Performance Audit

Oversight of Access to Primary Care

// Independent Auditor's Report

Office of the Auditor General of Ontario

ANNUAL REPORT 2025

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1.0 Audit at a Glance

// Why We Did This Audit

- Primary care is comprehensive care that promotes health and well-being at all stages of life. Patients seek out primary care for the diagnosis and treatment of common injuries and illness and to get referrals to health-care specialists and prescriptions for medication. Timely access to primary care can help patients prevent or delay the onset of chronic diseases, manage their illnesses, improve their overall well-being and avoid more costly visits to emergency rooms. Overall, access to primary care helps to improve patient care and reduce the cost of Ontario's health-care system.
- Primary care is delivered mostly by family physicians, also known as family doctors or general practitioners. Other health-care providers, including nurse practitioners, also provide primary care. According to the Ministry of Health's (Ministry's) most recent data, about 11,000 comprehensive family physicians (2025) and 2,000 nurse practitioners (2023) practise primary care in Ontario. Our audit focused on physicians who provide primary care.
- INSPIRE-PHC noted that around 2 million Ontarians needed a family physician as of March 2024. This is up from 1.8 million in 2020. In both 2020 and 2024, this represented about 12% of the total population of Ontario.
- As well, a 2022 Ontario Medical Association (OMA) survey estimated that 40% of family physicians were considering retirement in the next five years.
- The Ministry paid about $4.3 billion in 2024/25 to physicians who provide Ontarians with primary care. About 59% of the family physicians in Ontario are compensated based on a fixed amount per patient and the patient's age. They receive that amount regardless of the number of visits that patient makes.

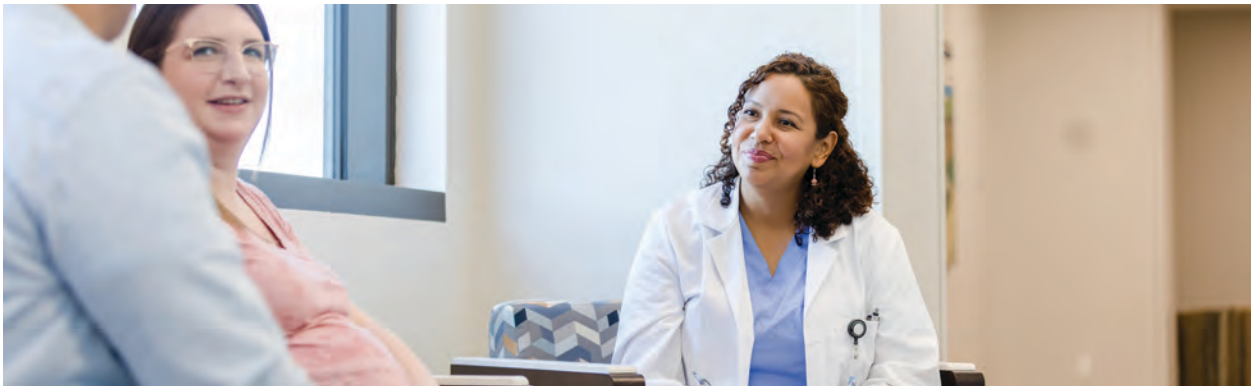
$4.3 billion
paid by Ministry in 2024/25 to primary care physicians

// What We Found

Health Care Connect (HCC) Has Not Fully Met the Needs of Ontarians Trying to Find a Primary Care Provider

- The Ministry launched HCC in 2009. HCC is the Ministry's only centralized mechanism to help Ontarians find a primary care provider. Based on the information the Ministry provided on people who registered with HCC between 2020/21 and 2024/25:
  - Referral data showed that of the 197,000 registrants who were referred to a primary care provider as of April 2025, over 92,000, or 47%, had waited fewer than 21 days, and over 28,800, or 15%, had waited over 260 days.
  - Wait-list data showed that of the 178,000 registrants who were still waiting to be referred as of June 2025, more than 108,000 had been waiting for longer than a year, including about 5,000 who had complex health needs.
- On average, for each year between 2022/23 and 2024/25, only 648, or 7%, of physicians funded under a patient enrolment model were accepting HCC registrants. This contributed to the long wait times.
- A group of 12 Ontario Health Teams (OHTs) informed the Ministry in December 2024 that they "do not support updating the existing legacy HCC tool as it is no longer fit for purpose." These OHTs communicated that HCC was not widely supported by providers or accessed by Ontarians, and that, as an outdated system from 2009, it required redesign to integrate with OHTs.
- The Ministry has not updated its HCC communication plan targeting the public and health-care providers since 2015. As of January 1, 2025, around 235,000 Ontarians were registered with HCC. This represents only about 11% of Ontarians who are known to be without a family physician.

» **Recommendations 4, 5 and 6**



Primary Care Networks (Networks) within OHTs Have No Authority to Require Local Providers to Participate in System Planning

- The Ministry has delegated the task of organizing regional primary care delivery to 58 Networks within the 58 OHTs. However, it has not granted the Networks the authority to require primary care providers to work with them in system planning to increase access to primary care.
- As a result, the Networks have varying levels of understanding of how many providers practise primary care in their communities. This increases the risk that Networks cannot effectively achieve the Province's Primary Care Action Team (PCAT) goal of 100% attachment to primary care by 2029 as they are not aware of how many providers currently practise.
- The Ministry does not have a provincial framework to enable a co-ordinated and equitable approach to recruiting family physicians. It expects Networks to support primary care health human resource planning within each OHT, but neither the Ministry nor Ontario Health requires OHTs to engage with municipalities to obtain information related to their health workforce planning.
- In summer 2025, the Association of Municipalities of Ontario (AMO) collected data from municipalities in Ontario to understand how much they spent on physician recruitment. AMO found that the responding municipalities, which cover about 89% of Ontario's population, collectively spent at least $6 million per year on recruitment and incentives for health human resources, which include primary care providers. Not all municipalities have these resources, which raises an issue of fairness for Ontarians.

» **Recommendations 1 and 2**

Ministry Did Not Ask OHTs to Submit Proposals with Scalable Options to Establish New or Expand Existing Team-Based Care

- In spring 2025, the Ministry invited 40 OHTs to submit up to a maximum of five proposals to establish new or expand existing primary care teams. The Ministry approved 75 proposals.
- Overall, the proposals we sampled received $30 million, or 36%, of their requested amounts, with one proposal receiving 10%. The Ministry had not asked applicants to develop scalable options assuming varying levels of funding provided. In some cases, this resulted in a loss of resourcing and delayed implementation as the Ministry and Ontario Health worked with successful applicants to refine their implementation plans to reflect the approved level of funding and new targets.

» **Recommendation 3**

Ministry Does Not Reduce Capitation Payments to Physicians in Family Health Organizations (FHOs) When Their Patients Receive Care Elsewhere

- As of February 2025, over 6,400 physicians were part of FHOs, the most common funding model for family physicians. FHO physicians receive a base, or capitation, fee to provide a basket of services to their enrolled patients. We found that even if patients go to another primary care provider, such as a walk-in clinic, to receive a service that should be captured under the basket of services, the Ministry's payment structure with these physicians does not require it to reduce the capitation payment.
- In 2022/23 and 2023/24, the Ministry could have potentially withheld about $14 million from FHOs that had gone into a negative access bonus due to their patients receiving a significant amount of primary care elsewhere.

» **Recommendation 7**

Ministry Has Not Established Timelines or Targets to Measure Performance

- Four of the five key performance indicators (KPIs) the Ministry identified in January 2025 to measure the progress of implementing the Primary Care Action Plan are similar to, or build upon, those outlined in a 2014 framework developed by Health Quality Ontario (HQO) to measure primary care performance. As some of the 2014 KPIs were never measured, the Ministry missed an opportunity to collect baseline data and establish targets over the last decade.
- The Ministry has not established timelines to collect data to measure the five KPIs or performance targets to understand if improvements are being made.

» **Recommendation 9**

// Our Conclusion

Our audit concluded that the Ministry, in conjunction with Ontario Health, did not consistently have processes in place to plan and oversee programs and initiatives to improve patients' access to primary care. Specifically, the Ministry:

- has not granted the Networks, which are part of OHTs overseen by Ontario Health, the authority to require primary care providers to work with them in system planning to increase access to primary care;
- does not have a provincial framework to enable a co-ordinated and equitable approach to recruiting family physicians;
- has not asked OHTs to develop proposals with scalable options to expand or create new primary care teams; and
- has not worked with Ontario Health to actively promote HCC to enable Ontarians to register to find a primary care provider.

As well, the Ministry did not effectively monitor whether physicians are complying with accountability measures designed to improve patients' access to primary care as outlined in the contractual agreements between physicians and the Ministry.

Finally, the Ministry did not have effective processes to measure and report on whether primary care is accessible to patients and has no timeline on how it will collect this data.

The Ministry and Ontario Health have agreed to all 11 of our recommendations.

2.0 Background

2.1 Overview and Importance of Primary Care

Primary care is comprehensive care that promotes a patient's health and well-being at all stages of life. It is meant to be the first point of contact between a patient and the health-care system. Primary care providers, most often family physicians, provide comprehensive family medicine across the lifespan, diagnose, treat and manage diseases, connect patients to specialist care when needed, and help patients prevent chronic diseases.

A 2024 report by the Ontario Hospital Association and the University of Toronto's Dalla Lana School of Public Health projects that, by 2040, approximately 3.1 million people in Ontario will be living with a major illness, such as diabetes, hypertension or cancer. This represents an increase of 1.3 million from 2020. The report notes that this will translate to one in four adults living with a major illness by 2040 and requiring significant hospital care. When primary care is accessible, it can proactively improve a person's overall health and help prevent more costly visits to hospitals, thereby reducing stress on the overall health-care system.

3.1 million people
in Ontario will be living with a major illness by 2040, an increase of 1.3 million from 2020

2.2 Attachment and Access to Primary Care

In the context of primary care, two terms, "attachment" and "access", are often used interchangeably to describe a person's ability to obtain the necessary care, but in practice these terms are quite distinct. Attachment refers to a documented and confirmed connection between a patient and a regular primary care provider; access refers to the ability to see a provider when needed.

INSPIRE-Primary Health Care (INSPIRE-PHC), a network of primary care researchers, noted that as of March 2024, the number of Ontarians who were not attached to primary care was around 2 million, or about 12% of the total population of Ontario. This was up from 1.8 million in 2020.

Attachment refers to a documented and confirmed connection between a patient and a regular primary care provider; access refers to the ability to see a provider when needed

Researchers also point to an expected decline in the number of family physicians practising comprehensive family care across the lifespan. A study, supported by the Institute for Clinical Evaluative Sciences (ICES) and published by the Ministry in 2025, noted that between 1993/94 and 2021/22, the proportion of family physicians practising comprehensive care decreased from about 92% to 81%.

A 2023 Ontario College of Family Physicians survey also found that 65% of family physicians were planning to leave the profession or reduce their working hours in the next five years due to reasons that included a lack of support and unnecessary administrative work, such as tracking down results of lab and diagnostic testing. As well, a 2022 OMA survey estimated that 40% of family physicians were considering retirement in the next five years.

According to the Ministry's 2023 Health Care Experience Survey, only 35% of people who had a family physician or other primary care provider were able to see them on the same day or the next day when sick.

2.3 Primary Care Delivery Models and Funding

While most people may associate primary care with their own family physician or a walk-in clinic, primary care in Ontario is far more complex. It is delivered under different models, and each model may have multiple funding arrangements. The funding arrangements generally do not correspond to the delivery model but are rather based on contractual agreements between the Ministry and physicians.

In terms of delivery, family physicians in Ontario generally work on their own, with other physicians or in team-based primary care where they work with an interprofessional primary care team (IPCT) consisting of multidisciplinary health-care providers, such as nurses, dietitians, midwives and social workers, to provide comprehensive care services to patients. According to a 2024 report from the Association of Family Health Teams of Ontario, 25% of Ontarians have access to team-based care. **Appendix 1** shows the four types of team-based primary care delivery models in Ontario.

According to the OMA, team-based primary care reduces clinician burnout and enables a more holistic approach to care. The Canadian Medical Association (CMA) notes that patients benefit from team-based primary care since they can be assessed, treated or connected to other health services in their community more quickly. The CMA also notes that team-based primary care helps to alleviate many downstream health system issues, including overcrowding in hospitals and pressure on emergency departments.

The Ministry funds many primary care services in Ontario either directly or indirectly through Ontario Health (explained in **Section 2.4**). Between 2021/22 and 2024/25, the Ministry spent an average of $4 billion annually compensating primary care physicians. There were two main funding models for all licensed family physicians in Ontario as of February 2025:

- **Fee-for-service** (FFS): About 1,600 family physicians are compensated by billing the Ministry for each service rendered under the Schedule of Benefits in accordance with the *Health Insurance Act*. The Act establishes the framework for access to publicly funded health-care services through the Ontario Health Insurance Plan (OHIP).
- **Patient enrolment models**: About 9,600 family physicians are compensated under a patient enrolment model. Of these, about 6,600 are members of an FHO or Family Health Network (FHN) and are compensated by having a fixed amount, called capitation, paid for each patient enrolled on their roster, regardless of services performed. The remaining approximately 3,000 family physicians are compensated primarily through enhanced FFS with small capitation payments or through specialized contracts. Examples include Family Health Groups (FHG) and Comprehensive Care Model (CCM) physicians. We describe these models further in **Section 4.3**.

The Ministry also has specialized contracts with about 500 physicians who provide services to specialized or complex need patients, such as those in homeless shelters and palliative care.

Figure 1 summarizes all major primary care delivery models and their funding agreement types. All types are funded by the Ministry or Ontario Health, with Ontario Health overseeing most of the team-based care models.

Figure 1: Most Common Primary Care Delivery Model Funding and Agreements

Prepared by the Office of the Auditor General of Ontario

Type	Team-Based	Funded by	Funding Agreement Type
Patient enrolment model (CCM, FHG, FHO, FHN)	No*	Ministry	Contract with the Ministry; combination of OHIP and incentive payments
Solo physician	No	Ministry	No contract; each physician bills the Ministry through OHIP's Schedule of Benefits
Indigenous Primary Health Care Organization (IPHCO)	Yes	Ministry	Transfer payment agreements
Community Health Centre (CHC)	Yes	Ontario Health	Multi-sector service accountability agreement
Family Health Team (FHT)	Yes	Ontario Health	Transfer payment agreements
Nurse Practitioner–Led Clinic (NPLC)	Yes	Ontario Health	Transfer payment agreements

* Some FHOs and FHNs that are affiliated with FHTs are in a team-based care model.

The OMA represents about 36,700 actively practising physicians in Ontario. Its work includes negotiating physician compensation with the Ministry, which is outlined in a multi-year Physician Services Agreement between the two parties. The Ministry and the OMA finalized their 2024–2028 agreement in September 2025, subsequent to the completion of our audit work. Key changes from this agreement include:

- hourly payments that can be billed for time spent doing administrative work;
- increases in after-hours premiums from 30% to 50%; and
- increases in bonuses paid for attaching new patients.

The impact of these changes on access to primary care will take time to materialize and was not assessed as part of this audit.

2.4 Responsible Parties in the Primary Care System

The Ministry sets priorities and direction for primary care in Ontario. It is responsible for negotiating physician accountability and compensation with the OMA. In addition, it oversees initiatives targeted at improving patient attachment and access to primary care through, for example, HCC. HCC is an online or telephone self-referral program that helps Ontarians find a family physician or other primary care practitioner.

Ontario Health is a provincial agency established in 2019 to connect, co-ordinate and modernize the health-care system. It oversees service accountability agreements and transfer payment agreements with three (CHC, FHT and NPLC) of the four primary care team-based models, partners with the Ministry to operate HCC, and helps support the implementation of 58 OHTs across the province.

OHTs were introduced as the Province's solution for organizing and delivering integrated and co-ordinated care for patients in their communities. Under the Province's 2023 health-care plan (discussed in **Section 2.5**), the Ministry noted that every OHT would include a group of primary care providers organized in a Network "to be part of decision-making and to improve access to care for patients."

The objectives of these Networks, as outlined in a Ministry guidance document from January 2024, are to organize the local primary care sector and support OHTs in implementing local and provincial priorities. The document also sets out the core functions of the Networks, which include supporting primary care health human resource planning within the OHT (see **Figure 2**).

Figure 2: Relationship between Ministry, Ontario Health and OHTs in Primary Care System Planning and Their Responsibilities

Prepared by the Office of the Auditor General of Ontario

Ministry of Health	Sets policy and direction for primary care
Ontario Health	Co-ordinates and supports delivery of primary care
OHTs	Organize local health-care providers to deliver co-ordinated care

Primary Care Networks: Connect primary care providers to support the OHTs and improve delivery of care through the five core functions:

1. Connect primary care within the OHT
2. Serve as the local primary care sector's voice in OHT decision-making
3. Support OHT clinical change management and population health management approaches
4. Facilitate access to clinical and digital supports and improvements for primary care
5. Support local primary care health human resource planning within the OHT

2.5 Primary Care Action Team

In October 2024, the Province announced the creation of the Primary Care Action Team (PCAT). Its mandate is to ensure that "100% of people in Ontario are attached to a family physician or primary care nurse practitioner in a publicly funded team, where they will receive ongoing, comprehensive and convenient care," by 2029, as shown in **Figure 3**.

Figure 3: PCAT Implementation Timelines

Source of data: Primary Care Action Team

	2025/26	2026/27	2027/28	2028/29	Total
# of new people attached	300,000	+500,000	+600,000	+600,000	**2,000,000***
# of new primary care teams added	76	+73	+78	+78	**305**

* Ministry estimate based on 2024 data.

PCAT was later established in December 2024, and, as of May 2025, the Province had announced funding of $2.1 billion to support PCAT's implementation of the Primary Care Action Plan. This includes $1.8 billion to connect every person to a family physician or primary care team, as well as $300 million to expand primary care teaching clinics as discussed in our 2025 audit of Oversight of Medical Education in Family Medicine.

The Province announced funding of $2.1 billion to support PCAT's implementation of the Primary Care Action Plan

This work builds on the Province's February 2023 plan aimed at improving the quality of health care. *Your Health: A Plan for Connected and Convenient Care* was the Ministry's vision for a patient-centred health-care system. The patient-centred approach to health care involves the patient in decisions around their care, and fosters a respectful, compassionate and culturally appropriate relationship between the patient and the provider that is responsive to the needs and values of the patient.

2.6 Primary Care Framework

In June 2025, the *Primary Care Act, 2025* (Act), part of the Primary Care Action Plan, was passed in the Legislature. It includes a primary care framework and establishes the Province's vision for primary care for Ontarians covered by OHIP. Ontario is the first jurisdiction in Canada to establish such a framework in legislation.

The Act sets out six objectives for Ontario's publicly funded primary care, as shown in **Figure 4**. These objectives are based on the OurCare Standard, which is the outcome of a pan-Canadian project about the future of primary care that took place between September 2022 and December 2023. Ontario is the first province or territory in Canada to require the Minister of Health to prepare an annual report on how the Province is working toward the six objectives.

Figure 4: *Primary Care Act, 2025* Objectives

Prepared by the Office of the Auditor General of Ontario

Objective	Definition
Province-wide	Insured persons across the province should have the opportunity to have a documented and ongoing relationship with a primary care clinician or team.
Connected	Insured persons should have the opportunity to receive primary care services that are co-ordinated with existing health and social services.
Convenient	Insured persons should have access to timely primary care services.
Inclusive	Insured persons should have the opportunity to receive primary care services that are free from barriers and discrimination prohibited by the *Human Rights Code* or the *Canadian Charter or Rights and Freedoms.*
Empowered	Insured persons should have the opportunity to access their personal health information through a digitally integrated primary care system that connects insured persons to clinicians involved in their care.
Responsive	The primary care system should respond to the needs of the communities it serves, and insured persons should have access to information about how the system is performing and adapting.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry, in conjunction with Ontario Health, has policies and processes in place to:

- plan and oversee programs, initiatives and physician funding models to improve patients' access to primary care; and
- measure and report on their effectiveness.

Our audit focused on the Ministry's planning and oversight related to access and attachment to primary care. This included the overall strategy, system planning (which also involves Ontario Health), oversight of contractual agreements with physicians, and other related activities relevant to improving patient access and attachment to primary care. PCAT's expansion of IPCTs was under way during our audit. We audited related activities as of August 31, 2025.

Our audit focused on physicians, but not on other primary care providers such as nurse practitioners. We also did not focus on increasing the number of family physicians through medical seat expansion, as this is covered in a separate audit.

Our audit did not focus on Practice Ready Ontario, which is a program in pilot phase to assess the skills of internationally trained physicians to confirm their readiness for independent practice in Ontario, as this program had only produced one cohort of participants when we completed the audit.

For more details, see our **Audit Criteria**, **Audit Approach** and **Audit Opinion**.

4.0 What We Found

4.1 System Planning and Monitoring of Attachment to Primary Care

4.1.1 About 70% of OHTs Have More than 10% of Their Population Unattached to a Primary Care Provider

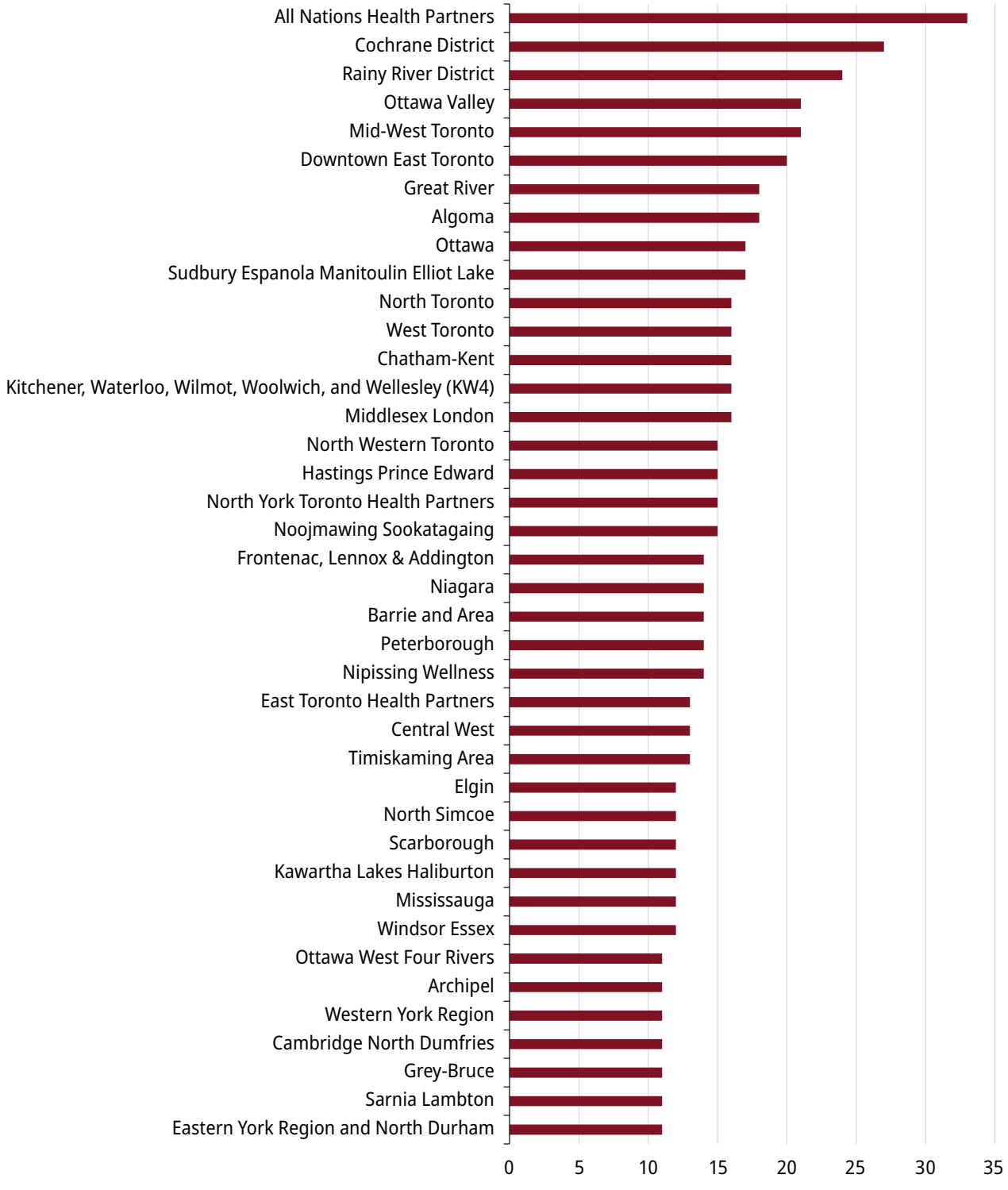
In February 2025, as part of planning for the expansion of primary care teams, the Ministry aggregated data on the number of unattached patients by region. This data showed that some regions in Ontario, especially in Northern Ontario, will face greater challenges in reaching the 100% attachment target.

We analyzed the February 2025 unattachment rates by OHT and found that in 40 OHTs, or about 70% of all OHTs, more than 1 in 10 residents were not attached to primary care (see **Figure 5**). Five OHTs had more than 2 in 10 residents unattached to primary care. Of these five OHTs, the top three are in the North, and the remaining two are in Toronto and eastern Ontario. **Appendix 2** shows the full list of 58 OHTs and their unattachment rates by Ontario Health region.

5 OHTs
had more than 2 in 10 residents unattached to primary care

Figure 5: 40 OHTs with Unattachment Rates Higher than 10%, as of February 2025

Source of data: Ministry of Health



4.1.2 Primary Care Networks (Networks) within OHTs Have No Authority to Require Local Providers to Participate in System Planning

We found that in May 2025, Ontario Health communicated to Ontario's 58 OHTs that primary care was now one of three key priorities for the fiscal year. Each Network is expected to develop its own regional approach to support 100% attachment of its local population by 2029.

While the Ministry has asked the Networks to organize primary care in their communities, the Networks do not have authority to require primary care providers to work with them in planning local primary care systems. As part of the 2025/26 required deliverables for OHTs, Networks are expected to identify existing primary care capacity to attach patients and engage with providers who are not part of the Networks. Without a clear governance structure and authority to support this collaboration, the Networks cannot effectively identify where gaps exist across their community, and which providers have the capacity to take on more patients.

During our audit, Ontario Health noted that all OHTs have a Network in development, but that these Networks are at different stages of maturity. In 2024/25, all 58 OHTs were required to complete self-assessments on the state of their Network and submit them to Ontario Health. Ontario Health informed us that it used these self-assessments to determine OHTs' successes, challenges and areas of support needed, and shared this feedback with OHTs and the Networks.

We reviewed the self-assessments and found that 32, or 55%, of Networks were able to measure the percentage of primary care providers in their region who had joined the Network. This percentage ranged from 4% to 100%. Among those 32 Networks, 12 Networks reported that fewer than 50% of primary care providers in their region were Network members.

55% of Networks were able to measure the percentage of primary care providers in their region who have joined the Network

The remaining 45% of Networks were unable to provide this information, citing unreliable or outdated data. Ontario Health informed us that there is currently no standardized methodology for tracking the participation of providers in Networks. This has resulted in varied definitions of participation among OHTs.

Why It Matters

Without establishing the role of Networks in primary care system planning and providing them with the necessary authority, these Networks will continue to evolve inconsistently. This impacts their ability to identify and address local primary care needs.

Recommendation 1

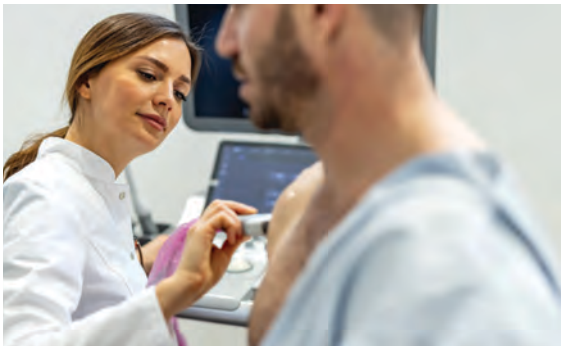
We recommend that the Ministry take the lead and work with Ontario Health to:

- work with OHTs to develop a framework for the Networks' engagement with primary care providers, including a standardized methodology to track providers' participation in Networks; and
- provide direction to the Networks to help them increase the number of participating primary care physicians, nurse practitioners and primary care teams.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.1.3 Physician Recruitment Results in Competition, Duplication of Effort and Inequities Across the Province

To address the primary care needs of their communities, some municipalities are spending public dollars on recruitment committees and providing financial incentives to attract family physicians. This results in competition between OHTs, the Networks and municipalities in Ontario. In addition, not all municipalities have the necessary resources, which raises an issue of fairness for Ontarians.



Along with providing oversight and support to OHTs, Ontario Health administers northern and rural physician locum programs for temporary physician coverage and shares resources with best practices to assist these and other communities with physician recruitment. HealthForceOntario, now part of Ontario Health, also has health workforce advisors who assist communities with physician recruitment by providing marketing, onboarding and succession planning support. While communities may work collaboratively with HealthForceOntario, Ontario Health is not responsible for overall physician recruitment in Ontario.

The Ministry expects Networks to support primary care health human resource planning within each OHT. In 2022, the Ministry informed OHTs that they had the discretion to include groups such as municipalities in their decision-making. However, neither the Ministry nor Ontario Health requires OHTs to engage with municipalities to obtain information related to their health workforce planning.

Through our review of the 2024/25 OHT self-assessments, we found that five Networks specifically work with municipalities for physician recruitment, with one Network stating "the HHR [health human resource] crisis is a provincial one and cannot be addressed via local solutions." As of May 2025, 39 OHTs, or two-thirds of the 58, have at least one municipal partner. However, these partnerships may be related to, for example, co-ordination of health services for those in social housing, and not specifically physician recruitment.

We found that multiple municipalities offer incentives such as financial signing bonuses, reimbursement of relocation expenses and free housing or clinic space to attract family physicians to work in their community. Municipalities also commonly employ physician recruiters, and some have even banded together to form physician recruitment alliances to share resources and reduce duplication of effort among recruiters.

For example, the Ontario Physician Recruitment Alliance (OPRA) is a membership organization that consists of 55 physician recruiter members representing various regions of Ontario. According to OPRA, every province and territory across Canada, except Ontario, has implemented centralized physician recruitment models to address shortages and improve access to health care.

A 2024 briefing note prepared by a family physician recruitment task force for a municipality in southern Ontario noted that, of the nine municipalities in southern Ontario in the scope of their analysis, eight provided funding toward a budget for recruiting physicians into their communities. The funding provided by municipalities ranged from 41% to 100% of their community's total funding budget. There were also other sources of funding, including hospital foundations and public health.

In spring 2025, AMO collected data from municipalities in Ontario to understand how much they spend on physician recruitment. AMO found that the responding municipalities, which cover about 89% of Ontario's population, are collectively spending more than $6.3 million per year on recruitment and incentives.

Every province and territory, except Ontario, has implemented centralized physician recruitment models

The lack of a provincial entity that is responsible for co-ordinating physician recruitment in the province has resulted in a fragmented and competitive approach to recruitment between Ontario Health, OHTs, the Networks and municipalities.

Why It Matters

Physician recruitment is a challenge being experienced across Canada. Access to and delivery of health care are provincial responsibilities that require system-level planning and resources, increasing the importance of a co-ordinated provincial strategy to recruitment. Failure to co-ordinate physician recruitment at the provincial level could lead to greater inequities in primary care access in Ontario. This could also put pressure on municipalities and individual organizations to compete and develop costly solutions.

Recommendation 2

We recommend that Ontario Health, in partnership with the Ministry, expand its work to co-ordinate equitable recruitment of family physicians with key partners, including municipalities, health-care organizations and communities.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.1.4 Ministry Spending to Expand Team-Based Primary Care

As described in **Section 2.5**, PCAT's main mandate is to connect every Ontarian to a family physician or primary care team by 2029. In January 2025, the Ministry announced an investment of over $1.8 billion to implement the Primary Care Action Plan over four years. Over $1 billion of this funding is dedicated to creating new or expanding existing primary care teams. The rest of the funding covers other aspects of the action plan, such as modernizing HCC, recruiting and retaining the health workforce, and supporting primary care teaching clinics.

In 2025/26, year one of a four-year plan, the Ministry committed to investing $132 million to support communities with higher needs to establish new or expand existing primary care teams. The Ministry selected these communities based on criteria such as the number of unattached patients and the size of the HCC wait list as of January 1, 2025. In spring 2025, the Ministry invited 40 OHTs located in these communities to each submit up to five proposals. The Ministry also allowed Indigenous-led organizations to submit proposals without being associated with an OHT. The Ministry's goal was to establish or expand up to 80 IPCTs across the province by the end of 2025/26.

Over $1 billion in Ministry funding is dedicated to creating new or expanding existing primary care teams

By August 2025, the Ministry had issued funding letters to all successful applicants, consisting of 130 IPCTs, based on 75 proposals.

Ministry Did Not Ask Applicants to Submit Proposals with Scalable Options to Account for Changes to Funding Allocation

We sampled 25% of the accepted proposals for detailed examination. We found that none of these proposals had received the full amount of requested funding.

Based on this review, we found that these proposals had received a total of nearly $30 million, or 36% of their requested amounts, with one proposal receiving as low as 10%.

The application material provided by the Ministry included mandatory information to be submitted. This included the number of:

- additional physician and health-care professional positions being requested;
- additional management and administrative staff being requested; and
- new patients the new team could attach to primary care.

The Ministry then evaluated the proposals to ensure that they aligned with the attachment targets established by the Ministry. The Ministry also considered other factors, such as the overall quality of the proposals and other transfer payment agreement obligations they may have, when determining the amount of funding it would award to successful applicants.

We found that the Ministry did not provide successful applicants with explanations as to why certain items were not approved, making it more difficult for applicants to know whether to apply again in the future, and which health-care professional positions to apply for.

The Ministry confirmed that its call for proposals had not asked applicants to develop scalable options assuming varying levels of funding provided. In one case, because the Ministry did not provide the full requested funding amount, the resources the applicants had identified were no longer available to them. In other cases, implementation was delayed as the Ministry and Ontario Health worked with successful applicants to refine their implementation plans to reflect the approved level of funding and new targets.

We noted that some successful applicants had put forward proposals with projections of attachment based on a variety of factors. These included the need for increased clinic space. They also had letters of commitment from physicians and other clinicians who conditionally committed to practise should the full funding be granted.

For example, one applicant, an Indigenous organization, received 14% of its requested funding amount. This organization had a signed letter of commitment from an Indigenous family physician to practise in their home community. The organization was instead provided with funding for a nurse practitioner. This resulted in the loss of the family physician, who signed elsewhere. In addition to this loss, the organization now needed to recruit a qualified nurse practitioner who would meet both the funding criteria and the needs of their community.

In one case, because the Ministry did not provide the full requested funding, the resources the applicants had identified were no longer available to them

Why It Matters

In order to expand primary health care, local organizations or OHTs need to secure clinic space and recruit clinicians to provide team-based care in their communities. Since the Ministry plans to invite more applicants to submit proposals to establish new or expand existing primary care teams, clear communication of expectations is critical to enable them to efficiently and effectively meet patient needs in their communities and, in turn, connect every Ontarian to a publicly funded family physician or primary care team by 2029.

Recommendation 3

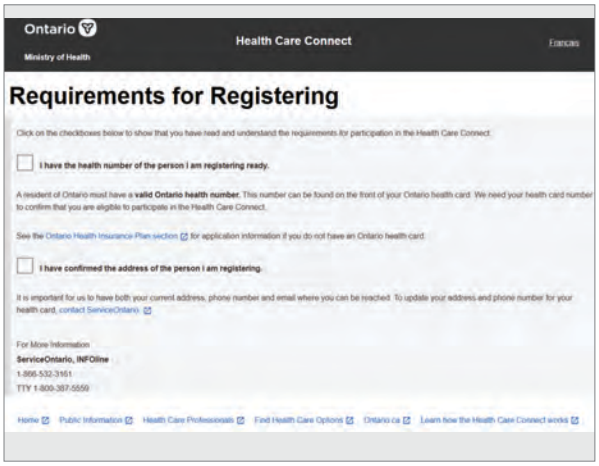
We recommend that the Ministry:

- identify lessons learned from previous calls for proposals, including where expectations of applicants were not aligned with those of the Ministry; and
- update future call for proposal requirements for applicants seeking funding to establish new or expand existing primary care teams to include more communication on what applicants can expect on the results of these proposals.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.2 Health Care Connect Program

The Ministry launched HCC in February 2009 to help Ontarians find a family physician or other primary care provider. In October 2021, the Ministry contracted with an external consortium to operate a health-care navigation service called Health811, an online and telephone health information platform funded by the Province. Those seeking primary care can register online or by calling Health811, as Health811 and HCC are linked. Later that month, the Ministry transferred contract oversight to Ontario Health, with the Ministry involved in providing policy direction.



Ontario Health atHome is responsible for operating the HCC program and is directly accountable to Ontario Health. Ontario Health atHome employs care connectors who help HCC registrants find primary care providers and identify primary care providers that indicate they are accepting new patients from HCC. The HCC process is shown in **Figure 6**.

Over 941,000 Ontarians registered with HCC from the launch of program in February 2009 to January 2025.

Figure 6: HCC Process Flow

Prepared by the Office of the Auditor General of Ontario

Registration	• Person (registrant) registers with HCC online or by telephone. • Registrant completes a questionnaire to assess health needs. • Registrant is encouraged to continue to seek their own health-care provider while on the wait list.
↓	
Prioritization	• HCC system assigns wait list priority based on complexity determined through health questionnaire.
↓	
Care connector seeks referral	• Registrant is connected to a nurse, known as a care connector, who searches for family physicians or nurse practitioners that confirm with the care connector they are accepting new patients.
↓	
Referral	• Care connector processes referral and sends letters to registrant and provider. • Primary care provider accepts new referral.

4.2.1 Implementation of HCC Program Has Not Fully Met the Needs of Ontarians

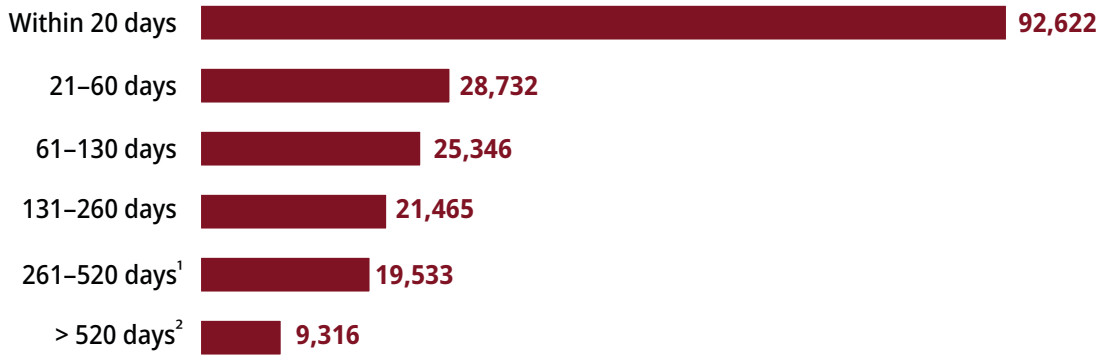
Ontarians Registered with HCC Have Experienced Long Wait Times

Prior to the establishment of PCAT in December 2024, the Ministry had not established an official wait-time target. We found that the program experienced long wait times, with some people waiting for more than four years.

We analyzed referral wait times for people who registered with HCC between 2020/21 and 2024/25. We found that, of the approximately 197,000 people referred as of April 2025, over 92,000, or 47%, had waited fewer than 21 days, and over 28,800, or 15%, had waited more than 260 days, as shown in **Figure 7**.

Figure 7: Number of People Registered with HCC Between 2020/21 and 2024/25 Who Were Referred as of April 2025, by Wait Times

Source of data: Ministry of Health



Note: These registrants were referred to physicians who are funded under a patient enrolment model. Prior to July 2025, the Ministry did not collect data on wait times for referrals to other primary care providers such as those in community health centres, nurse practitioner–led clinics or IPHCOs.

1. This category excludes registrants from 2024/25 as they have waited less than 261 days as of April 2025.
2. This category excludes registrants from 2023/24 and 2024/25 as they have waited less than 520 days as of April 2025.

As well, wait-list data showed that, of the approximately 178,000 people who registered between 2020/21 and 2024/25 and who were still waiting to be referred as of June 2025, more than 108,000 had been waiting for more than a year. This includes 5,000 people with complex needs. See **Figure 8**.

Figure 8: Number of HCC Registrants Pending Referral as of June 2025, by Year of Registration, 2020/21–2024/25

Source of data: Ministry of Health

Fiscal Year	Complex Needs Registrants	Other HCC Registrants	Total
2020/21	453	7,080	**7,533**
2021/22	905	16,405	**17,310**
2022/23	1,394	30,483	**31,877**
2023/24	2,286	49,044	**51,330**
2024/25	3,228	66,650	**69,878**

In January 2025, PCAT announced plans to modernize HCC, with a goal of connecting Ontarians on the HCC wait list to a to a primary care provider within 12 months of the time of registration. PCAT also announced plans to attach the 235,000 registrants who were on the HCC wait list as of January 1, 2025, to a primary care team by spring 2026. During our audit, the Ministry pursued targeted outreach by letter, email, text and phone call to those on the January 1, 2025 HCC wait list to inform them of the Ministry's commitment to connect them to primary care and capture any changes to their registration information.

We noted that HCC considers a person connected when they are referred to a provider, regardless of whether the person chooses to enrol with that provider. This may have the potential of overstating the actual attachment of registrants removed from the HCC wait list.

Referral wait times are impacted by the availability of primary care providers participating in HCC. Provider participation in HCC is discussed in **Section 4.2.2**.

HCC Online Registration May Not Meet the Needs of Diverse Ontario Populations

We found that HCC's online registration process does not collect sociodemographic details that may help care connectors connect Ontarians to providers who can best meet their care needs. Examples of this are factors such as race, ethnicity and self-identification of Indigenous status or as a member of the 2SLGBTQQIA+ community.

HCC's online registration is also only available in English and French, unlike the phone registration process, which is available in over 120 languages. Census data from 2021 found that over 3.7 million Ontarians, or about 27% of the population, had a mother tongue other than English or French.

The Province's website, which links to HCC, does not include information on how to register by telephone in languages other than English or French.

As well, HCC's online registration does not ask for the person's preferences for providers they will be matched with, such as the language spoken by the provider. In comparison, Manitoba's online registration includes provider preferences such as the gender, location and language of the provider, with up to 15 available language options. Similarly, Alberta has a "Find a Doctor" website that gives Albertans the ability to search for providers accepting new patients, with the option to filter by provider location, gender and language. The website was launched in 2019 through a partnership between Alberta's Primary Care Networks, the Government of Alberta and Primary Care Alberta.

The Province's website does not include information on how to register by telephone in languages other than English or French

Why It Matters

Collecting information about a person's identity when they register with HCC can help care connectors refer them to primary care providers who can better understand their needs. Improved access to providers with some form of shared identity could help remove barriers and encourage people from marginalized communities to access care when they need it.

Recommendation 4

We recommend that the Ministry take the lead and work with Ontario Health and Ontario Health atHome to update the HCC registration and matching process to:

- direct Ontarians who access the online registration to use the telephone registration services for assistance in languages other than English and French;
- allow registrants the option to include their preferences for providers and their sociodemographic information, including language, race, ethnicity, Indigenous identity, sexual orientation and gender identity; and
- enable matching of registrants with providers based on registrant preferences and sociodemographic information.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.2.2 Implementation of HCC Program Has Not Fully Met the Needs of Physicians

On Average, 7% of Physicians Funded Under a Patient Enrolment Model Participate in HCC

We found that very few physicians participate in HCC, which contributes to long wait times. The Ministry tracks the number of physicians funded under a patient enrolment model who accept people off the HCC wait list. We looked at data for each year between 2022/23 and 2024/25. The data shows that, on average, only 7% of the physicians who are funded under a patient enrolment model were accepting HCC registrants. This is an average of 648 physicians in each of those years. In addition, only 5% of physicians funded under a patient enrolment model were accepting HCC registrants with complex health needs.

On average, for each year between 2022/23 and 2024/25, only 7% of physicans who are funded under a patient enrolment model were accepting HCC registrants

The Ministry noted that only providers who are accepting new patients are able to participate in HCC. An average of approximately 250 other primary care providers and 40 primary care teams were also accepting HCC registrants each year between 2022/23 and 2024/25.

A 2023 HCC program review conducted by the Ministry and Ontario Health noted that physicians found that the self-assessment of medical complexity was often inaccurate, increasing the time required for physicians to manage patient needs. Physicians, and in particular new physicians, found it challenging to prioritize people with complex health needs, resulting in fewer providers participating in the HCC program and some providers being unwilling to take on certain patients.

To respond to these concerns, in the 2024 Physicians Services Agreement negotiation for years 2–4, the Ministry and the OMA agreed to increase payments to physicians for taking registrants from the HCC wait list, with a premium paid for taking on patients with more complex health needs. Physicians will also be able to bill the premium if, in their clinical opinion, a person listed as non-complex presents as complex.

OHTs Told Ministry That HCC Was Not Meeting Their Needs

In November 2024, Ontario's 58 OHTs met to discuss digital solutions to support provincial primary care access and attachment. A month later, 12 of these OHTs communicated to the Ministry that they "do not support updating the existing legacy HCC tool as it is no longer fit for purpose." These OHTs communicated that HCC is not widely supported by providers or accessed by Ontarians, and it has an outdated system (created in 2009) that requires redesign to integrate with Networks and OHTs.

The 12 OHTs recommended that a new program, including a digital patient registry and a more reliable source of data for unattached people, be co-designed with primary care, OHTs and Ontarians. They recommended that the program be operated by Ontario Health to ensure it is embedded within the Networks and OHTs.

Why It Matters

A program that can efficiently and effectively connect Ontarians without a family physician or other primary care provider can help Ontarians better prevent and manage illness. It can also allow the Province to more efficiently realize the goal of connecting 100% of Ontarians to primary care by 2029 and reduce the need for people to use other more expensive alternatives to obtain the care they need. Our Office's 2023 audit of Emergency Departments noted that the direct cost of an emergency department visit in Ontario was approximately $165, which was almost three times higher than alternative options like primary care, which cost about $56 per visit at that time.

Recommendation 5

We recommend that the Ministry take the lead and work with Ontario Health and Ontario Health atHome to:

- monitor the number of primary care providers now using HCC based on the new incentives;
- engage OHTs, Networks, primary care providers and patients to identify the necessary elements of new or enhanced HCC program systems; and
- develop and implement options to update or replace HCC with a new program to meet the needs of registrants, primary care providers and system planners.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.2.3 HCC Wait List Is Not Representative of the True Need in Ontario

As of January 1, 2025, there were approximately 235,000 Ontarians registered with HCC, representing about 11% of Ontarians who are known to be without a family physician. This means that most unattached Ontarians are not on the HCC wait list, which is the only centralized mechanism the Province has to help Ontarians find a family physician.

In their 2023 review of HCC, the Ministry and Ontario Health identified that lack of awareness and promotion of HCC was a weakness, but no change was made as this was not identified as a priority. We found that the Ministry has not updated its HCC communication plan targeting the public and health-care providers since 2015.

Why It Matters

HCC is the Ministry's only centralized mechanism to help Ontarians find a primary care provider. There is a risk that not everyone is aware of the program and therefore not given a fair opportunity to become attached to primary care. This may result in increased hospital use and poorer health outcomes over time, both of which result in increased health-care costs.

Recommendation 6

We recommend that the Ministry take the lead and work with Ontario Health and Ontario Health atHome to:

- update HCC communication plans; and
- monitor the effectiveness of its communication plans and adjust as needed.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.3 Ministry Oversight of Patient Enrolment Model Accountability Measures

As discussed in **Section 2.3**, about 9,600 family physicians are compensated under a patient enrolment model, compared to about 1,600 family physicians who provide comprehensive primary care and are compensated on an FFS basis. **Figure 9** describes the features of each of the four patient enrolment models and highlights the distribution of physicians across the models.

Figure 9: Patient Enrolment Models Used in Primary Care[1]

Prepared by the Office of the Auditor General of Ontario

Model	Basis of Compensation	# of Model Type as of Feb 2025	# of Physicians in Each Model	# of Physicians as of Feb 2025
Comprehensive Care Model (CCM)	FFS and bonuses, including small monthly capitation payments made for all enrolled patients	362	1 (solo physician)	362
Family Health Group (FHG)	FFS and bonuses, including small monthly capitation payments made for all enrolled patients	218	≥3	2,150
Family Health Network (FHN)	Capitation for a defined basket of services,[2] including bonuses	12	≥3	132
Family Health Organization (FHO)	Capitation for a defined basket of services[2] (larger than FHNs), including bonuses	601	≥6	6,479
Total				**9,123**

1. Excludes IPCTs and specialized contracts.
2. Any services provided outside of this basket of defined services may be billed as FFS.

The physician services agreement between the Ministry and the OMA, and the separate patient enrolment model agreements that outline additional terms and requirements, include two main accountability measures for physicians who are part of a patient enrolment model. These two measures, as seen in **Figure 10**, serve as proxy measures of access, and are intended to encourage continuity of care and ensure that patients are receiving care from the physician they are enrolled with:

- **After-Hours Care**: At least one physician is available outside of regular office hours for scheduled and unscheduled enrolled patient appointments/visits. Completed in three-hour after-hours blocks, the required number of blocks per week varies based on the number of physicians in each model, with a CCM physician being required to perform one block per week and FHOs required to perform a minimum of five blocks per week.
- **Outside Use**: Enough physicians are available to provide services during reasonable and regular office hours to avoid their patients seeking primary care services elsewhere, such as a walk-in clinic.

Figure 10: Monitoring of Key Accountability Measures Related to Access to Care

Prepared by the Office of the Auditor General of Ontario

		Applicability of Accountability Measure			
Accountability Measure	**Basis of Monitoring**	**CCM**	**FHG**	**FHN**	**FHO**
After-hours care	% of required after-hour blocks completed with at least five patients seen	✓	✓	✓	✓
Outside use*	% of primary care visits by rostered patients to physicians outside of their enrolled group	–	–	✓	✓

* This measure is tied to an access bonus, which is applicable to only FHN and FHO physicians.

As well, the Ministry has established thresholds at which point it would issue a letter to FHN or FHO physicians or physician groups to notify them of their failure to comply with the accountability measure requirements. The Ministry follows up with an FHN or FHO physician if 30% or more of their enrolled patients' care was provided by other physicians, or if 35% or less of required after-hour blocks were completed.

4.3.1 Ministry Does Not Reduce Capitation Payments to Physicians When Their Patients Get Care Elsewhere

Physicians in an FHO receive the following payments for each enrolled patient:

- **Capitation Payment**: Paid to the physician to provide a basket of services to their enrolled patients;
- **Access Bonus**: A special monthly payment, at up to 18.59% of the capitation, to encourage compliance with the outside use measure, deducted by the amount the Ministry spent paying other providers who provided care to the enrolled patients who sought care outside of the FHO; and
- other premiums, such as multipliers dependent on age, incentives and bonuses for services provided.

The Ministry requires each FHO physician to provide a basket of health services to their enrolled patients, but some patients still see other providers for these services. The Ministry monitors outside use cases where patients who are enrolled with an FHO physician obtain care from other providers, such as walk-in clinics.

Information about an enrolled patient is stored in the Client Agency Program Enrolment (CAPE) dataset. Information about the patient's rostering physician and group, which is information generated from OHIP billing data, is also included. The Ministry uses CAPE and OHIP billing data to monitor outside use by enrolled patients and identifies groups where 30% or more of an FHO physician's patients' care is provided outside the group. For groups exceeding the threshold, the Ministry notifies the FHO that they have not met the conditions of funding as set out in their agreement. The Ministry expects the group will rectify this issue, mainly through educating patients about their outside use, but does not require the group to report back with detailed plans on how it will do this. In 2023/24, enrolled patients in FHOs across Ontario sought primary care services outside of their group over 3 million times.

When a patient gets care elsewhere, the Ministry reduces the FHO physician's access bonus payment. Once this payment is depleted, the Ministry does not claw back any further funds from the FHO physician.

We found that even if patients go to a walk-in clinic to receive a service that should be captured under the basket of services, the Ministry does not reduce the capitation payment, just the bonus. In 2023/24, the Ministry paid over $103 million to other primary care providers to provide care to rostered patients.

This issue was also raised in our 2016 audit of Physician Billing. We analyzed FHOs that had gone into a negative access bonus due to their patients having accessed a significant amount of primary care elsewhere and found that the Ministry could potentially have withheld about $14 million in 2022/23 and 2023/24 if that option had been available in the terms of the agreement.

Based on Ministry data, the number of low-performing FHOs that had 30% or more of their roster's primary care provided outside of the group increased from 20 in 2021/22 to 28 in 2023/24. These low-performing FHOs on average experienced 35% to 38% of their enrolled patients receiving care elsewhere. In 2023/24, of the 28 FHOs performing above the Ministry's threshold, 19 had their access bonus reduced to $0, while the remainder received on average 32% of their maximum bonus despite being considered a low performer.

In the 2021 Physician Services Agreement, the Ministry and the OMA established a bilateral working group to study walk-in clinic use. This working group had two mandates:

- develop a framework to enable and require walk-in clinics to communicate back to an enrolled patient's primary physician; and
- develop a process to communicate with patients who regularly use walk-in clinics to better understand why they do so.

The working group released its final report in March 2024, making recommendations to address its second mandate, but noted that it would abstain from making recommendations around the first mandate. The Ministry and the OMA agreed that more work was required but had not completed this at the time of our audit.

In September 2025, after our audit work, the Ministry and the OMA reached an agreement for 2024–2028 that removed the access bonus and the negation when FHO patients receive services elsewhere. In its place, the Ministry and OMA introduced a continuity of care measure that may reduce the capitation rate by 15% if an FHO physician does not provide care for at least 75% of their roster's primary care visits. The impact of this change on access to primary care will take time to materialize and was not assessed as part of this audit.

4.3.2 Ministry Has Not Taken Corrective Action Against Physicians Compensated under CCM, FHG and FHN Models Who Do Not Meet the Contractual Requirements to Provide After-Hours Care

We found that the Ministry does not hold over 2,600 physicians who practise under the CCM, FHG and FHN models accountable for not meeting their after-hours care requirement.

As part of its agreement with physicians in patient enrolment models, the Ministry requires them to provide a set number of after-hours care blocks to their patients. The Ministry reviews claims data from FHOs annually and sends letters notifying those that do not provide more than 35% of their after-hours care block requirements. The Ministry does not similarly follow up with physicians belonging to the other three models to notify them of their poor performance or to ask how this situation will be improved.

We analyzed data from 2023/24 and found that 27, or 11%, of FHGs and one FHN did not meet their after-hours care requirements. The 27 FHGs on average completed only 12% of the required after-hours blocks. The FHN did not complete any required after-hours blocks. Additionally, the Ministry conducted an analysis that showed only 39, or 11%, of CCM physicians fulfilled their after-hours care requirements in 2023/24, with 106 physicians, or 29%, having completed none of their requirements.

4.3.3 After-Hours Care and Outside-Use Indicators Do Not Factor in Use of Emergency Department Services

The Ministry's definition of after-hours care and outside use in payment models to family physicians does not extend to patient visits to the emergency department for services that could have been managed through primary care.

Hospitals track non-urgent and less urgent visits to the emergency department, such as for sore throats and mild muscle pain, as levels 4 and 5 on the Canadian Triage and Acuity Scale. We asked the Ministry to analyze the estimated cost of these visits. In 2023/24, we found that over 136,000 visits were classified as level 4 or 5, and nearly 70% of these visits were made by enrolled patients. The estimated costs of the enrolled patients' visits totalled $36 million that year, as shown in **Figure 11**. About 53% of the visits by enrolled patients occurred during regular office hours.

Figure 11: Potentially Avoidable Emergency Department Visits by Enrolled Patients, 2023/24

Source of data: Ministry of Health

Patient Enrolment Model	Regular Office Hours[1] (%)	After-Hours[2] (%)	Cost ($ million)
CCM	50	50	1
FHG	47	53	5
FHN	59	41	2
FHO	53	47	26
Other models[3]	58	42	2
Total			**36**

1. Monday–Friday between 8 a.m. and 5 p.m.
2. Monday–Friday between 5 p.m. and 8 a.m. or weekends.
3. Examples include Blended Salary Model, Rural and Northern Physician Group Agreement, and St. Joseph's Health Centre.

Our Office's 2023 audit of Emergency Departments also highlighted this issue, noting that one of the key reasons for longer wait times in emergency rooms was the lack of available primary care services in the region, specifically during evenings and weekends.

A 2019 Ontario study by physicians from ICES noted, "physicians in this Ontario capitation-based model would be more likely to receive the access bonus if they encouraged their patients to visit the emergency department instead of a walk-in clinic."

The Canadian Institute for Health Information (CIHI) also tracks an indicator that measures the relationship of emergency department use and primary care, where patients visit the emergency department for reasons or conditions such as antibiotic prescriptions, colds and prescription refills. In 2022/23 and 2023/24, the two years that this indicator was tracked in Ontario, the percentage of patients who visited the emergency department for conditions that could be managed in primary care was around 13%.

Why It Matters

Patient enrolment models were created to improve patient access to care and provide better continuity of care from a consistent group of providers. If their rosters are full of people who seek care elsewhere, these people are taking the place of other Ontarians who could be attached to the team.

During the 2024 Physician Services Agreement negotiations, the independent arbitrator stated that it is "entirely appropriate to track FHO physician accountability." Without enforcing compliance with existing accountability measures, the Ministry cannot effectively detect cases where Ontarians are not able to access the care they need, when they need it.

Recommendation 7

We recommend that the Ministry:

- examine the primary reasons why enrolled patients obtain primary care from outside providers, such as walk-in clinics and emergency departments, and apply that knowledge in its next refresh of accountability measures;
- work with the OMA and physicians to educate patients to help change this behaviour;
- monitor physicians in all four patient enrolment models who do not meet the minimum requirements for the after-hours care accountability measure and work with non-performing physicians to meet these requirements;
- work with the OMA to review after-hours care and outside-use accountability measures in the funding agreements to incorporate instances of emergency department use for reasons and conditions that could have been addressed through primary care; and
- use the information gathered through this review to support planning for the next round of OMA negotiations.

For the auditee responses, see **Recommendations and Auditee Responses**.

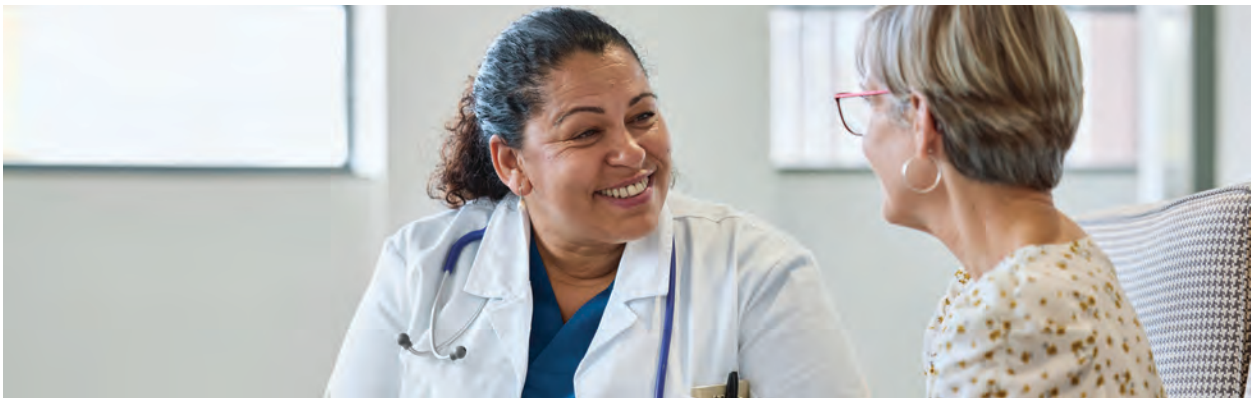
4.3.4 Ministry Cannot Detect Instances of Enrolled Patients Obtaining Primary Care from an Interprofessional Primary Care Team (IPCT) Overseen by Ontario Health

As discussed in **Section 2.3**, four IPCT models exist in Ontario: Indigenous Primary Health Care Organizations (IPHCOs), Community Health Centres (CHCs), Family Health Teams (FHTs) and Nurse Practitioner–Led Clinics (NPLCs). The Ministry oversees IPHCOs. It transferred oversight of CHCs, FHTs and NPLCs to Ontario Health in 2023. NPLCs, CHCs and IPHCOs do not bill through OHIP, and do not generate any information into CAPE, meaning CAPE does not include rosters for these models.

The Ministry is unable to detect when a patient enrolled with a family physician seeks care at an IPCT to which their physician does not belong, which would be another form of outside use as discussed in **Section 4.3.1.** As a result, the Ministry is unable to examine whether the outside use was driven by patient needs not being adequately met by their own physician.

In 2025, the Ministry performed a one-time analysis of data from 2022/23 to 2024/25 and found, during that time, that about 39,000 patients enrolled with about 7,000 physicians had regularly received primary care from a CHC. One physician in Ontario with a roster of about 1,600 patients had 66% of them regularly receiving care from a CHC.

The Ministry is unable to examine whether this outside use was driven by patient needs not being adequately met by their own physician



This type of data was unavailable for FHTs, IPHCOs or NPLCs, meaning the Ministry is unable to determine the extent to which this may be happening with these teams. The Ministry explained that since the patient enrolment data was pulled at a point in time for this analysis, it is unable to determine definitively whether these patients had received primary care from a CHC while being enrolled with a primary care physician.

Why It Matters

In a primary care system that is shifting toward team-based care, there is now a gap in the Ministry's ability to identify instances of enrolled patients visiting an IPCT for care that their own family physicians could provide. This creates the potential for increased outside use and inefficient use of other primary care settings. It also reduces the capacity of these systems as they are caring for the same patient when another patient could be provided with care.

Recommendation 8

We recommend that the Ministry take the lead and work with Ontario Health to:

- develop a methodology to include IPCT rosters in CAPE or other systems; and
- monitor the use of IPCTs by enrolled patients on a regular basis and determine actions needed to promote more efficient use of primary care services.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.4 Measuring Patients' Experiences with Access to Primary Care

4.4.1 Ministry Has Not Established Timelines or Targets to Measure Performance of the Primary Care System

In January 2025, PCAT identified five KPIs to measure its progress, including one indicator that measures access to primary care. At the time of our audit, the Ministry has not established timelines to collect data to measure these KPIs or targets to drive improvement.

The *Primary Care Act, 2025* came into effect in June 2025. According to the Act, the Minister of Health is required to report, by June 2026 and thereafter annually, on:

- how the Province is working to achieve the six objectives of the Act (discussed in **Section 2.6**);
- the percentage of insured persons in Ontario who have an "ongoing relationship" with a primary care clinician or team; and
- any other metrics prescribed through regulation.

At the time of our audit, the Ministry had not yet determined whether the Minister's annual report would include the five KPIs PCAT identified. We also noted that some of these indicators are similar to, or build upon, the measures that HQO had proposed in its 2014 primary care performance measurement framework, as shown in **Figure 12**. While these measures were proposed, not all were tracked, missing an opportunity to collect baseline data and establish targets over the last decade.

Figure 12: Key Performance Indicators Planned by PCAT Compared to HQO Indicators

Prepared by the Office of the Auditor General of Ontario

PCAT Indicators (2025)	HQO Indicators (2014)
1. Percentage of Ontarians who have ongoing connection to primary care	Access to a regular primary care provider
2. Percentage of primary care providers who work in interdisciplinary teams	Access to an interprofessional primary care team
3. Percentage of Ontarians who can access their health records online	Patient access to their own health information (outlined as a measurement area for future consideration)
4. Percentage of Ontarians who can get an appointment same day or next day when needed	Timely access at regular place of care
5. Percentage of Ontarians cleared from Health Care Connect wait list	n/a

While PCAT's goal is to attach all Ontarians to primary care, as discussed in **Section 2.2**, attachment does not equal access, and prioritizing the development of indicators related to access will help ensure that PCAT's work meets the needs of Ontarians. Of the five indicators PCAT identified, only the fourth relates directly to patient access to primary care services. The first KPI measures attachment and the remaining three measure other aspects of primary care.

The fourth indicator is not a new indicator, as it was already measured at the provincial level in the Ministry's 2023 Health Care Experience Survey. The survey included a question on whether patients were able to access a same-day or next-day appointment with a primary care provider when sick. At the time of our audit, HQO had a disclaimer regarding the 2023 survey results, noting that some results were not reported because data was unreliable. As a result, this number was not reported for the North East and North West regions of Ontario.

Prioritizing the development of indicators related to access will help ensure that PCAT's work meets the needs of Ontarians

In addition to the five indicators identified by PCAT, we noted a potential additional indicator of access, which is known as the "third next available appointment." Nova Scotia and Saskatchewan use this measure. The third next available appointment is considered a more accurate system measure of access than the "next available" appointment, as the next or even second next available appointment may have become available due to a cancellation or other event that is not predictable or reliable.

A 2022 Ontario study by a group of physician researchers that looked at patient-reported access measures evaluated through a patient experience survey found that their results "reinforce that timely access to primary care is a complex concept that is best assessed using multiple measures."

Why It Matters

Establishing performance indicators to measure access to primary care and setting goals are basic tools that can help the Ministry identify instances of poor access to primary care and improve system performance. Managing performance allows for adjustments to be made based on what is and is not working. Publicly reporting on these indicators provides transparency on how the Province is managing this important element of the health-care system.

Recommendation 9

We recommend that the Ministry:

- identify reliable data sources for KPIs related to patient access to primary care;
- develop a data collection plan with timelines, and begin collecting this data prior to the end of PCAT's mandate; and
- establish targets and publicly report on performance against these targets, such as through the Minister's annual report as described in the *Primary Care Act, 2025*.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.4.2 Ministry Does Not Encourage the Collection of Data on Patient Experiences at the Clinic Level

The Ministry does not monitor patient experiences across all primary care settings to ensure care is patient-centred and responsive to the needs of the community served, which is one of the objectives of the *Primary Care Act, 2025*.

Patient experience is currently measured in some, but not all, primary care settings. For example:

- As per their agreements with Ontario Health, CHCs, FHTs and NPLCs are required to submit a quality improvement plan, which places an emphasis on patient engagement.
- While not contractually obligated to, some IPHCOs have developed and implemented their own patient experience surveys.

- Hospital-based teaching sites that provide primary care must have a patient experience survey since they are part of a hospital. This is subject to the *Excellent Care for All Act, 2010*, which requires hospitals under the *Public Hospitals Act* to have client satisfaction surveys as part of their quality improvement plans. For example, the University of Toronto's community-based teaching clinics launched a patient experience survey in spring 2020, which includes questions around understanding timely access to care, perspectives on virtual care and patient engagement. As a result of the survey, the clinics updated their processes related to phone wait times and after-hours care.

While the Ministry administered the Health Care Experience Survey in 2023, this measured patient experience at a population level and did not include clinic-specific information. For example, this survey did not include access-related questions on appointment booking and care experience.

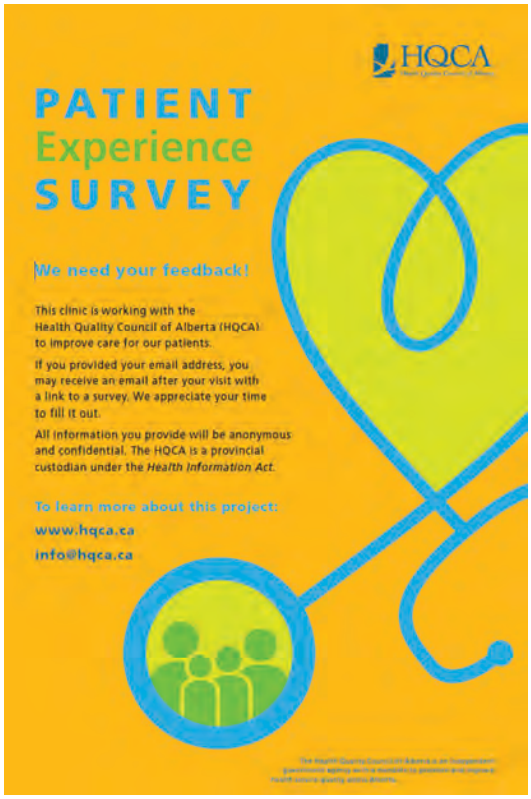
In May 2015, HQO issued a guide on primary care patient experience surveys to help clinicians measure patient experience at their clinics. Over a decade later, this guide has not been implemented across all primary care settings.

In contrast, the Health Quality Council of Alberta (HQO's equivalent) developed a clinic-level primary care patient experience survey in 2018. It has used the survey results to develop KPIs around patients' perceived quality of care. This survey asks about 25 questions, with four questions related to access, aiming to better understand the patient's ability to get care when needed.

To reduce administrative burden on the clinics, the Health Quality Council of Alberta has provided marketing materials (see **Figure 13**) and other resources to support survey administration. Similar strategies could be considered for use in Ontario to collect patient experience data, while not burdening clinics with additional administrative responsibilities.

Figure 13: Alberta Primary Care Patient Experience Survey Marketing Material

Source: Health Quality Council of Alberta



Why It Matters

Gathering patient experience data in a consistent way can help the Ministry and primary care providers identify opportunities to improve patient experience. This will allow the Ministry and primary care providers to respond to what matters most to their patients. It also provides the Ministry with more information to consider when determining whether primary care services are being provided in a patient-centred manner that is responsive to the needs of the community served. For example, if it takes weeks to get an appointment, the patient may go to a walk-in clinic or an emergency department. Understanding their experience will help them get the access they need.

Recommendation 10

We recommend that the Ministry:

- conduct a jurisdictional scan to determine best practices for patient experience surveys and undertake a feasibility assessment regarding the development of a clinic-level patient experience survey for use in Ontario in settings where this is not already being done; and
- consider next steps based on the results from the feasibility assessment.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.4.3 Ministry Relies on Incentives to Encourage the Provision of Accessible Care Without Collecting Sufficient Data to Assess Effectiveness

The Ministry only uses data collected through OHIP claims to monitor physician workload in primary care, but this data is incomplete because not all physicians bill through OHIP. The Ministry has no other means to effectively monitor whether physicians compensated under one of the patient enrolment models are providing access to care when needed, especially to patients with more complex health needs. While the Ministry has introduced multiple incentives, it is unable to confirm with confidence whether these incentives are working.

Patients with more complex health needs may require more visits to manage chronic health conditions. Since family physicians receive capitation payments even if patients do not receive their care, this creates risks that these physicians may prefer to select healthier patients for their roster, as seen with HCC patients (discussed in **Section 4.2.2**). There also may not be enough appointments available for patients with complex care needs to access their family physician when they need care.

The Ministry has attempted to mitigate these risks through several incentives, such as:

- changing the capitation rates to resolve issues related to maintaining complex patients in a capitation-based funding model;
- signing bonuses and increased capitation on a patient's first year of enrolment;
- bonuses to take Ontarians off the HCC wait list;
- bonuses to take on a larger roster and attach more patients; and
- additional payments based on acuity of patients enrolled in FHO and FHN models, as measured by the CIHI Population Grouper. This measure factors in a patient's demographic and clinical profile to better reflect the complexity of their care needs, aiming to provide more equitable compensation for physicians serving a patient population with more complex care needs.

Despite these incentives, patients are not receiving the care they need when they need it. According to the Ministry's 2023 Health Care Experience Survey, only 35% of Ontarians can see their family physician or someone else in the office on the same or next day. As we noted in **Section 4.3**, there are patients also turning to IPCTs and other primary care settings, such as walk-in clinics, for care while being enrolled with a family physician.

To ensure physicians are not taking on larger rosters than they are able to handle and misusing the incentives, the Ministry is required under the 2021 Physician Services Agreement to review FHOs with roster sizes over an average of 2,400 per physician on a quarterly basis. We found that the Ministry has been monitoring roster sizes according to the threshold. However, this measure in isolation does not speak to the value added from the incentives to increase access.

The OMA has noted that physicians over the age of 50 had roster sizes over 1,370, while those under 40 had an average of 986. The Ministry also noted that some areas have more than enough physicians to reach a 97% attachment rate if those physicians took on more patients. Although available incentives have increased, and average roster sizes have decreased, access as measured through compliance with after-hours care and outside use has gone down (discussed in **Section 4.3**).

A 2019 study supported by INSPIRE-PHC linked multiple databases to determine whether access bonus payments (discussed in **Section 4.3.1**) are aligned with their intended purpose of incentivizing primary care access and minimizing visits outside of capitation practices. The researchers recommended completing evaluations of financial incentives to ensure their relevance, alignment with system goals and equity. Our 2011 Funding Alternatives for Family Physicians audit also highlighted the need to analyze the benefits of new incentives periodically.

Why It Matters

Collecting and analyzing data related to patient access in patient enrolment models can help ensure that measures implemented, including incentives to encourage the provision of accessible care, are actually improving patients' access to primary care and resulting in a meaningful change to patient care.

Recommendation 11

We recommend that the Ministry collect data and evaluate annually whether existing financial incentives intended to improve access to primary care have contributed to improved patient access, and adjust these incentives as needed.

For the auditee responses, see **Recommendations and Auditee Responses**.

Recommendations and Auditee Responses

Recommendation 1

We recommend that the Ministry take the lead and work with Ontario Health to:

- work with OHTs to develop a framework for the Networks' engagement with primary care providers, including a standardized methodology to track providers' participation in Networks; and
- provide direction to the Networks to help them increase the number of participating primary care physicians, nurse practitioners and primary care teams.

Ministry Response

The Ministry agrees with this recommendation.

The government has established clear strategic direction through the Primary Care Action Plan. OHTs and their Networks have been directed to work closely with primary care clinicians and teams to co-ordinate local efforts and plan for attachment of 100% of their communities to primary care by 2029.

This work is already under way, with OHTs and their Networks working closely with primary care clinicians and teams to clear the HCC wait list. As of November 2025, 60% of the people who were on the HCC wait list on January 1, 2025 have been cleared. In addition, OHTs and their Networks are supporting the call for proposals process to establish new and expanded primary care teams across the province.

The Ministry and Ontario Health will set requirements for the consistent measurement of primary care providers participating in Networks.

Recommendation 2

We recommend that Ontario Health, in partnership with the Ministry, expand its work to co-ordinate equitable recruitment of family physicians with key partners, including municipalities, health-care organizations and communities.

Ministry Response

The Ministry agrees with this recommendation.

The Ministry, which is responsible for capacity planning and health human resources (HHR) strategies, recognizes the importance of recruiting family physicians and other valued HHR across Ontario in an equitable manner.

Work to improve the distribution of physicians and primary care clinicians and allied health professionals is under way through the implementation of Ontario's Primary Care Action Plan. Supported by a $2.1 billion investment, this plan takes a targeted, evidence-based approach to expanding and establishing new interprofessional primary care teams (IPCTs) across the province to help connect the two million unattached patients in Ontario to primary care.

The Ministry will continue to work with Ontario Health, which implements the Ministry's direction for workforce planning. Ontario Health and its regional offices will continue to develop the local recruitment strategies that are tailored to the unique needs of each region and community.

Recommendation 3

We recommend that the Ministry:

- identify lessons learned from previous calls for proposals, including where expectations of applicants were not aligned with those of the Ministry; and
- update future call for proposal requirements for applicants seeking funding to establish new or expand existing primary care teams to include more communication on what applicants can expect on the results of these proposals.

Ministry Response

The Ministry agrees with this recommendation.

The call for proposals process for new and expanded primary care teams has been, and will continue to be, refined based on stakeholder feedback and lessons learned.

As part of the Primary Care Action Plan, communities are developing strategies to achieve 100% attachment to primary care in their communities. Funding through the call for proposals process is a critical step toward realizing this vision. Interest in the call for proposals process has been strong, with the number of proposals submitted reflecting broad support for the government's commitment to fund new and expanded primary care teams.

In response to feedback from primary care stakeholders, the Ministry has provided additional guidance and clarified expectations to support successful proposals and will continue to do so going forward.

Recommendation 4

We recommend that the Ministry take the lead and work with Ontario Health and Ontario Health atHome to update the HCC registration and matching process to:

- direct Ontarians who access the online registration to use the telephone registration services for assistance in languages other than English and French;
- allow registrants the option to include their preferences for providers and their sociodemographic information, including language, race, ethnicity, Indigenous identity, sexual orientation and gender identity; and
- enable matching of registrants with providers based on registrant preferences and sociodemographic information.

Ministry Response

The Ministry agrees with this recommendation.

Through the Primary Care Action Plan, the government committed to connect the approximately 235,000 people on the HCC wait list as of January 1, 2025 to primary care by spring 2026.

Under the Ministry's strategic leadership, and in partnership with Ontario Health and Ontario Health atHome, the wait list has been reduced by 60% as of November 2025.

Recent improvements made to HCC include removing the requirement to de-enroll from an existing primary care clinician to register and allowing individuals to update their information online. Additional enhancements will be undertaken, such as providing assistance in languages beyond English and French.

Recommendation 5

We recommend that the Ministry take the lead and work with Ontario Health and Ontario Health atHome to:

- monitor the number of primary care providers now using HCC based on the new incentives;

- engage OHTs, Networks, primary care providers and patients to identify the necessary elements of new or enhanced HCC program systems; and
- develop and implement options to update or replace HCC with a new program to meet the needs of registrants, primary care providers and system planners.

Ministry Response

The Ministry agrees with this recommendation.

Through the Primary Care Action Plan, the government committed to connecting the approximately 235,000 people on the HCC wait list as of January 1, 2025 to primary care by spring 2026. The Ministry, in partnership with Ontario Health and Ontario Health atHome, have reduced the wait list by more than 60% as of November 2025.

A key initiative supporting this progress is the funding of new and expanded primary care teams across the province. These teams are actively attaching individuals in their communities to care, including those on the HCC wait list. The Ministry will lead efforts to monitor progress and adapt processes to reach its goals, informed by input from OHTs, Networks, clinicians and patients.

Further improvements to HCC will continue to be made to ensure the system meets the needs of both patients and providers.

Recommendation 6

We recommend that the Ministry take the lead and work with Ontario Health and Ontario Health atHome to:

- update HCC communication plans; and
- monitor the effectiveness of its communication plans and adjust as needed.

Ministry Response

The Ministry agrees with this recommendation.

HCC is a critical component of the government's Primary Care Action Plan and will continue to be the key provincial program for individuals to find a primary care provider.

Recent improvements made to HCC include removing the requirement to de-enroll from an existing primary care clinician to register and allowing individuals to update their information online.

Since the Primary Care Action Plan was announced in January 2025, numerous public and stakeholder communications tactics specifically related to HCC have been pursued.

Recommendation 7

We recommend that the Ministry:

- examine the primary reasons why enrolled patients obtain primary care from outside providers, such as walk-in clinics and emergency departments, and apply that knowledge in its next refresh of accountability measures;
- work with the OMA and physicians to educate patients to help change this behaviour;
- monitor physicians in all four patient enrolment models who do not meet the minimum requirements for the after-hours care accountability measure and work with non-performing physicians to meet these requirements;
- work with the OMA to review after-hours care and outside-use accountability measures in the funding agreements to incorporate instances of emergency department use for reasons and conditions that could have been addressed through primary care; and
- use the information gathered through this review to support planning for the next round of OMA negotiations.

Ministry Response

The Ministry agrees with this recommendation.

Work to improve access to primary care services is under way, including increasing after-hours care. This commitment is reflected in the expansion of primary care teams under Ontario's Primary Care Action Plan and the recently negotiated Physician Services Agreement with the OMA.

The Ministry will continue monitoring compliance and further examine barriers to timely access to primary care as we implement the 2024–2028 Physician Services Agreement and continue to invest in team-based care across the province.

Monitoring will expand across all primary care patient enrolment models to support consistent after-hours access and advance our vision for convenient, comprehensive and reliable primary care.

Recommendation 8

We recommend that the Ministry take the lead and work with Ontario Health to:

- develop a methodology to include IPCT rosters in CAPE or other systems; and
- monitor the use of IPCTs by enrolled patients on a regular basis and determine actions needed to promote more efficient use of primary care services.

Ministry Response

The Ministry agrees with this recommendation.

With the commitment to attach two million more people to primary care by 2029, the Ministry recognizes the importance of knowing the attachment status of Ontarians and communicating progress through the Primary Care Action Plan to stakeholders and the public.

Going forward, the Ministry will explore opportunities to develop a process to capture and monitor the formal attachment status of IPCT patients to support the government's commitment to attach everyone in Ontario to primary care.

Recommendation 9

We recommend that the Ministry:

- identify reliable data sources for KPIs related to patient access to primary care;
- develop a data collection plan with timelines, and begin collecting this data prior to the end of PCAT's mandate; and
- establish targets and publicly report on performance against these targets, such as through the Minister's annual report as described in the *Primary Care Act, 2025*.

Ministry Response

The Ministry agrees with this recommendation.

The Ministry has established data collection and other processes to monitor the impact of the government's $2.1 billion investment through the Primary Care Action Plan. This includes measuring progress on our commitment to provide the two million unattached individuals in Ontario with access to comprehensive primary care.

The Ministry will continue to explore additional data sources and key performance indicators to strengthen its monitoring, evaluation and reporting efforts.

Recommendation 10

We recommend that the Ministry:

- conduct a jurisdictional scan to determine best practices for patient experience surveys and undertake a feasibility assessment regarding the development of a clinic-level patient experience survey for use in Ontario in settings where this is not already being done; and
- consider next steps based on the results from the feasibility assessment.

Ministry Response

The Ministry agrees with this recommendation.

Through its Primary Care Action Plan, the Ministry is making progress in attaching two million patients to primary care by 2029, achieving the government's goal of connecting every person in Ontario to primary care. To ensure that patient experiences and perspectives continue to guide decision-making, the Ministry will maintain consultations with stakeholders, including the Minister's Patient and Family Advisory Council.

The Ministry will also conduct a jurisdictional scan and a feasibility assessment to determine best practices for patient experience surveys and identify potential options for government consideration.

Recommendation 11

We recommend that the Ministry collect data and evaluate annually whether existing financial incentives intended to improve access to primary care have contributed to improved patient access, and adjust these incentives as needed.

Ministry Response

The Ministry agrees with this recommendation.

Through the Primary Care Action Plan investment of $2.1 billion to connect two million more people to primary care by 2029, along with new and modernized investments and incentives under the 2024-2028 Physician Services Agreement, patients will have improved access to primary care.

The Ministry currently has a monitoring process and levers in place to oversee primary care teams, and will continue to monitor the impact these incentives are having to improve patient access.

Any potential adjustments or changes to financial incentives for physicians would need to be addressed through discussions and negotiations with applicable stakeholders, such as the OMA.

Audit Criteria

In planning our work, we identified the audit criteria we would use to address our audit objectives (outlined in **Section 3**). These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry and Ontario Health reviewed and agreed with the suitability of our objectives and associated criteria:

1. The Ministry has considered options and developed a strategic plan with well-defined goals and an interdisciplinary approach to improve access to primary care. The plan guides programs, initiatives and activities that support its goals.
2. The Ministry equitably allocates primary care physicians and interprofessional primary care teams in communities of higher need.
3. The Ministry and Ontario Health regularly review Health Care Connect to identify gaps and make necessary improvements.
4. The Ministry regularly collects accurate, timely and complete financial and operational information from funding recipients to ensure they comply with contractual agreement requirements related to access to primary care for physician funding models and takes corrective actions on a timely basis when issues are identified.
5. Key performance indicators and targets related to access to primary care are established, monitored and compared against actual performance.

Audit Approach

We conducted our audit between January 2025 and August 2025. We obtained written representation from Ministry and Ontario Health management that, effective November 24, 2025, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

As part of our audit work, we interviewed and reviewed information from relevant staff in:

- the Ministry, primarily from the Capacity and Health Workforce Planning Branch, Primary Health Care Branch, Digital Health Program Branch, Ontario Health Teams Policy and Operations Branch, and Health Analytics and Insights Branch;
- Ontario Health, primarily from the Primary and Community-Based Care Team, the Ontario Health Team Implementation Team and HealthForceOntario; and
- the Primary Care Action Team, and reviewed documents related to its work, including a sample of primary care team expansion proposals and evaluations.

In addition, we:

- analyzed OHIP claims data and budgetary funding requests, program data, and stakeholder communications;
- reviewed relevant legislation and regulations, program policies and frameworks, funding and accountability agreements, and internal Ministry documents related to access to primary care;
- spoke with and/or obtained information from multiple Ontario Health Teams, Primary Care Networks and primary care providers, including representation from northern and rural regions;
- spoke with and obtained data from primary care researchers in Ontario;
- spoke with and/or obtained information from external stakeholders and subject-matter experts to better understand issues related to primary care access, including INSPIRE-PHC, the Ontario College of Family Physicians, the Ontario Medical Association, the Indigenous Primary Health Care Council, the Alliance for Healthier Communities, the Association of Family Health Teams of Ontario, the Ontario Health Coalition, the Ontario Physician Recruitment Alliance and the Association of Municipalities of Ontario; and
- reviewed publicly available information regarding access to primary care from other jurisdictions, including British Columbia, Alberta, Manitoba, Nova Scotia and Saskatchewan.

We also engaged a primary care physician from another province to provide input and advisory services to inform our audit work.

Audit Opinion

To the Honourable Speaker of the Legislative Assembly:

We conducted our work for this audit and reported on the results of our examination in accordance with Canadian Standard on Assurance Engagements 3001—*Direct Engagements* issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies Canadian Standards on Quality Management and, as a result, maintains a comprehensive system of quality management that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our conclusions.

December 2, 2025

Shelley Spence, FCPA, FCA, LPA
Auditor General
Toronto, Ontario

Acronyms

Acronym	Definition
AMO	Association of Municipalities of Ontario
CAPE	Client Agency Program Enrolment
CCM	Comprehensive Care Model
CHC	Community Health Centre
CIHI	Canadian Institute for Health Information
CTAS	Canadian Triage and Acuity Scale
HCC	Health Care Connect
HQO	Health Quality Ontario
FFS	Fee-for-Service
FHN	Family Health Network
FHG	Family Health Group
FHO	Family Health Organization
FHT	Family Health Team
ICES	Institute for Clinical Evaluative Sciences
IHP	Interprofessional health provider
IPCT	Interprofessional Primary Care Team
IPHCO	Indigenous Primary Health Care Organization
KPI	Key performance indicator
NPLC	Nurse Practitioner-Led Clinic
OHIP	Ontario Health Insurance Plan
OHT	Ontario Health Team
OMA	Ontario Medical Association
PCAT	Primary Care Action Team

Appendix 1: Team-Based Primary Care Models as of February 2025

Source of data: Ministry of Health

Model	# in Ontario	# of Health-care Providers	Funded by
Family Health Team (FHT)	183	• 3,000+ affiliated physicians • ~2,600 interprofessional health providers (IHPs)	Ministry through Ontario Health
Community Health Centre (CHC)	79	• 311 full-time equivalent (FTE) salaried physicians • 3,712 IHPs	
Nurse Practitioner-Led Clinic (NPLC)	27	• 255 IHPs, including 133 nurse practitioners	
Indigenous Primary Health Care Organization (IPHCO)	25	• 51.6 FTE salaried physicians • 499 IHPs	Ministry

Appendix 2: List of 58 OHTs and Unattachment Rates by Region

Source of data: Ministry of Health

Region	OHT	Unattachment Rate (%)
Central	Barrie and Area	14
	Central West	13
	Connected Care Halton	9
	Couchiching	10
	Eastern York Region and North Durham	11
	Hills of Headwaters Collaborative	8
	Mississauga Health	12
	Muskoka Almaguin	9
	North Simcoe	12
	Northern York South Simcoe	9
	South Georgian Bay	10
	Western York Region	11
East	Archipel	11
	Durham	9
	Frontenac, Lennox & Addington	14
	Great River	18
	Hastings Prince Edward	15
	Kawartha Lakes Haliburton	12
	Lanark, Leeds and Grenville	9
	Northumberland	8
	Ottawa	17
	Ottawa Valley	21
	Ottawa West Four Rivers	11
	Peterborough	14
North East	Algoma	18
	Cochrane District	27
	Maamwesying*	n/a
	Nipissing Wellness	14
	Sudbury Espanola Manitoulin Elliot Lake	17
	Timiskaming Area	13
	West Parry Sound	10

Region	OHT	Unattachment Rate (%)
North West	All Nations Health Partners	33
	Kiiwetinoong Healing Waters	5
	Noojmawing Sookatagaing	15
	Rainy River District	24
Toronto	Downtown East Toronto	20
	East Toronto Health Partners	13
	Mid-West Toronto	21
	North Toronto	16
	North Western Toronto	15
	North York Toronto Health Partners	15
	Scarborough	12
	West Toronto	16
West	Brantford Brant Norfolk	10
	Burlington	6
	Cambridge North Dumfries	11
	Chatham-Kent	16
	Elgin	12
	Greater Hamilton Health Network	9
	Grey-Bruce	11
	Guelph Wellington	10
	Huron Perth and Area	9
	Kitchener, Waterloo, Wilmot, Woolwich, and Wellesley (KW4)	16
	Middlesex London	16
	Niagara	14
	Oxford	10
	Sarnia Lambton	11
	Windsor Essex	12

* No data available due to an inability to determine the Indigenous OHT's population by geography.

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An electronic version of this report is available at **www.auditor.on.ca**
Ce document est également disponible en français.

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