally, with FFS payment rising at an average annual rate of 6.8 percent. In 2023, the average annual compensation per FTE FP in Quebec reached \$414,000, the highest in Canada, once adjusted for cost-of-living differences between provinces (second highest without adjustment; Benatia et al. 2025). Yet, service volumes declined over this period, indicating a negative relationship between compensation

18 The capitated component in GMFs has been gradually increasing over the years; however, FFS remains the dominant payment model. This persists even though nearly 2,200 family doctors who teach in GMF-U are paid using a mixed model of capitation, hourly rates, and fee-for-service acts.

and physician labour supply. Benatia et al. (2025) estimated that a 10 percent increase in fees is associated with a 3.9 percent decline in services provided and a 2.3 percent drop in visits.¹⁹ As a result, increasing the remuneration of practicing physicians is likely to lead them to reduce the number of hours or services (Wyonch 2021). This suggests that compensation-based incentives alone are unlikely to increase FP's labour supply in Quebec.

FFS remuneration is widely recognized as incompatible with the development of multidisciplinary teams in primary care (Levesque et al. 2012b; Wankah et al. 2022; Aggarwal et al., 2025). It has done little to improve monitoring for vulnerable populations or patients with chronic diseases (Pomey, Martin, and Forest 2013). Most new family medicine graduates prefer team-based practices and non-FFS payment models (Myran et al. 2025), highlighting the need for a blended, risk-adjusted, comprehensive capitation model that incorporates quality and patient experience metrics (Bodenheimer et al. 2014; Blomqvist and Wyonch 2019).

A blended remuneration – combining components such as capitation (a fixed payment per patient regardless of how many services are provided), FFS, infrastructure funding, program funding, performance payments, and benefit packages – is needed to better align physician payments with health system goals and to respond more effectively to diverse population needs (Hutchison, Abelson, and Lavis 2001; Aggarwal and Hutchison 2012; Aggarwal et al. 2023). Such a model can also mitigate the drawbacks of each individual approach: overserving under FFS, cream-

skimming under capitation, and shirking under salary (Breton et al. 2011).

While the current reform Bill 2 aims to improve access and accountability, rigid targets and financial penalties overlook lessons from past initiatives (e.g. Bill 20) and risk exacerbating access issues without achieving its intended goals. The existing FFS model fails to incentivize collaboration and does not account for patient complexity; it should be phased out in favour of approaches that better support team-based care and patient outcomes. Yet many elements of Bill 2 fail to encourage these objectives and, in some cases, actively discourage them. A redesigned payment model should prioritize clinical value and health outcomes over service volume, ensuring that high-impact services such as prevention and chronic care receive appropriate value. This issue will be explored further later in the paper.

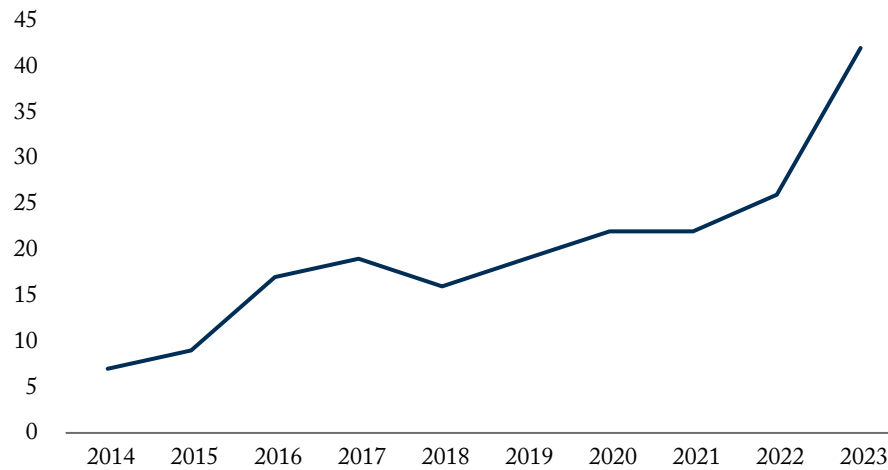
On the other hand, physician compensation agreements in Quebec remain as complex today as they were in 2015, hindering effective compensation management and making it challenging to evaluate practices or implement necessary changes (VGQ 2021). The Auditor General of Quebec (2021) has highlighted the emergence of an industry dedicated to optimizing medical remuneration – a concerning symptom of the system's inefficiency.

Since 2014, the number of FPs billing \$1 million or more to the RAMQ has steadily increased, with a sharp uptick in 2023 (Figure 4).²⁰ Although these gross billings also cover expenses such as office rental, insurance, staff salaries and supplies, the growth among high-billing FPs is striking, surpassing that of many other specialists such as

19 While not sufficient to establish causality, multiple studies suggest that increasing physician pay alone is unlikely to boost service hours. Instead, efforts should focus on increasing the density of FTE physicians, which would increase the volume of services delivered per capita. For example, see Wyonch (2021).

20 The RAMQ did not provide detailed information behind these figures, making it difficult to determine whether the high billings reflect a corporate practice model in which one physician bills on behalf of a group of physicians or residents. If so, the data would obscure how many services each individual physician actually provided, raising concerns about transparency and potential inefficiencies.

Figure 4: Number of Family Physicians Who Billed \$1 Million or More to the RAMQ



Source: RAMQ data.

cardiologists and general surgeons. The current FFS model creates incentives for FPs to prioritize high-volume or high-billing procedures, often through group practice arrangements that maximize revenue generation. This aligns with extensive literature demonstrating that FFS structures can drive overserving behaviour. While increased billing volumes may signal greater productivity, they more likely reflect an incentive structure that rewards quantity over comprehensive patient care. In a healthcare system already facing physician shortages and access challenges, these dynamics risk exacerbating inequities by encouraging shorter, fragmented patient encounters focused on billable procedures rather than holistic, relationship-based care.

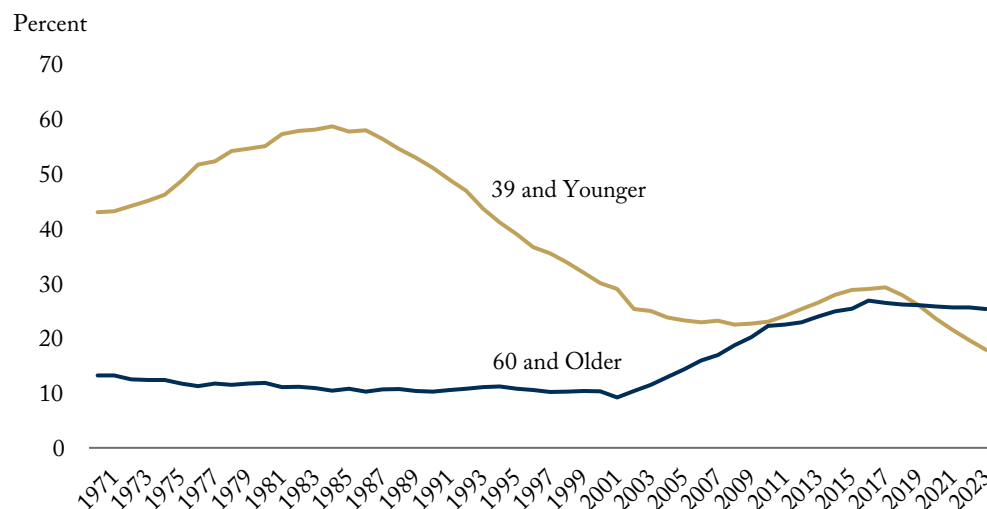
The complexity of physician compensation also imposes costs on RAMQ, which must devote substantial resources to overseeing medical billing. To address these challenges, the Quebec government needs to simplify and increase transparency regarding physician remuneration (VGQ 2021). It also needs to establish mechanisms to systematically collect

data on how physicians allocate their time between clinical and non-clinical tasks.

LIMITED INFLOW OF NEW PHYSICIANS

Historically, the annual growth rate of FPs almost always outpaced that of the population (Appendix Figure C). Since 2023, however, this pattern has reversed: the population growth rate (2.3 percent) has far exceeded that of FPs (0.9 percent), compounding concerns about access to primary care. Quebec's ageing physician workforce has also intensified the crisis. The proportion of FPs aged 60 and older has nearly tripled, rising from 9.2 percent in 2002 to 26.8 percent in 2017 before levelling off (Figure 5). In 2020, for the first time, FPs aged 60 and over outnumbered those under 40, a trend that has continued in subsequent years. This imbalance exists because the inflow of new FPs is insufficient to replace those retiring, further straining access to primary care services.

Figure 5: Family Physicians in Quebec by Age Group, Percentage of Total, since 1971



Notes: In 2019, the College des Médecins in Quebec changed its policy on what personal physician information it makes publicly available. Since then, the number of FPs with “unknown status” has increased. For this reason, data from 2019 onwards should be interpreted with caution.

Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2024 – Historical Data.

According to Zhang (2024), Quebec requires an additional 2,658 FPs to meet current demands, yet recruitment continues to fall short. Burdensome bureaucracy, restrictive working conditions and heavy administrative workloads have made family medicine increasingly unattractive (Zhang 2024). But a broader trend exacerbates this challenge: since 2015, an increasing share of newly graduated family physicians have chosen not to pursue a career in family medicine (Myran et al. 2025). Between 2015 and 2023, McGill University reported the lowest proportion of Canadian medical graduates ranking family medicine as their first-choice specialty – 26.3 percent compared with a national average of 33 percent.

Since 2021, the number of unfilled family medicine residency positions in Quebec has doubled and, by 2025, the province accounted for nearly three-quarters of all vacant spots in

Canada. Notably, the unfilled residency positions are concentrated in French-speaking regions, highlighting the importance of language. Medical school quotas may also play a role. In 2023/24, Quebec’s medical faculties admitted only 1,144 students from 4,835 applicants, rejecting three out of every four candidates who met the application requirements. Granting universities greater flexibility in setting enrollment levels by relaxing provincial quotas could help alleviate the FP shortage over the medium to long term (Wittevrongel and Shaw 2022).

Quebec also relies far less on foreign medical graduates than the rest of Canada. Except for temporary increases in 2008 and 2014, the share of foreign-trained physicians in Quebec has declined from 13.5 percent in 1971 to just 7.6 percent in 2024, compared with a national average of 31.6 percent. Quebec’s particularly burdensome

accreditation process makes the province less attractive to foreign medical school graduates and physicians trained elsewhere in Canada. In 2024–25, internationally trained physicians accounted for only 15 percent of all permits issued in Quebec.²¹ Even under the bilateral agreement with France, the application process for French doctors remains complex and time-consuming (Wittevrongel and Shaw 2022). Over the past five years, Quebec received 223 restrictive permit requests from French doctors, but only two-thirds were approved under the Quebec–France Agreement.

Easing these regulatory barriers could help alleviate shortages. Other provinces have begun to streamline credential recognition.²² For instance, Nova Scotia was the first province in Canada to allow physicians who received training in the United States to bypass certification exams and begin practicing immediately. Ontario has recently made it easier for internationally trained family doctors from the United States, Ireland, Australia, and the United Kingdom to practice medicine in the province by removing supervision and assessment requirements. Alberta, on the other hand, has capped the processing time for applications from Canadian-trained physicians at 20 business days. Quebec needs to adopt similar measures to attract physicians trained elsewhere to practice in the province, especially those from France. Given its unique language requirements, it could evaluate training equivalency with other French-speaking jurisdictions and potentially

cooperate with New Brunswick on international physician recruitment and mutual recognition.

Growth of Non-participating Physicians

Quebec is the only province in Canada where FPs can entirely opt out of the provincial health insurance plan and instead be compensated through private insurance (Fierlbeck 2025). The 2005 *Chaoulli v. Quebec* ruling,²³ along with subsequent legal changes regarding double-billing, paved the way for a growing number of physicians to withdraw from the public system (Contandriopoulos and Law 2021). This trend accelerated during the pandemic, with the number of FPs and specialists working exclusively in the private sector rising by 70 percent since 2020.²⁴ By July 2024, 780 of them had withdrawn from the public insurance system; about two-thirds were general practitioners.²⁵

In response to the growing exodus of physicians from Quebec’s public healthcare system, the government passed Bill 83 this April, which obligates new physicians to work in public institutions for their first five years or face daily fines ranging from \$20,000 to \$200,000. Under Bill 83, physicians must now receive prior authorization from Santé Québec before withdrawing from the public system. Previously, they only needed to notify the RAMQ of their intention to practice privately; no authorization was required. While designed to curb departures, the approach does not appear to

21 College of Physicians of Quebec. 2025. “Portrait of International Medical Graduates.” <https://www.cmq.org/en/acc%C3%A9der-%C3%A0-la-profession/international/portrait-dim>

22 More recently, the Prairie provinces, Ontario, Nova Scotia, New Brunswick and Prince Edward Island have all moved to allow US-trained, Board-certified physicians to begin independent practice immediately, without additional examinations or certification. For more information, see <https://www.cma.ca/about-us/what-we-do/press-room/commentary-provinces-smoothing-road-us-doctors-come-canada-ottawa-must-do-more>

23 The Supreme Court of Canada ruled that Quebec’s legal prohibition on private insurance for publicly insured services violated Quebec’s Charter of Rights and Freedoms, as long wait times in the public system do not mean access to care.

24 For more information, see this new [article](#) from *Radio Canada*.

25 Derfel, Aaron. 2025. “Exodus of Quebec Family Doctors to the Private System is Accelerating: Stats.” *The Gazette*. <https://www.montrealgazette.com/news/health/article890653.html#storylink=cpy>

work. For example, as of November 17, 2025, a total of 1,179 physicians had withdrawn entirely from Quebec's public insurance system – a 45 percent increase since April (RAMQ 2025). Of these, 557 were family physicians. While this represents a relatively small share of Quebec's total actively practising FPs (approximately six percent), the upward trend is nonetheless concerning.

While Bill 83 may keep some physicians in the public system in the short term, it could also make medical education and residency training in Quebec less attractive (Zhang 2025b). Students may choose to study elsewhere, favouring environments that feel less restrictive and more supportive. Highly skilled professionals are likely to pursue opportunities in other provinces or abroad that offer more rewarding working environments. Even those who stay may be more inclined to leave the public system once their five-year obligation ends, which could further destabilize primary care in the long run.

Moreover, there is little evidence that restrictive regulatory measures are effective in retaining physicians within the public system. For instance, in 2001, the UK proposed requiring newly appointed public consultants to commit exclusively to the National Health Service for seven years but abandoned the plan soon after (Hargreaves 2002). Instead, it introduced a new consultant contract that offered a 20 percent increase in starting salaries and better working conditions – an approach that proved more successful.

High-performing countries, such as the UK and the Netherlands, have expanded private financing and service delivery within publicly funded frameworks to improve access. By contrast, Quebec appears to be moving in the opposite direction, further reinforcing single-tier medicare. Notably, the CHA requires coverage for medically necessary services, but provinces and territories determine which services are medically necessary, often in conjunction with the medical profession within their jurisdiction. Provinces, therefore, have considerable discretion in determining terms like “medically necessary” or “insured services”

(Fierlbeck 2024). This means private healthcare is not prohibited; instead, provinces determine the conditions under which private spending is permitted and could broaden the role of private care through provincial legislation and regulation (Fierlbeck and Berman 2025).

Canada already operates a *de facto* “two-tier” system, where publicly insured services can also be accessed privately through non-physician health providers, out-of-province services, virtual platforms, or non-participating physicians (Fierlbeck and Berman 2025). As the system evolves – reshaping who provides medically necessary care, and where and how it is delivered – more Canadians will continue to gain access to these services. As Fierlbeck and Berman (2025) argue, the rigid structure of the CHA has both limited access to publicly insured healthcare and facilitated the rise of a two-tier system. The recent CHA Services Policy, which requires provinces to cover all “physician equivalent” health services, does not apply to non-physician professionals who work outside the public system and appears limited in its ability to curb the growth of for-profit healthcare clinics (Fierlbeck 2025). As health demand grows and market opportunities arise, private, for-profit practices such as nurse practitioner-led clinics and virtual care platforms will continue to play a role within legitimate parameters. People who are unable to access the free healthcare system will continue accessing care through employer-sponsored insurance or by paying for it directly (Falk and Wyonch 2025c).

If a separate private tier becomes normalized in Quebec, it will signal that the public system has left critical access gaps unfilled. Rather than reflexively opposing private options, the government should recognize these gaps and decide where, and under what conditions, private financing can offer alternatives. The key policy question becomes not “private or public?” but “how can carefully regulated private capacity help clear bottlenecks without undermining equity, quality, or the public workforce?” When a quarter of Quebecers lack

Box 2: Benefits and Risks of Dual Practice

Dual practice allows FPs to work in both the public and private sectors.^a It presents both benefits and risks, requiring governments to carefully weigh trade-offs when designing policy (García-Prado and Gonzalez 2007; Moghri et al. 2016).

On the positive side, dual practice can improve access in the public sector, enhance overall physician productivity and job satisfaction, increase physician retention within the public sector, and help address budgetary constraints (Moghri et al. 2016; WHO 2024). At the same time, dual practice can also create challenges. Potential downsides include longer wait times in the public sector, deterioration in the quality of public care, predatory behaviour and induced demand, absenteeism, and weakened equity (Moghri et al. 2016; WHO 2024). Notably, these adverse effects vary across contexts, and the evidence base remains limited (WHO 2024). Most studies are descriptive rather than causal, making it difficult to quantify the actual impact of dual practice.

Ultimately, dual practice functions as a double-edged sword; its outcomes heavily depend on the characteristics of each healthcare system, and the strength of regulatory and governance frameworks (WHO 2024). Standard regulatory tools include caps on service earnings, limits on hours, service types, or practice locations, codes of conduct, requirements for employer approval, and restrictions on using public resources for private gain (García-Prado and Gonzalez 2007; WHO 2024). Alternative strategies focus on positive incentives, such as higher public salaries, exclusive work benefits in the public sector, or permitting private practice within public facilities (García-Prado and Gonzalez 2007; WHO 2024).

a Notably, according to the CHA, dual practice often results in patient charges as the physician remains enrolled in the public plan. This would result in mandatory dollar-for-dollar reductions to the Canada Health Transfer.

access to a regular healthcare provider, private alternatives such as virtual care enable people to get the care they need.²⁶

Quebec can draw on the experience of high-performing countries that already manage mixed systems. These jurisdictions use regulatory and policy tools such as strict data reporting, limits on dual practice (Box 2), caps on private volume, and requirements that private providers participate in wait-time guarantees, to capture the benefits of additional capacity while curbing the worst effects of private options. These mechanisms demonstrate

that private capacity can supplement public delivery when properly structured and rigorously regulated.

POLICY IMPLICATIONS

Over the past two decades, the Quebec government has attempted to reform the governance, funding, and service delivery of primary care, but has achieved limited success in improving access, despite increasing physician density and higher proportions of the population being registered with a family doctor. Quebec's centralized, top-down

26 For example, 10 million Canadians are covered by employer-paid virtual care (Falk and Wyonch 2025c).

approach to primary care has failed to translate a high physician supply into timely access. High-performing countries show that meaningful improvement comes from redefining planning – setting provincial goals and funding while giving local teams the autonomy to design and deliver care.

A comprehensive reform that addresses longstanding systemic failures is also crucial. Such reform requires optimizing physician time allocation, building effective team-based care, and establishing continuous monitoring systems. These reforms vary considerably in implementation difficulty and political feasibility. The following sections examine them in order of their potential impact on improving primary care access and quality, recognizing that the most transformative changes often face the greatest implementation barriers.

Structural Lessons from Quebec's Primary Care Failures

Quebec has among Canada's highest physician density yet suffers the worst primary care access – a paradox only structural reorganization can resolve. Over two decades, Quebec has centrally designed and operationalized primary care from the provincial level, an approach that has demonstrably failed. The result is a rigid, one-size-fits-all system ill-suited to diverse contexts from urban Montreal to remote northern communities. Effective healthcare delivery depends on tacit, local knowledge of clinical needs, team capacity, patient mix, workflow constraints, and community context, which exists only at the point of care. Centralized mandates cannot efficiently gather local feedback to determine what works best.

International evidence unambiguously refutes centralized operational control. High-performing systems in the Netherlands, Germany and New Zealand employ “allocation architectures”: central authorities set broad parameters for funding levels, quality standards, and coverage requirements while granting substantial local autonomy for implementation.²⁷ This enables structured variation, allowing models to adapt to local conditions while maintaining accountability through outcome measurement rather than process dictation. As Martin (2025) emphasizes, effective systems balance central authority with local autonomy for innovation, stakeholder engagement, and population health planning.

Quebec requires governance that separates allocation from operations. Provincial policy should define objectives and measure outcomes – access rates, patient satisfaction, health results – while granting local entities budgetary control and autonomy to design care delivery. This leverages local information advantages and stakeholder engagement to foster innovation tailored to community needs, particularly in disadvantaged and peripheral areas. Some regions of Quebec have recently developed local innovations, such as nurse-led clinics, mobile proximity clinics, and pharmacist-led care pathways, which have shown promising local results. However, there are currently no plans to scale them up across the province (Breton et al. 2024b).

Other provinces should take note of Quebec's experience. Ontario – now undertaking ambitious primary care reforms involving regional patient-physician allocation, and changes/expansions to team-based care models – needs to heed this

27 For example, around 2000, Dutch primary care physicians reorganized after-hours care into large-scale cooperatives, many integrated with hospital emergency departments as “emergency care access points.” These cooperatives initially arose locally and then spread nationally through incentives and shared learning. They triage and treat walk-in patients, reducing overall ER visits by 13–22 percent while providing a safe, cost-effective alternative to traditional emergency care (Smits et al. 2017). Physicians reported higher job satisfaction and lower workloads, and patients were generally satisfied. This model is a valuable lesson for countries, including Canada, considering reforms to after-hours care (Giesen et al. 2011).

cautionary tale (see Falk and Wyonch 2025a, 2025b). Centralized systems do not always fail, but they often struggle, particularly when they attempt to manage inherently local, information-rich services from the top down. Provinces such as Alberta should critically assess whether their current structures truly serve their populations' needs. Unless provinces move away from command-and-control management and adopt allocation models that empower local teams, they risk repeating Quebec's outcomes: physician disengagement, shrinking system capacity, and widening access gaps compared with international peers.

Optimizing FP Time on Patient Care

Doctor shortages are not the root cause of access issues in Quebec's primary care system – FPs in Quebec are 20.6 percent more numerous per capita than those in Ontario. Significant unused capacity exists among Quebec FPs, and leveraging this potential could free up to a third of their current time for primary care delivery.

AMP hours should be gradually reduced to allow FPs to devote more time to primary care. Heavy reliance on FPs to cover hospital staffing without adequate backfilling may help hospitals in the short term, but it creates significant access gaps in primary care. This reflects a trade-off: using FPs for their intended primary care role, versus diverting them to hospital duties in place of hospitalists and specialists. Yet one of the central goals of primary care is to prevent conditions from escalating into secondary care needs. Allocating FP time to hospitals inevitably reduces their time for comprehensive primary care, which can lead to worsening patient outcomes over time. While rural areas may require FPs to provide secondary

care, this is less necessary in urban settings. A more flexible approach is needed, one that balances FP roles, allows some to support emergency departments at a sustainable workload, and ensures others can focus exclusively on primary care without hospital obligations.

PREMs parameters also need to be updated to better reflect actual health needs and regional population growth, while limiting distortions created by local hospital demands. Monitoring the type and volume of work performed by eligible FPs would provide a more accurate picture of community health needs.

Building Effective Team-Based Primary Care

The implementation of GMFs has been underway for two decades, yet access rates have shown little improvement. To address this, the Quebec government needs to prioritize remuneration reform, the full integration of non-physician professionals, and mandatory enrollment to realize the benefits of team-based care.

Remuneration Reform

Quebec must transition away from FFS toward integrated payment systems that better support team-based care and patient outcomes.²⁸ This transformation requires fundamental changes in how services are valued, delivered and compensated.

Risk-adjusted capitation should become the foundation of FP compensation, providing fixed per-patient payments that account for patient complexity, chronic disease burden, and administrative overhead. While specific high-cost procedures could retain fee-for-service elements, most payments should become predictable and population-based. Compensation also needs

28 BC introduced a longitudinal primary care payment model in 2023, which attracted 800 FPs to practice in the province. While this demonstrated early positive results, the model needs to be reviewed, evaluated, and revised to better reflect patient outcomes and team-based care.

to recognize the full scope of physician work, including charting, care coordination, and administrative tasks, particularly for patients with multiple chronic conditions. The new model should prioritize clinical value and health outcomes over service volume, ensuring that high-impact services, such as prevention and chronic care management, receive appropriate valuation. International examples from Norway and the Netherlands demonstrate successful implementation of similar integrated payment structures (Zhang 2024).

Payment reform also needs to eliminate artificial barriers to collaborative practice. Allowing GMFs to bill directly for services delivered by any qualified team member, regardless of professional designation, would enable task sharing based on competency rather than billing restrictions. The current FFS model discourages physicians from delegating tasks, while the medical profession's resistance to change further limits the implementation of effective team-based primary care. To promote true collaboration, NPs and pharmacists should be permitted to bill the provincial insurance plan for the same services as FPs.

Team performance incentives should reward collaborative outcomes, including patient satisfaction, care coordination, and population health metrics, aligning financial incentives with GMF care principles. Effective reform also requires robust risk adjustment formulas and clear accountability mechanisms for organizations, administrators and providers, directly linked to performance outcomes (Tan et al. 2023; Aggarwal et al. 2025).

Better Integration of Other Healthcare Professionals

GMFs need fundamental strengthening to eliminate skill duplication, enhance productivity, and foster effective teamwork that enables

each provider to practice at their full scope of competency. The Quebec government needs to prioritize outcome measurement while granting GMFs greater flexibility to tailor their provider mix to patient population needs – allowing practices to determine optimal combinations of physicians, nurse practitioners, pharmacists, and other professionals based on evidence rather than rigid staffing formulas.

Recent legislation has broadened the scope of NPs, pharmacists and other primary care providers, creating opportunities for more comprehensive interdisciplinary teams. However, realizing this potential requires addressing fundamental structural barriers. While most team-based models remain physician-driven, NP-led clinics represent untapped potential for both rural and urban settings. Saskatchewan and Alberta have adopted NP-led clinics in both public and private models, while Atlantic provinces have varying degrees of NP integration into primary care. However, unlike physicians, NP services are not covered under public insurance, even when providing equivalent care. As a result, patients may pay out of pocket for NP consultations that would be publicly covered if delivered by a physician, raising equity concerns about two-tiered access based on provider type rather than medical need (Fierlbeck 2025). This may evolve as provinces respond to the recent CHA Services Policy. Regardless, Quebec and other provinces should invest in expanding NP-led clinics while better integrating NPs into existing GMFs – both strategies require increased NP training capacity.

Quebec also significantly lags other provinces in pharmacist utilization. Alberta leads the nation by allowing pharmacists to practice at the broadest scope and opening the first pharmacist clinic in 2022, with other provinces following suit. In 2023, Ontario allowed pharmacists to prescribe for minor ailments and recently further expanded pharmacist

prescribing authority.²⁹ Recent evidence shows that this policy change led to a 16 percent rise in pharmacy visits and a 3 percent increase in visits to other providers, particularly in lower-income and materially deprived neighbourhoods (Hoagland and Wang 2025). As pharmacists provide more primary care services, demand for hospital-based care, including emergency departments, has declined. Quebec should similarly expand pharmacists' scope of practice through consultation with healthcare professionals, enabling them to contribute more fully to primary care delivery.

Mandatory Enrollment

While risk-adjusted capitation provides stronger incentives for FPs to roster patients, its effectiveness depends on setting and closely monitoring enrollment targets (Forget 2014). Currently, the average enrollment per physician in GMFs is 837, well below the target range of 1,200 to 1,500 patients. King et al. (2025) found that Quebec's voluntary enrollment policies had little effect on strengthening patient-physician affiliation. This suggests that mandatory participation or stronger incentive mechanisms are needed to increase enrollment across both GMFs and non-GMF practices. More strategic targeting – focusing on patients lacking established primary care relationships and providers whose practice patterns diverge from desired outcomes – could yield substantial improvements in care affiliation and continuity.

Effective empanelment³⁰ provides a framework for calculating risk-adjusted panel sizes, enabling clinicians and teams to maintain a sustainable balance between patient demand and care capacity (Bodenheimer et al. 2014). Panel sizes may vary

depending on the mix of patients and providers, and those below the average range should be encouraged to enroll more patients. When accepting new patients under a risk-adjusted capitation model, GMFs should take all eligible patients rather than selecting them, avoiding “cherry-picking.” Within GMFs, expanding service delivery options, such as e-visits, telephone encounters, group appointments, and visits with other team members, can enhance access and patient choice. While continuity and immediate access can sometimes be in tension, flexibility allows patients to choose between seeing their regular physician or accessing timely care from another qualified healthcare professional, thereby optimizing both relationship-based care and system responsiveness.

Patient registration with GMFs does not guarantee timely access to care when needed; therefore, policy targets should prioritize actual access over enrollment numbers. This applies to all provinces, as three-quarters of Canadians surveyed indicated that they could not access same- or next-day appointments (Zhang 2025a). However, how enrollment is structured affects both system efficiency and care continuity.

Quebec could learn from both the strengths and limitations of Ontario's primary care enrollment experience. In Ontario, most patients now have a formal connection with a doctor or institution, often under capitation or other alternative payment models, yet enrollment is voluntary, and patients can still see non-enrolled providers, including those on traditional FFS (Blomqvist and Wyonch 2019). This flexibility has made it difficult to ensure that patients seek care from their “contracted” regular provider, particularly when timely access is unavailable, resulting in the government paying twice for the same service – first to the regular

29 Ontario. 2024. “Ontario Exploring More Ways to Expand Role of Pharmacists.” July 24. <https://news.ontario.ca/en/release/1004860/ontario-exploring-more-ways-to-expand-role-of-pharmacists>

30 Empanelment means linking each patient to a family physician or a care team, creating a defined patient panel for accountability, continuity, and proactive management.

practice receiving the capitation payment, and again to the different provider the patient ultimately visits. Ontario's partial solution is to place the enforcement burden on physicians by reducing their capitation payments when rostered patients receive "core services" from another provider (Blomqvist and Wyonch 2019). Since enrolled patients face no penalty for seeking care elsewhere, Quebec could consider requiring them to cover all or part of the cost when using a different provider (except in emergencies), similar to the approach used in the UK (Blomqvist and Wyonch 2019). Payment models and provider obligations should be clearly communicated to patients.

Engaged Leadership and Continuous Improvement

According to Aggarwal and Hutchison (2012) and Bodenheimer et al. (2014), a high-performing primary care system also requires engaged leadership and data-driven improvement. Leaders need to be fully engaged in the change process and create concrete, measurable goals and objectives. Investments in leadership development, training and practice guidelines are also crucial for strengthening team collaboration and clarifying the roles and responsibilities of different providers.

Robust evaluation of reforms is essential for transparency and evidence-informed decision-making.³¹ However, policymakers' priorities often shift before evaluation results are available, leading to frequent policy changes without consistent monitoring (Strumpf 2014). The absence of clear accountability for performance applies across all provinces in Canada (Tan et al. 2023).

To address this, provincial governments should establish a performance measurement framework with clear accountability metrics, such as patient access to care, ensure compliance with agreements,

and implement corrective measures when results fall short of expectations. Governments need to prioritize developing robust data systems that capture clinical, operational, and patient experience metrics. Establishing regular public reporting can also help strengthen transparency. Involving primary care providers in the design and ongoing development of these reporting mechanisms can ensure relevance, foster trust, and build buy-in.

Public Engagement and Unattached Patients

Effective reform requires active public engagement and patient education. Many Quebecers have become accustomed to using emergency departments for immediate access, and are uninformed about how primary care reforms will provide more accessible, reliable and adequately resourced alternatives (Forget 2015). Governments should implement communication campaigns to explain how the healthcare system functions, to articulate the services offered by different care models, including GMFs, and to identify where patients can appropriately obtain care. Setting realistic expectations and promoting behavioural change are essential for sustaining reform outcomes (Levesque et al. 2012b).

For patients without regular providers, improving GAPs and linking all primary care offices to online booking systems with real-time availability are crucial initial steps. Quebec should also explore virtual care opportunities, following the models in the Atlantic provinces (Fierlbeck and Wyonch, *forthcoming*). For example, Nova Scotia's VirtualCareNS program, delivered through a contracted platform (Maple), offers an instructive example. Unattached patients can register for publicly insured virtual services at no cost, while those with existing providers receive two free annual

31 For example, the Quebec government has stopped making its CMWF results public since 2017 on CSBE (Commissaire à la santé et au bien-être). Some of the questions, such as the number of patients enrolled per physician, were no longer included in recent surveys. Thus, data monitoring and evaluation on primary care reforms become difficult.

services. VirtualCareNS has also established a dedicated primary care clinic for patients requiring in-person follow-up, staffed by physicians and nurse practitioners. This model addresses continuity of care concerns while leveraging the benefits of virtual access.

Diverting non-urgent, non-attached patients from emergency departments to appropriate alternatives, such as walk-in clinics, semi-urgent clinics, or virtual care, can substantially alleviate pressure on the hospital system. However, achieving effective diversion requires a comprehensive data infrastructure that enables patients to access their health records and supports coordinated care across settings. Without integrated information systems, patients will continue defaulting to ERs as the most reliable access point.

CONCLUSION

Quebec's reforms have struggled for the same reason that many central-planning efforts fall short: they assume the health system can be effectively directed from the centre. PREMs, AMPs, and GMFs all rely on province-wide structures that require information and coordination beyond the central authority's capacity. Successful international health systems have the state set funding, accountability, and equity parameters, while local teams design their own structures, workflows and staffing patterns. For two decades, Quebec has taken the opposite approach, legislating delivery models from above. This has contributed to misallocation, physician disengagement and organizational rigidity. Until the province shifts from model-by-legislation to allocation-by-design, meaningful improvements in access and system performance will remain difficult to achieve.

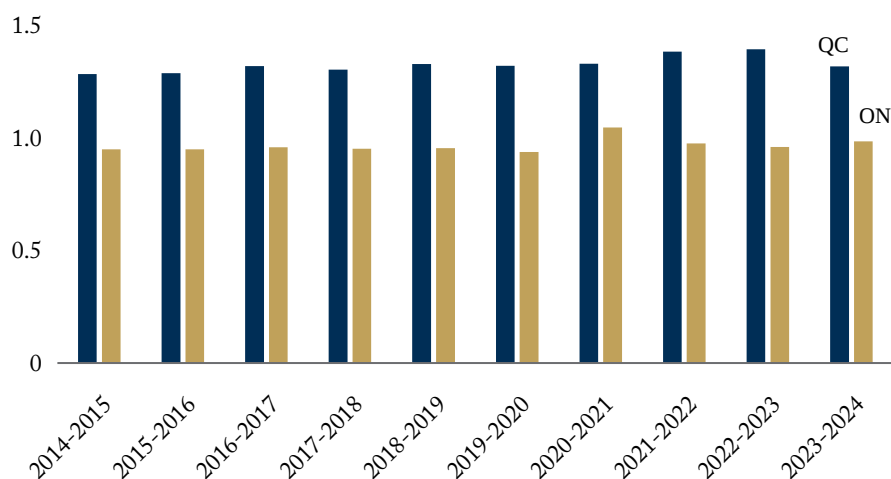
Quebec also has substantial untapped capacity within its existing family physician workforce. Adjusting PREMs and AMPs to reduce mandatory hospital obligations could significantly expand primary care access in the short term. Combined with building effective team-based care through remuneration reform, better integration of other healthcare professionals, and mandatory enrollment, these changes will realign incentives toward comprehensive primary care and make the most efficient use of physician time.

The growth of Quebec's informal private sector and the rising number of physicians opting out of the public system reflect the strong pull of private options beyond the public insurance plan. As private care becomes the norm, the Quebec government needs to consider how it can fill emerging care gaps and provide alternatives. They can learn from other high-performing countries that have taken a middle ground, adopting a mixed system through a range of regulatory and policy instruments.

Improving primary care access and quality will require additional investment and sustained commitment from both governments and healthcare providers. As provincial governments pursue different strategies to enhance access, strong performance measurement and quality improvement mechanisms are essential. All policy innovations should be subject to transparent public reporting and accountability frameworks that enable ongoing refinement based on outcome data. Without systematic evaluation, reforms risk perpetuating rather than solving existing problems.

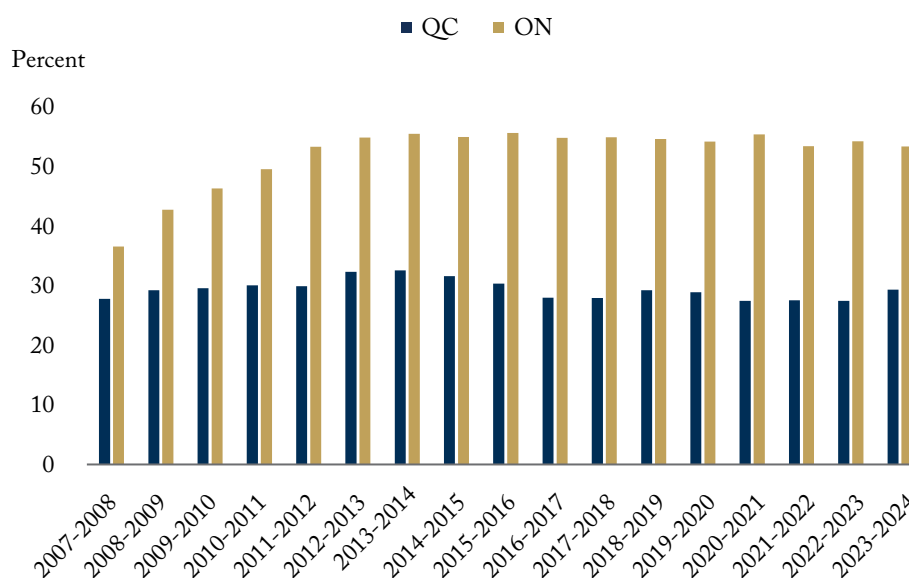
APPENDIX:

Figure A: Ratio, Family Physicians Working to Full-time Equivalent, 2014-2023



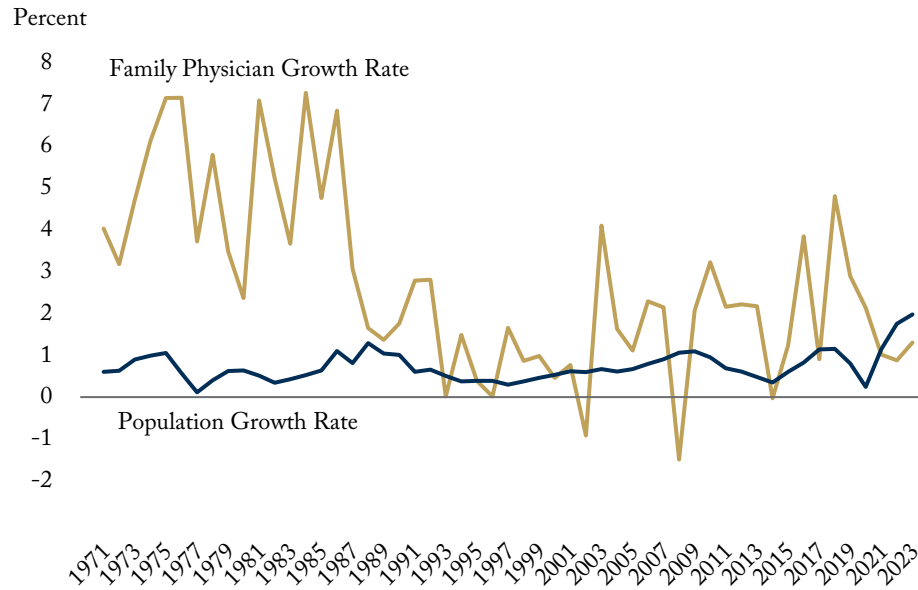
Source: Canadian Institute for Health Information. National Physician Database Historical Payments – Data Tables, 1999-2000 to 2023-2024. Table D.3.

Figure B: Share of Alternative Clinical Payments for Family Physician, 2007-2023



Source: Canadian Institute for Health Information. National Physician Database Historical Payments – Data Tables, 1999-2000 to 2023-2024. Table D.1.

Figure C: Annual Growth Rate in Family Physicians and Population, Quebec, 1972-2024



Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2024 – Historical Data.

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