ORIGINAL ARTICLE

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

Canada's primary care crisis: Federal government response

Colleen M. Flood, SJD, LLM, BA, LLB[1]; Bryan Thomas, SJD, MA, BCL/LLB, BA[2]; and Ella McGibbon, JD, BA[2]

Healthcare Management Forum
2023, Vol. 36(5) 327–332
© 2023 The Canadian College of Health Leaders. All rights reserved.
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/08404704231183863
journals.sagepub.com/home/hmf
Sage

Abstract

Primary healthcare in Canada is in crisis. One in six Canadians lack a regular family physician and less than half of Canadians are able to see a primary care provider on the same or next day. The consequences are significant in terms of the stress and anxiety foisted upon Canadians in need of care, including limited diagnoses and referrals for potentially life-threatening conditions. This article explores options for the federal government to take a more hands-on role responding to the present crisis that are constitutionally compliant: investments in virtual care; additional funding for primary care tied to a strengthened condition of reasonable access within the *Canada Health Act*; a federally-funded direct incentive scheme to lure back providers who have left due to burnout; and the establishment of a commission for access and quality in primary care.

Introduction

Primary healthcare in Canada is in crisis. One in six Canadians report not having a regular family physician, and less than half of Canadians are able to see a primary care provider on the same or next day.[1,2] The consequences are significant in terms of the stress and anxiety foisted upon Canadians in need of care as well as the risks flowing from limited diagnoses and referrals for potentially life-threatening conditions. In addition, there are the costs for hospitals (and stress for staff) resulting from visits to the emergency room for issues that would be better treated in primary care. Although a number of jurisdictions have seen worsened access to primary care resulting from the COVID-19 pandemic, Canada's access issues have compounded over time. A 2020 Commonwealth Fund survey found that 39% of Canadian respondents had visited the Emergency Room (ER) in the past two years, for a condition that could have been treated by a doctor, had one been available. Canada tied with the United States as the worst performer on this metric, among the 11 countries surveyed.[3] There is, further, a significant equity dimension to these access challenges, with racialized and lower income adults reporting disproportionately that they lack a family doctor.[4]

High-quality, accessible primary care is the cornerstone of a well-functioning healthcare system, and a critical requirement in achieving compliance with the right to health under international law.[5] While others in this collection focus on provincial reform to improve primary care, our aim in this article is to identify steps the federal government can and should take—within the parameters of its constitutional jurisdiction—to drive transformative change in primary care. In doing so, we attempt to move past the tired (and incorrect) discourse that the federal government has no jurisdiction in healthcare and explore options for the federal government to take a more hands-on role to respond to the present crisis that is both constitutionally compliant and tailored to respond to the policy problem. In doing so, we build on calls by various health leaders for both increased investment and an increased federal role in this area.[6] The options we develop below are a federal program for funding virtual primary care; additional funding for primary care tied to a strengthened condition of reasonable access within the *Canada Health Act* (CHA); and a federally-funded direct incentive scheme to lure back providers who have left due to burnout.

Factors limiting supply of primary healthcare

The reason for the primary care crisis is connected to the supply of physicians and other health professionals per capita, the hours worked, and patients cared for. On average, there are 140 Primary Care Providers (PCPs) per 100,000 Canadians, approximately half of whom are registered nurses or nurse practitioners.[1,7] Family physicians are the slowest growing category of new physicians in Canada.[8] The reasons for this are not yet fully understood but there appear to be a mix of factors. In part, the shortage may be explained by higher earning potential of other specialities.[7] In addition, a significant number of physicians in Canada are nearing retirement age, and a single retirement can leave nearly 1,000 patients without a family doctor. In 2021, 6,819 family physicians were over 65 years of age and nearing retirement.[9,10] Feminization of the primary care physician workforce is sometimes discussed as contributing to access problems, with female physicians working fewer hours than their male counterparts, and having fewer patient encounters but, on the other hand, spending more time with their patients and dealing with more issues within a given visit.[11] According to Canadian Medical Association surveys, pregnancy, childbirth, and child-rearing obligations are important contributing factors. Female health workers also

[1] Queen's University, Kingston, Ontario, Canada.
[2] University of Ottawa, Ottawa, Ontario, Canada.

Corresponding author:
Colleen M. Flood, Queen's University, Kingston, Ontario, Canada.
E-mail: colleen.flood@queensu.ca

report higher rates of depression and burnout.[12] PCPs may also be increasingly drawn from the public to the private sector, for example, working for private virtual care clinics or practising in cosmetic clinics, as the demand for such services has grown exponentially.[13,14]

The COVID-19 pandemic has certainly exacerbated these challenges as is true in other jurisdictions.[15,16,17] Some PCPs saw their incomes drop at the start of the pandemic, causing stress in terms of sustaining the overhead needed for their offices and staff. The number of Ontario family physicians leaving the profession in the first half of 2020 was three times the normal number—some retiring and others shifting to potentially less stressful fields, as discussed above.[18]

Solutions to the problem of access to primary care

One widely endorsed strategy to improve primary care access is a shift to a team-based care model, as opposed to models where family physicians work in isolation, or with only a small support staff. Team-based care is likely much more appealing to PCPs, as it allows them to share the workload and leverage one another's expertise. For example, a nurse can perform preventive care services like immunizations and routine screenings, giving more time to a doctor to focus on diagnosing and treating complex issues. Further efficiencies can be made by re-assigning administrative tasks; a 2022 study of Nova Scotia physicians found they spent 10.6 hours per week on administrative tasks—equivalent to 1.73 million patient visits annually and that 38% of this work could be reassigned to a non-physician or eliminated altogether.[19]

The efficacy of team-based care is largely dependent on the funding model. In Ontario, the Ministry of Health and Long-Term Care began implementing Family Health Teams in 2005, employing alternate funding arrangements rather than compensating physicians through a typical fee-for-service model.[20] However, an assessment by Ontario's Auditor General raised questions as to efficacy, finding that physicians participating were being paid, via capitation payments, at least 25% more than their fee-for-service counterparts. The Auditor General also cautioned that, as remuneration was not tied to patient health status, providers were incentivized to enroll healthier patients.[19] With respect to this, a study of primary care across three provinces showed that members of primary care teams collaborate best—which is in turn beneficial for their patients—when funding is tied to the actions of the whole team, rather than solely dependent on the doctor's actions. When the physician on a care team is responsible for making payments to the other providers on the team, the efficacy of a team-based model is weakened.[21] Focusing on the physician in the payment structure incentivizes physicians to be present in as many patient interactions as possible, even when the visit could be handled effectively by another provider.[20]

It seems clear that family care teams do provide a better work environment for family doctors (thus making it a more attractive field for medical trainees), and better match the training of PCPs to the heterogeneity of needs presenting in primary care. Further investments in family care teams, appropriately funded, are needed and there are some encouraging signs in this direction. For example, as part of the federal government's recent healthcare deal, Ontario has committed to its first real advancement in team-based care in over a decade.[22]

Other possibilities for expanding access include changing scope of practice. Indeed, there is mounting evidence that nurse practitioners and other health professionals can provide a quality of care that matches or even surpasses that offered by doctors.[23] In 2007, Alberta passed new regulations under its *Health Professions Act,* expanding pharmacists' scope of practice to include prescribing Schedule 1 drugs, ordering laboratory tests, and administering injections. Similar expansions in scope of practice for pharmacists are finally underway in Ontario—as of January 1, 2023, Ontario pharmacists are authorized to prescribe medications for 13 minor ailments, such as conjunctivitis, dermatitis, cold sores, and urinary tract infections.[24] The COVID-19 pandemic has also prompted the Ontario government to explore further expanding the professional scope of registered nurses, to include prescribing powers, and the ability to order and apply defibrillation and apply electrocardiograms—reforms the Registered Nurses' Association of Ontario has been demanding for more than a decade.[25]

Another means to address access issues is to recruit foreign-trained PCPs, and there have been calls to more quickly recognize the qualifications of those trained in other jurisdictions.[26] In its 2022 budget, the federal government committed $115 million over five years, and $30 million ongoing, to expand its Foreign Credential Recognition Program for health sector workers. That certainly makes sense for fast-tracking the credentialling of foreign-trained PCPs residing here already, but larger ethical issues are raised when syphoning skilled workers from resource-strapped jurisdictions. And this is particularly so given that many other jurisdictions, in the wake of COVID-19, are also experiencing a crisis in health human resources and looking to recruit more foreign skilled workers.[27]

Perhaps a more obvious way to address supply issues is for provinces to reduce the gap in remuneration between speciality care and primary care. Another important option is to evaluate the length of training required by colleges for PCPs and compare this to other leading jurisdictions. Length and cost of training obviously has a significant impact on the supply of PCPs and the prices/income they seek once in practice.[28] For example, between 1994 and 2000, a decline in family doctors was partly attributable to the introduction of a two-year residency as a prerequisite for primary care practice.[27]

What role for the federal government?

Having identified some approaches to improving PCP supply, we turn here to evaluate policy options for the federal

government to help respond to the primary care crisis. We acknowledge of course that the division of powers under Canadian federalism constrains the pathways available to the federal government. However, too often this limitation is boiled down by pundits to "provinces have jurisdiction over healthcare." In truth, jurisdiction is shared and, for example, the federal government can and has used its spending power to incentivize provincial initiatives in targeted areas of healthcare.[29] In what follows, we discuss some of the levers available to the federal government, whether through the existing *Canada Health Act,* or modelled on past, stand-alone initiatives like the Primary Health Care Transition Fund of the early 2000s. We also highlight some more novel pathways by which the federal government can use its spending power directly to drive transformative improvements in primary care.

Drive change through enforcement of the Canada Health Act?

The federal government, under the *Canada Health Act*, flexes its spending power by offering block grants (the Canada Health Transfer) to induce provincial participation in the country's universal healthcare system (Medicare).[28] Under this arrangement, provincial and territorial governments must meet certain criteria in their health insurance coverage but retain jurisdiction over the day-to-day administration of healthcare, including most decisions about how primary care is organized and remunerated.[28]

The CHA provides that if a province actively or passively allows extra-billing and/or user fees, the federal government must withhold funding on a dollar-for-dollar basis.[30] Alongside this mandatory withholding of dollars, the Act gives the federal government discretionary power to withhold its cash contribution to provinces that fail to comply with general CHA principles (public administration, comprehensiveness, universality, portability, and accessibility).[29] It is the enforcement of that last criterion—accessibility—that is relevant for present purposes. This criterion requires, among other things, that insured persons have "reasonable access" to medically necessary care. With Canadians by the millions in search of a regular family doctor, it seems inarguable that most if not all provinces are in breach of the CHA's accessibility criterion.

The reality, however, is that in the CHA's nearly 40 years of enactment, the federal government has never exercised its discretionary power to penalize provinces for failures viz-a-viz accessibility—and this is not for wont of access issues, over the years. Given that the country's healthcare system still reverberates with the shock of the pandemic, it seems extremely unlikely the federal government would achieve much (apart from political turmoil) were it to withhold dollars from provinces because of lack of access to primary care at this time.

The federal government has, on occasion, enforced CHA prohibitions on extra-billing and user charges.[31] More recently, the Federal Minister of Health threatened enforcement of the *Canada Health Act*, in response to the proliferation of privately financed virtual care.[32] Web sites like Maple allow patients, for a fee, to consult with doctors on-line (either by chat message or video consultation), receive a diagnosis, and even have a prescription sent directly to their local pharmacist.[33] These services exploit loopholes in the CHA, for example, by connecting patients with providers in other provinces and therefore not subject to the provincial laws of the patient's province limiting two-tier care. Nonetheless, the Federal Minister of Health has promised that a CHA interpretation letter is forthcoming, signalling a clampdown on this form of private-pay care.

The federal government is right to view the proliferation of private-pay virtual care as a breach of the spirit, if not the letter, of the CHA. But to withhold federal transfers would be to treat the symptoms and not the disease—and the disease is inaccessible primary healthcare. Moreover, the modality of virtual care has much to recommend it for diagnosing and treating routine ailments, particularly after-hours or in remote settings. Through its VirtualCareNS program, Nova Scotia has taken the approach of partnering with the private sector, publicly funding consultations on Maple's platform for patients on the province's "Need a Family Practice Registry."[34] Rollout of the program prioritized communities with the largest number of people on the registry. Via virtual appointments, PCPs can prescribe medications, order tests, refer patients to specialists, and provide options for in-person care where necessary. The province limits the hours and overall capacity of the system to around 250-300 virtual consultations a day, with hundreds more queued.[35]

As part of the effort to address access issues around primary care, the federal government could explore scaling up Nova Scotia's pilot project and providing insurance directly for virtual care services to Canadians who do not have a primary care home. This would be a bold step on the part of the federal government, aligning with its recent initiative to provide dental care insurance, thus bypassing complex federal/provincial/territorial negotiations. Indeed, by taking a leadership role in providing insurance for virtual care, the federal government could directly ensure that the system complies with CHA principles.

A foreseeable objection here is that access to a national virtual care system is no substitute for true primary healthcare, with its promise of personalized, comprehensive, continuous, and coordinated care. However, as a supplemental to in-person care, virtual care surely has a vital role to play given Canada's geography. Any discussion of the relative merits of virtual care should begin with an honest assessment of whether our in-person primary healthcare system is truly well-coordinated and continuous. For example, a Commonwealth Fund study in 2019 reports only 22% of Canadian primary care practices are able to electronically exchange patient clinical summaries with doctors outside their practice, and only 1% of practices are capable of four basic functions (on-line appointment booking, prescription refills, test results, and patient summaries).

Conditional and targeted investments in primary care

The federal government has attempted in the past to drive change by targeting new funding to the provinces in specific areas in need of attention, for example, wait times. With respect to primary care, in the early 2000s it established the Primary Health Care Transition Fund (PHCTF), an $800 million fund to support the provinces and territories over six years.[36] Most recently, the federal government in its 2023 budget has $5.5 billion earmarked for primary care and public health on reserve, and increased investments in student loan forgiveness for physicians and nurses who work in remote communities (discussed below).[37]

Historically, targeting funding to drive specific improvements has been less than successful as either the conditions themselves were too vague and/or there was no real enforcement thereof.[38] In our view, the federal government should take the opportunity of new investments in primary care to provide content to the criteria of "reasonable access" in the CHA. For example, the federal government could issue guidelines for the provinces requiring at minimum each province have a transparent timeline for ensuring each resident is assigned to a primary care home. Each province, in exchange for a federal contribution, would be required to account for the numbers of residents without primary care and ensure back-up coverage (e.g. virtual care) until a match is made between a patient and a primary care practice.

Direct funding for primary care

Although we recommend tying and enforcing conditions to the *Canada Health Act*, experience of federal/provincial dynamics suggests the use of strong conditionality is not likely. But another path forward is for the federal government to directly fund improvements in primary care. As an example, in 2013, the federal government launched a student loan forgiveness program for family physicians and nurses who practice in underserved communities. In the 2022 budget, the dollar amount of forgiveness was increased by 50%, up to $30,000 for nurse and $60,000 for doctors, amortized over five years of service. In its most recent budget, the federal government commits $45.9 million over the next four years, and $11.7 million per year ongoing, to expand the scope of this program to all communities with populations under 30,000.[36] In 2019-2020, approximately 5,500 doctors and nurses participated in the program[39]; to get a sense scale, Canada has a supply of approximately 500,000 family physicians and nurses in 2020, meaning that the student loan program impacted around 1% of this labour force.[40]

An even bolder approach is possible, for example, the federal government could create a five-year fund for any PCP that returns to a full practice (and pre-determined bonuses paid every six months to encourage continuation). Another possibility, as we discussed above, is for the federal government to directly insure Canadians for virtual primary care. These kind of direct approaches are in line with the federal government's recent announcement of dental care insurance coverage that it will implement directly as supplemental to provincial and territorial coverage. Although there will be the inevitable claim that "healthcare is provincial jurisdiction," provided the federal government does not, in the exercise of its spending power, take on the colour of regulating healthcare this should withstand constitutional scrutiny.[41]

Conclusion

In this article, we have put forward possible policy options for the federal government to flex its constitutional powers to address the present crisis in primary care. As explained, the federal government can offer targeted investments for primary care teams and achieve greater accountability by specifying that reasonable access in the CHA must include access to primary care. We acknowledge the political challenges surrounding this approach of conditional transfer agreements. Rightly or wrongly, the federal government is often accused of failing to live up to its end of the CHA. The sheer complexity of funding arrangements tends to blur the lines of accountability as between federal and provincial governments.

We acknowledge as well that Canadian health leaders have actively lobbied the federal government for targeted investments in primary care: for example, during the 2019 election cycle, the CMA and other PCP associations called on all federal parties to commit $1.2 billion to a renewed Primary Health Care Transition Fund.[7] In our view, such calls for increased investments should incorporate demands for greater accountability—ideally a commitment from federal leaders to clarify and enforce the CHA criterion of reasonable access.

There are also initiatives that the federal government could fund and administer on its own, such as a national virtual care program for patients on waiting lists for a family physician; a program to incentivize the return of PCPs who have retired from the profession; and establishing a commission for access and quality in primary care to develop guidance on best practices and eventually to provide accreditation to primary care teams or practitioners. It is surely clear that to truly realize a high-functioning healthcare system, the federal government must step up in new and creative ways to move past tired federal-provincial wrangling. While the federal government is in no position to single-handedly fix Canada's major challenges in primary care, it can flex its constitutional powers strategically, in ways that complement provincial efforts.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Ethical approval

Institutional Review Board approval was not required.

ORCID iD

Bryan Thomas https://orcid.org/0009-0006-7056-4954

References

1. Canadian Institute for Health Information. Has a regular health care provider [indicator]. https://www.cihi.ca/en/indicators/has-a-regular-health-care-provider. Accessed March 6, 2023.
2. The Commonwealth Fund. Eleven-country survey shows income inequality in the U.S. and lack of access to primary care could threaten COVID-19 recovery. https://www.commonwealthfund.org/sites/default/files/2020-12/Doty_income_inequality_11_countries_2020_intl_survey_HA_PR.pdf. Published December 9, 2020.
3. The Commonwealth Fund. Mirror, mirror 2021: reflecting poorly: health care in the U.S. compared to other high-income countries. https://www.commonwealthfund.org/sites/default/files/2021-08/Schneider_Mirror_Mirror_2021.pdf
4. Thuy-Nga P, Kiran T. More than 6.5 million adults in Canada lack access to primary care. Healthy Debate. https://healthydebate.ca/2023/03/topic/millions-adults-lack-canada-primary-care/. Accessed May 6, 2023.
5. *World Health Organization: Regional Office for Europe*. Declaration of Alma-Ata. 1978. https://apps.who.int/iris/handle/10665/347879
6. Canadian Medical Association. Health care providers band together to advocate for investments in primary care. https://www.cma.ca/news-releases-and-statements/health-care-providers-band-together-advocate-investments-primary-care. Published October 3, 2019. Accessed May 27, 2023.
7. Canadian Institute for Health Information. Primary health care in Canada: a chartbook of selected indicator results. https://secure.cihi.ca/free_products/PrimaryHealthCareinCanada-SelectedPan-CanadianIndicators_2016_EN.pdf. Published April, 2016.
8. Canadian Institute for Health Information. A lens on the supply of Canada's health workforce. https://www.cihi.ca/en/health-workforce-in-canada-in-focus-including-nurses-and-physicians/a-lens-on-the-supply-of-canadas. Published November 17, 2022.
9. Howlett K, Sun Y. One in six family doctors are near retirement age, leaving millions of Canadians in health care limbo. The Globe and Mail. https://www.theglobeandmail.com/canada/article-family-doctors-retiring/. Accessed February 10, 2023.
10. The Canadian Press. Ontario in 'full support' of Federal push to tie health-care funding to data. CBC. https://www.cbc.ca/news/canada/toronto/ontario-health-care-1.6734734. Accessed April 3, 2023.
11. Hedden L, Barer ML, Cardiff K, et al. The implications of the feminization of the primary care physician workforce on service supply: a systematic review. *Human Resources for Health*. 2014; 12:1-11. doi:10.1186/1478-4491-12-32
12. Canadian Medical Association. CMA national physician health survey: a national snapshot. https://www.cma.ca/sites/default/files/2018-11/nph-survey-e.pdf. Published October, 2018.
13. Trumpfeller S. *Cosmetic Plastic Surgery Trends of 2023 in Canada*. SixSurgery. https://torontosurgery.com/blog/cosmetic-plastic-surgery-trends-of-2023/. Published January, 2023.
14. Morzycki A, Retrouvey H, Alhalabi B, et al. The Canadian plastic surgery workforce analysis: forecasting future need. *Plast Surg (Oakv)*. doi: 10.1177/2292550318800328
15. Duong D. Primary care is facing a capacity crisis—can pandemic lessons help chart a path forward? *CMAJ*. 2022;194(43):E1488. doi:10.1503/cmaj.1096023
16. Majeed A, Maile E, Bindman A. The primary care response to COVID-19 in England's National Health Service. *J R Soc Med*. doi: 10.1177/0141076820931452
17. Woodly M. What are the major healthcare challenges facing the new government? https://www1.racgp.org.au/newsgp/professional/what-are-the-major-healthcare-challenges-facing-th. Published May, 2022.
18. Dunn T. Nearly 20% of Toronto family doctors planning to close practices in next 5 years, survey finds. CBC. https://www.cbc.ca/news/canada/toronto/family-doctors-quitting-toronto-survey-shows-1.6653832. Accessed April 28, 2023.
19. Canadian Federation of Independent Business. Patients before paperwork: Nova Scotia's approach to improving patient care by reducing physician red tape. https://20336445.fs1.hubspotusercontent-na1.net/hubfs/20336445/red_tape/pdfs/Patients_Before_Paperwork_Report_2023.pdf. Published January, 2023.
20. Ministry of Health and Long-Term Care. Funding alternatives for family physicians. 2011:150-170. https://www.auditor.on.ca/en/content/annualreports/arreports/en11/306en11.pdf
21. Wranik DW, Haydt SM, Katz A, et al. Funding and remuneration of interdisciplinary primary care teams in Canada: a conceptual framework and application. *BMC Health Services Research*. 2017; 17:1-12. doi:10.1186/s12913-017-2290-4
22. Crawley M. How Ontario's new health-care deal could change the way your family doctor works. CBC. https://www.cbc.ca/news/canada/toronto/ontario-canada-doctors-family-health-teams-1.6764329. Accessed May 18, 2023.
23. Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews*. 2005;(2):1-34. doi:10.1002/14651858.CD001271.pub2
24. Ontario College of Pharmacists. Minor ailments. https://www.ocpinfo.com/practice-education/expanded-scope-of-practice/minor-ailment/. Accessed May 18, 2023.
25. Jones A, Casey L. Ontario considers expanding scope of practice for nurses, pharmacists, and more. *Global News*. https://globalnews.ca/news/9539654/ontario-nurses-pharmacists/. Accessed May 18, 2023.
26. Singer CR. Ontario plans foreign-trained doctor credential recognition program. Immigration.ca. https://www.immigration.ca/ontario-plans-foreign-trained-doctor-credential-recognition-program. Accessed May 18, 2023. The College of Physicians and Surgeons of Ontario (CPSO) responded to this pressure by proposing a 3-month program to expedite the practice of foreign-trained physicians in Canada.
27. Williams G, Maier C, Scarpetti G, et al. What strategies are countries using to expand health workforce surge capacity during the covid-19 pandemic? *Eurohealth*. https://apps.who.int/iris/handle/10665/336296

28. Chan B. From perceived surplus to perceived shortage: what happened to Canada's physician workforce in the 1990s? https://secure.cihi.ca/free_products/chanjun02.pdf. Published June, 2002.
29. Flood CM, Lahey W, Thomas B. *Federalism and Health Care in Canada: A Troubled Romance? Oxford Handbook of the Canadian Constitution*. s 15. 2017. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2978138
30. *Canada Health Act*, RSC 1985, c C-6, s 18.
31. Health Canada. *Canada Health Act Annual Report 2021-2022*. Government of Canada. 2023. https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/canada-health-act-annual-report-2021-2022/canada-health-act-annual-report-2021-2022-eng.pdf
32. Government of Canada. Letter to provinces and territories on the importance of upholding the Canada Health Act. https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act/letter-provinces-territories-importance-upholding.html. Accessed May 18, 2023.
33. Lupton A. Controversial for-fee service connects Ontario doctors and patients via video chat. CBC. https://www.cbc.ca/news/canada/london/maple-health-online-doctor-visits-1.4194285. Accessed May 18, 2023.
34. Government of Nova Scotia. VirtualCareNS pilot program expansion. https://novascotia.ca/news/release/?id=20211210006. Accessed May 18, 2023.
35. Willick F. Nova Scotia's virtual health-care service can't keep up with demand. CBC. https://www.cbc.ca/news/canada/nova-scotia/virtualcarens-virtual-health-care-maple-high-demand-1.6823083. Accessed May 18, 2023.
36. Ministry of Health and Long-Term Care. *Application for primary health care transition fund projects 2003/04*. Government of Ontario. 2003:1-11.
37. Department of Finance Canada. *Budget 2023: A made-in-Canada plan, strong middle class affordable economy healthy future*. Government of Canada. 2023:52. https://www.budget.canada.ca/2023/pdf/budget-2023-en.pdf
38. Hutchison B. Reforming Canadian primary care – don't stop halfway. *Healthcare Policy*. 2013; 9(1):12-25.
39. Doucette K. Freeland visits Halifax to highlight new student loan forgiveness program for doctors, nurses. CBC. https://www.cbc.ca/news/canada/nova-scotia/Federal-finance-minister-medical-student-load-dalhousie-1.6417105. Accessed May 18, 2023.
40. Canadian Institute for Health Information. *A Lens on the Supply of Canada's Health Workforce*. Published November 17, 2022. Accessed June 1, 2023. Canadian Institute for Health Information. A lens on the supply of Canada's health workforce.Published November 17, 2022. Accessed June 1, 2023.
41. Flood CM, Allin S, Lazin SJ, Marchildon G, Oliver P, Ouiñonez C. *Policy Options for Canadian Dental Care*. Forthcoming (IRPP, 2023).