



CFPC Brief: Family physician panel sizes in Canada

Executive Summary

In health care, a **patient panel** refers to the number of patients that a family physician provides comprehensive care for, acting as the most responsible provider.

This brief offers an overview of family physician panel sizes across Canadian provinces.* Drawing on academic literature, stakeholder interviews, and provincial data, it demonstrates variation in average panel sizes from less than 1,000 to 1,500—shaped by patient complexity, practice models, physician demographics, and care demands. Key findings are below.

- **No universal benchmark:** Panel size is highly context-specific and influenced by several complex factors
- **Wide variation in targets and requirements:** Some provinces have established minimum thresholds while others have no stated targets or requirements
- **Complexity adjustments:** Most provinces use or are developing systems to adjust payment and panel size expectations based on patient complexity†

- **Eligibility criteria tied to panel size:** In several provinces, panel size thresholds determine physician eligibility for certain funding models or billing options
- **Assessment tools in use:** Multiple provinces offer tools to help physicians understand and manage their panels, often linked to quality improvement efforts

Excessive patient panels can compromise care quality,^{1,2,3} access to care,^{3,4,5} and physician wellness.^{5,6} Panel standards should prioritize flexibility, local context, and family physician engagement to build a primary care system that meets patient and provider needs. Panel size thresholds must be developed in consultation with physician organizations to avoid unrealistic, arbitrary standards that worsen physicians' professional experiences and compromise care quality.

* Based on provincial data available for family physician panel sizes up to September 2025.

† For an example of how complexity can be addressed, see: British Columbia Ministry of Health. Medical Services Commission Longitudinal Family Physician Payment Schedule. Victoria, BC: British Columbia Ministry of Health; 2025. Accessed September 8, 2025. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/longitudinal-family-physician/web-lfp-payment-schedule_may-1-2025.pdf



Policy Landscape Across Provinces

Province	Key Information
British Columbia	Average panel size: N/A Minimum panel size: N/A Complexity modifiers: N/A Panel assessment and management support tools: FPSC Practice Support Program with coaching; Health Data Coalition allows physicians to assess their practice/panel to better understand their own patient population and patterns of practice on its own and as it compares to their clinic/community
Alberta	Average panel size: 1,199⁷ (year: 2020) Minimum panel size: 500⁸ Complexity modifiers: Panel payments are complexity-weighted⁹ using the Canadian Institute for Health Information Population Grouping methodology Panel assessment tools: Alberta Medical Association offers a tool to calculate ideal panel size¹⁰
Saskatchewan	Average panel size: 1,001 to 1,500¹¹ (year: 2024) Minimum panel size: 250¹² Complexity modifiers: Transitional Payment Model modifiers not yet developed¹² Panel assessment tools: Best Practice Primary Care Panel Reports provides physicians in Saskatchewan with information about their panel¹³
Manitoba	Average panel size: N/A Minimum panel size: 250¹⁴ Complexity modifiers: N/A Panel assessment tools: N/A; the Winnipeg Regional Health Authority offers a guideline with panel measurement calculations¹⁵

Province	Key Information
Ontario	Average panel size: 1,187¹⁶ (year: 2025) Minimum panel size: 2,400–4,000 for FHOs consisting of 3-5 family physicians¹⁷ Complexity modifiers: Panel payments are complexity-weighted using the Canadian Institute for Health Information Population Grouping Methodology with additional age modifiers for specific services Panel assessment tools: N/A
Quebec	Average panel size: N/A Minimum panel size: N/A Complexity modifiers: N/A Panel assessment tools: N/A
Prince Edward Island	Average panel size: N/A Minimum panel size: 1,300¹⁸ (year: 2025) Complexity modifiers: N/A Panel assessment tools: N/A
New Brunswick	Average panel size: 1,025[‡] (year: 2025) Minimum panel size: N/A Complexity modifiers: Calculation based on age/sex, applicable only to Family Medicine New Brunswick program[§] Panel assessment tools: N/A
Nova Scotia	Average panel size: N/A Minimum panel size: No minimum threshold¹⁹ Complexity modifiers: Calculation includes time caring for non-panel patients and other activities²⁰; longitudinal family model includes a community complexity modifier²¹ Panel assessment tools: N/A
Newfoundland and Labrador	Average panel size: N/A Minimum panel size: None, though new agreement unlocks additional funding for practices with 1,200+ patients by Year 2 of service²² Complexity modifiers: N/A Panel assessment tools: MyQ Proxy Panel Reports tool offers information on panels to help physicians improve their practice²³
Territories	Average panel size: N/A Minimum panel size: N/A Complexity modifiers: N/A Panel assessment tools: N/A
Canada	Average panel size: 1,351²⁴

‡ New Brunswick Medical Society (qualitative interview), based on data from 90th percentile of fee-for-service and Family Medicine New Brunswick family doctors.

§ CFPC electronic communication with New Brunswick Medical Society.

Factors Influencing Panel Size

Determining an appropriate family physician patient panel size is complex and context specific, as panel sizes are shaped by various interrelated elements.

Supply: Physician Factors

Physician factors impact how much time and capacity a family physician can dedicate to patient care and how many patients they can reasonably manage. Many insights below were derived from qualitative interviews with physician organizations across Canada.

- **Physician workload:** Physician workload has increased,^{25,26} particularly with non-face-to-face activities (filling out forms, telephone encounters, lab tests, prescription refills, electronic messages)
- **Rural context:** In rural areas, family physicians often take on broader roles due to limited consulting specialist availability. This expands their responsibilities and workload, limiting the size of panel they can sustainably maintain.
- **FTE considerations:** Many family physicians work part-time or split their time between clinic care and other essential roles, such as hospitalist work, emergency care, or palliative care, resulting in smaller panel sizes
- **Teaching, research, and leadership:** Family physicians support the sustainability of the primary care system through roles in teaching, research, and leadership, including clinical supervision of medical students
- **Practice models and team supports:** Access to team-based care, administrative support, and incentive structures vary across settings, influencing how family physicians deliver care and manage their workload
- **Gender:** Males are more likely to have larger panels; mean total roster size for comprehensive male family physicians in Ontario is 1,318 compared to 1,062 for their female counterparts¹⁶
- **Age and career stage:** Early-career physicians often have smaller panel sizes as they build their practices,¹⁶ while larger rosters are more common among older and international medical graduate physicians²⁷



Demand: Patient factors

Patient characteristics directly influence the amount of time a physician spends with a patient in face-to-face visits and in indirect care. Greater complexity typically results in longer appointments, more frequent visits, and more care coordination, which reduces the number of patients (panel size) a physician can effectively manage.^{5,28}

- **Age:** Older adults are more likely to have multiple chronic conditions and geriatric syndromes; nearly one fifth of Canadians are now over 65 and this population group is growing
- **Chronic disease and multimorbidity**^{28,29}: These patients require ongoing coordination and more frequent and longer visits. Nearly 45 per cent of Canadians already live with at least one major chronic condition, and multimorbidity is increasing.³⁰ Medication use⁵ and visit patterns²⁸ reflect this complexity and directly impact panel size.
- **Language ability and preferences:** Communication with patients who require interpretation services takes more time; for example, a phone call can take two to three times longer⁵
- **Mental health conditions:** Mental health primary care visits have increased post-pandemic,³¹ as rising rates of mood and anxiety disorders³² and declining self-rated mental health³³ contribute to greater patient complexity
- **Social determinants of health:** Patients with low socioeconomic status, inadequate housing, or trauma often need more support to navigate care and more coordination with community resources

Risks of excessive patient panels

Panel size data can support planning and policy discussions but should be interpreted and applied cautiously. Physicians engaged in teaching, leadership, hospitalist roles, or those transitioning to retirement often maintain smaller rosters for valid reasons. Mandatory panel minimums could disincentivize these mixed practice models, reducing system flexibility and overall access to care.

Patient panels that are larger than a physician can manage are consistently linked to negative outcomes for both physicians and patients. Evidence indicates that quality

of care, comprehensiveness of care,¹ cancer screenings,¹ and diabetes care quality² decline with increasing panel size. Larger panel size is also associated with greater hospitalizations for ambulatory-care sensitive conditions,¹ less appropriate prescribing,^{2,34,35} reduced access to timely care,^{3,4,5,29} lower patient satisfaction,²⁹ and fewer opportunities for in-depth visits.²⁷ Larger panel size is also associated with greater physician burnout.^{5,6} Family physicians in Canada already spend 10 to 19 hours weekly on administrative tasks,³⁶ which will likely increase if physicians are overpanelled.

Pressuring physicians to expand panels without accounting for infrastructure, complexity, or workload may worsen burnout, reduce appointment availability, and compromise care quality. National data reflect the reality of increasing complexity, higher administrative burden, and evolving practice styles: average patient panels have declined from 1,746 in 2013 to 1,353 in 2021.²⁴

Example of target panel sizes

The calculation below demonstrates how many visits a family physician would need to complete per day to maintain panel targets of 1,200 and 1,600, respectively.

Assumptions:

- Panel of average patient complexity
- Average number of 3.8 visits per patient per year³⁷
- Six weeks reserved for continuing medical education, holidays, and vacation time, leaving 46 working weeks
- Average visit length of 20 minutes with a family physician (most family physicians spend 15 to 25 minutes³⁸)
- At least 10 hours per week of administrative work,^{36,39} averaging two hours daily in a five-day work week

Panel Size: 1,200

$1,200 \times 3.8 = 4,560$ patient visits per year – 46 weeks – 99 visits per week, 5 days per week = ~20 visits per day

$20 \text{ visits} \times 20 \text{ minutes per visit} = 6.6 \text{ hours per day} + 2 \text{ hours of administrative work} = \mathbf{8.6 \text{ hours per day}}$

Panel Size: 1,600

$1,600 \times 3.8 = 6,080$ patient visits per year – 46 weeks – 132 visits per week, 5 days a week = ~26 visits per day

$26 \text{ visits} \times 20 \text{ minutes per visit} = 8.6 \text{ hours per day} + 2 \text{ hours of administrative work} = \mathbf{10.6 \text{ hours per day}}$

This calculation shows that maintaining a panel size of 1,600 patients would require a family physician to spend approximately 10.6 hours per day on patient care and administrative duties. Imposing panel targets without considering team resources, available administrative support, or practice setting turns a full workday into an unsustainable one, increasing the risk of physician burnout and reduced care quality.

CFPC Recommendations on Panel Sizes

Minimum panel size thresholds are already in place in select provinces, tied to eligibility for funding models. While these benchmarks can support system planning, overly high or rigid thresholds can have unintended consequences.

The CFPC recommends:

Avoid setting high or inflexible minimum panel thresholds

- Policymakers must ensure panel thresholds reflect patient complexity, physician availability, and system capacity
- Flexibility and complexity considerations should be built into panel size targets

Engage family physicians and provincial partners

- Provinces should collaborate on panel size policy design with family physicians to reflect local context and care models

- Consult family physicians who teach, supervise students, and/or work part-time, as well as physicians across all career stages and practice settings to develop panel size guidance and benchmarks

Invest in infrastructure to sustain comprehensive family practice

- Before creating larger panel size targets, provinces must ensure that physicians have the necessary infrastructure to successfully manage these changes. This includes resources that directly assist the physician in their work, such as dedicated administrative support and adequate digital tools (e.g., comprehensive EMR, AI scribes, effective referral solutions).
- Reducing excessive administrative workload would enable physicians to dedicate more time to direct patient care and maintain larger patient panels. Solutions include:
 - Streamlining or eliminating federal paperwork requirements⁴⁰ like the Disability Tax Credit form⁴¹
 - Introducing legislation to prohibit reliance on family doctors for sick notes and insurance benefit access⁴²
 - Funding long-term use of AI scribes⁴³
 - Investing in cross-provincial expansion of successful referral platforms like Pathways BC
 - Robust investment in interprofessional teams to support family physicians, expanding services provided and spreading the administrative workload



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