THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Family Physician Remuneration in Canada



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This document provides a high-level summary of key physician compensation models. It is important to note that remuneration models vary by province/territory depending on local policies and agreements between governments and provincial/territorial medical associations. In addition, the models can be part of an organizational practice model that is already in place. Although physicians may be able to choose the practice model type they would like to practice in, there is less flexibility when choosing a specific remuneration model at the individual level.[1] This document is meant to be a high-level guide on methods of remuneration and does not provide an exhaustive list of contract types available throughout Canada. The examples provided do not encapsulate all of the advantages and disadvantages of the model. Rather, they serve as an overarching scenario a family physician may find themselves in. The CFPC recommends physicians connect with their provincial and territorial medical associations to review the agreements in place and options available to them.

Various remuneration models for family physicians influence physician income, practice style, and patient care dynamics. Model preferences will vary based on individual preferences and practice needs. The advantages and disadvantages of each model are outlined below, focusing on work-life balance, available support, physician autonomy, and income security.

While broad characteristics of the models are provided, the significant variance within each type should be considered – the document offers sources of additional information for additional detail for specific jurisdictions.

Where possible, reported income figures are provided, but those too should be considered as general estimates dependent on multiple factors including provinces/territories, context, size of practice, etc.

Fee For Service (FFS)

Definition: Physicians are self-employed and are compensated through a provincial/territorial health insurance plan for each service rendered. Each province and territory has a schedule of fees paid for the many services and procedures that a family physician provides.[1] Enhanced FFS includes supplemental payments (i.e., time premiums) for seeing complex patients, rural practice, or services delivered during weekends/evenings. This is the most prominent payment model, with 72 per cent of physicians compensated by FFS.[2]

Example: Michael has set up his own practice in Alberta and sees a pregnant patient for a maternal well-being visit. After the visit, he submits the appropriate billing claim to the provincial health insurance plan and is compensated according to the fee schedule for that service.

Advantages	Disadvantages
• Incentives and premiums (enhanced FFS) that incentivize family practice to desired ends (complex and chronic care management, preventive care, formal patient enrolment) can be included[1] • More patients served (in visits and services rendered, including diagnostic tests and curative services), dependent on model structure and if operating in a team-based environment[1] • Increases physician control over their practice and income • Greater flexibility in determining clinic hours compared with some contractual payment models.[3] Many provinces use enhanced or blended FFS models where physicians commit to blocks of after-hours care in exchange for bonuses or premiums.[4]	• Limited fee schedule, which may not adequately incentivize complex case management and collaboration • Compensation for virtual care varies between provinces and territories[1] • Some systems discourage follow-up care by limiting one billing per day, creating incentives that favour less comprehensive visits[1] • Incentivizes high patient volumes and procedures, contributing to physician burnout[5,6] • Income can vary substantially depending on the region (rural/urban) or significant changes in practice patterns (such as a shift to telemedicine during COVID-19)[7,8] • Overhead from the business is deducted from gross payment (an estimated 17 per cent to 35 per cent can go toward lease costs, staffing, and equipment,[9,10] although this can be shared among co-located physicians) • The family physician has to make individual accommodations for pension, insurance, and absence coverage
Average gross annual payment: $268,181 to $348,774[11] (2023–2024)	

Capitation

Definition: Physicians receive a set fee for each patient on their roster, which may be adjusted by age, sex, morbidity, or other modifiers.[1] Pure capitation models are rare and have been combined with other methods of remuneration to avoid negative outcomes associated with the model, such as preferential rostering of low-risk patients.[1]

Example: Mirai works in a Family Health Organization in Ontario, a collaborative comprehensive primary care delivery model involving three or more physicians working together, with a maximum roster size of 2,400 patients each. She is paid a set annual amount to cover predefined services, regardless of how often the patient visits the clinic. In addition to the base capitation rate that is based on patient age, sex, and clinical risk factors, she can charge FFS and keep 30 per cent of schedule benefits for expected services, and 100 per cent of billings for out-of-basket services (obstetrics, palliative, etc.). She will also receive a 50 per cent premium for providing after-hours care. In addition, she is compensated with an hourly rate for indirect care and administration.[12]

Advantages	Disadvantages
• Collaboration within health teams, delivery of preventive care services, and/or health promotion increased[1,13] • Encourages addressing multiple issues per visit[14] • Recent agreements increase physician incomes under this payment method[1] • Incentivizes larger patient panels[15] • Overhead costs can be shared between physicians in the same practice[1] • Leads to less workload stress due to lower visit volume[16]	• May create incentives to preferentially enrol lower-complexity patients though complexity modifiers, where they exist, may compensate for this[17] • Often combined with other models to avoid shifting responsibility of care to other settings or providers • There may be financial penalties if rostered patients receive care from walk-in clinic physicians (Ontario, Alberta)[18] • Decreased autonomy as the model may determine how many patients each physician must have on their roster and how many physicians can make up a team (specifically in Ontario family health organizations)[19] • Family physician must make individual accommodation for pension and insurance
Average gross annual base payment: approximately $204,773 to $224,000[20,*] (Ontario, 2024)	

Salary

Definition: In a salary model, physicians are employees who receive wages, similar to how other salaried workers would be paid. The salaries are often based on units of time and paid in regular instalments. This method of payment is often accompanied by a contract stipulating practice responsibilities and privileges, in the case of hospital medicine.[1] Often used in community health centres, rural physician groups, territories, and some academic centres (such as Sick Kids Hospital).[2] A small proportion of physicians work in this model.

Example: Mahmoud works as an employee of the Government of Nunavut, receiving a salary from the territorial Department of Health to treat residents at the Rankin Inlet Health Centre.

* This number does not include incentives or bonuses.

Advantages	Disadvantages
• Stable and predictable income for physicians[1] • Improved work-life balance[18] • May spend less time on administrative tasks[21] • Often includes paid vacation, paid sick leave, RRSP matching, and paid maternal/parental leave benefits[11] • In most cases, the employer pays the overhead expenses of the practice.[22] This may not cover professional overhead (licensing, accountant assistance, etc.).	• Availability may be restricted to community health centres, underserved settings, specific limited academic or administrative opportunities[1] • Detailed terms and conditions of employment and performance monitoring systems are required, which adds to administrative burden and reduces autonomy[1,23] • May have limited input into how the practice is set up and functions • May be professionally isolating, offering less access to resources[18] • Highly specialized roles tend to be compensated through salary-based models

Average gross annual payment: $232,915 to $457,789[24,25] (2026)

Blended/Block Fees

Definition: New, blended payment models were rapidly implemented in several Canadian provinces over the past few years. These models can include compensation based on hours worked, fees per patient visit, and annual incentives for panel size and patient complexity.[26]

Example: Anya practices under the Longitudinal Family Physician Payment Model in British Columbia. To reflect the comprehensive and continuous nature of family medicine, it is a blended payment model that uses FFS and capitation to compensate physicians for time, interactions, and their overall patient panel.[27] Anya bills for the total time she spends providing care, including time spent on direct care, indirect care, and clinical administration. She can also bill for each patient interaction and communication/conferencing activities. Finally, Anya will receive a quarterly panel payment based on the number and complexity of patients on her roster.[28]

Advantages	Disadvantages
• Offers financial stability and predictability somewhat independent of patient volume[29] • Balances the various facets of payment – time spent on direct and indirect care, patients seen, and patients rostered • Offers compensation for administrative tasks[18] • Overhead costs can be shared among physician partners, if practising in a group – multiple blended remuneration models encourage group practices[22]	• There are financial penalties in Ontario if rostered patients receive care from walk-in clinic physicians[21] • Less physician autonomy in this model as the government stipulates minimum patient panel size, hourly clinic requirements, and limits the provision of non-panel services[30]

Annual gross payment: approximately $365,000[31] to $385,000[17,32] (2023)

This document is not an exhaustive summary of all payment models available across the country. We recognize that the generalizations cannot reflect the differences of all practice environments and the CFPC wants to hear from you as we continue to develop a layered understanding of the context-specific considerations of each compensation model and opportunities to offset the challenges of each. If you have specific questions regarding family physician remuneration within your province/territory, please reach out to the appropriate contact below.

Provincial and Territorial Medical Associations/ Regulatory Bodies	Contact
Doctors of British Columbia	Email: contact@doctorsofbc.ca mail
College of Physicians and Surgeons of British Columbia	Phone: (604) 733-7758 www.cpsbc.ca
Alberta Medical Association	Email: amamail@albertadoctors.org
College of Physicians and Surgeons of Alberta	Phone: (780) 423-4764 www.cpsbc.ca
Saskatchewan Medical Association	Meric Osman Email: meric.osman@sma.sk.ca Omid Ghaderi Email: omid.ghaderi@sma.sk.ca
College of Physicians and Surgeons of Saskatchewan	Phone: (306) 244-7355 Email: cpss@quadrant.net
Doctors Manitoba	Braden Kalichuk Email: bkalichuk@doctorsmanitoba.ca
College of Physicians and Surgeons of Manitoba	Phone: (204) 774-4344 www.cpsm.mb.ca
Ontario Medical Association	Steve Nastos Email: Steve.Nastos@oma.org
College of Physicians and Surgeons of Ontario	Phone: (416) 967-2600 www.cpso.on.ca
Fédération des médecins omnipraticiens du Québec	Email: president@fmoq.org
Collège des médecins du Québec	Phone: (514) 933-4441 Email: info@cmq.org www.cmq.org

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Provincial and Territorial Medical Associations/ Regulatory Bodies	Contact
Doctors Nova Scotia	Alana Patterson, Director of Physician Compensation and Negotiations Email: alana.patterson@doctorsns.com
New Brunswick Medical Society	Michel Leger Senior Advisor - Physician Compensation Email: mleger@nbms.nb.ca Email: info@nbms.nb.ca
Medical Society of Prince Edward Island	Email: admin@mspei.org
College of Physicians and Surgeons of Prince Edward Island	Phone: (902) 566-3861 Fax: (902) 566-3986 Email: mmacdonald@collegeofphysicians.pe.ca
Newfoundland and Labrador Medical Association	Noah Donovan Physician Compensation Specialist Phone: (709) 702- 4102 Email: ndonovan@nlma.nl.ca
College of Physicians and Surgeons of Newfoundland and Labrador	Phone: (709) 726-8546 Email: cpsnl@cpsnl.ca www.cpsnl.ca
Northwest Territories Medical Association	William Gagnon, Executive Director Email: nwtmda@gmail.com
Northwest Territories Professional licensing Health and Social Services	Phone: (867) 920-8058 Fax: (867) 873-0484
Yukon Medical Association	Email: office@yukondoctors.ca
Yukon Medical Council	Phone: (867) 667-3774 www.yukonmedicalcouncil.ca Email: ymc@yukon.ca
Nunavut Professional Licensing Dept. of Health Government of Nunavut	Phone: (867) 982-7668 Fax: (867) 982-3256

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Dr. Heba Shahaed
(Section of Residents, College of Family Physicians of Canada)

Dr. Trina Stewart
(President, Prince Edward Island College of Family Physicians)

Derek Law
(Manager of Economics and Data, Doctors of Nova Scotia)

Alberta Medical Association

Doctors of British Columbia

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