

Medical Education Priorities for the Federal Health Infrastructure Fund

To: Health Canada and Infrastructure Canada
From: Association of Faculties of Medicine of Canada (AFMC)
Date: December 17, 2025.

The Association of Faculties of Medicine of Canada (AFMC) represents all 19 medical schools in Canada and is the national voice of academic medicine in the country. AFMC also oversees Canada's national resident match program, as facilitated through the *Canadian Resident Matching Service* (CaRMS), which matches new medical graduates with residency positions across the country.

Given its critical role in the physician training pipeline, the AFMC is keen to collaborate closely with the federal government in the design and delivery of the new Health Infrastructure Fund, in ways that will expedite the training and successful integration of more family physicians in Canada.

AFMC has consulted with experts in medical education, family medicine, and rural delivery of care.ⁱ Below is a summary of the findings:

- The community acknowledges that, while generous, a \$5B investment in hospital infrastructure will not create more family doctors. Investment in the training pipeline will have a higher, faster and more widespread impact.
- There is consensus in the community that Canada does not need more new medical schools. Our current schools are world class. It is better to build upon these assets, rather than spreading dollars and talent thin to build new institutions from the ground up.
- Canada's medical schools have a variety of infrastructure needs across campuses and specialties. The infrastructure needs identified by the schools to train more family physicians across Canada fall in 3 priority areas, including:
 1. Clinical teaching clinics
 2. Temporary housing for learners
 3. Modernized and new Information Technology

Therefore, in order to effect focused and rapid increases to family medicine training in Canada, the AFMC recommends an investment of \$1.07 B to:

- Build and equip up to 50 new teaching clinics in small urban and non-urban settings, to increase the number of family medicine residents being trained in the communities that need them most; and
- Improved and new IT and housing infrastructure in rural, remote and underserved communities, to facilitate recruitment and retention of family medicine residents in these areas.

The role teaching clinics, housing and IT play in making more family doctors:

Once a medical student completes three to four years of undergraduate training, they must pursue a residency position in a clinical setting before being licensed to practice. Learners rank and are matched to residency programs in medical schools through the CaRMS process, which ensures fair access to residency options across the country. The process is complex and highly competitive. The number of residency positions offered depends primarily on the clinical teaching capacity of each school, up to date IT in learning sites, and the temporary housing infrastructure in communities hosting learners.

Learners pursuing family medicine must complete two to three years of residency. These learners are not typically placed in hospitals, but rather in teaching clinics at the community level, where they can learn from experienced practitioners (called “preceptors”), who provide supervision and help bridge the gap between classroom theory and real-world application.

Currently, there is strong interest among Canadian and international medical graduates to pursue family medicine, but there are not enough teaching clinics to place them all.ⁱⁱ The clinics that do exist lack sufficient examination rooms, adequate classroom space, multipurpose space and dedicated learner space, and space for research and innovation. In rural, remote, and northern settings, family medicine residents also lack access to basic housing and IT infrastructure. These learners require safe lodging with shared eating and workspaces, to foster peer learning and community connection while they are training. Strong IT is also required for communication, simulations, virtual learning, library access, and research activities.

Knowing these deficiencies exist – and understanding the pay equity issues in family medicine – new graduates can be easily dissuaded from pursuing residency in smaller communities, or from pursuing family medicine altogether.

The federal government can help solve this problem by making a generational investment in teaching clinics in small urban and non-urban areas, complete with housing and IT infrastructure where required.

Costs and return on investment:

Building upon recent estimates from the Government of Ontario, AFMC estimates costs as follows:

Infrastructure	Investment
50 new teaching clinics (\$19.5 M / clinic)	\$ 975,000,000.00
IT infrastructure per clinic or community (5%)	\$ 48,750,000.00
50 co-located housing options (\$1 M / clinic)	\$ 50,000,000.00
	\$ 1,073,750,000.00

AFMC estimates that this investment would enable medical schools to place 350 more new graduates in family medicine settings each year, with an emphasis on small urban and non-urban locations.ⁱⁱⁱ

This investment would also have the immediate, parallel effect of improving access to care for Canadians in these communities. Family medicine residents can see patients (under preceptor supervision) and help to disperse patient care load for preceptors. Housing and IT infrastructure will foster the conditions for better virtual care, and help improve physician retention rates in community.

In ten years, this investment would generate 3,500 net new family doctors in the system. Using a conservative estimate, this would equate to care for approximately 3,500,000 previously unserved Canadians.^{iv}

How AFMC can lead and support:

AFMC has access to the data, expertise, leadership, and partnerships necessary to:

- ✓ Identify where the new teaching clinics should be located
- ✓ Identify which medical schools are best equipped to launch and sustain these clinics
- ✓ Provide guidance on the core teaching needs and structural design of these clinics
- ✓ Identify and leverage best practices for rural, remote and underserved communities, through the AFMC Distributed Medical Education (DME) Network, Indigenous Health Committee, and Family Medicine Network
- ✓ Ensure learner perspectives and needs are addressed
- ✓ Develop and deliver professional development and other supports for preceptors in these new clinics
- ✓ Support fulsome Indigenous participation
- ✓ Provide guidance in matters related to planetary health and sustainability

ⁱ **To date, the AFMC has consulted with following leaders regarding this proposal:** leaders at the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC), the Chair of Chairs of Family Medicine, the Chair of Distributed Medical Education, Quebec family doctors, Indigenous family doctors, Brent Norton, Jane Philpott, each of the three AFMC Vice Presidents, and a member of the AFMC Administrators Network.

ⁱⁱ In the 2025 CaRMS match cycle, 1883 Canadian medical graduates (CMGs) ranked family medicine as one of their preferred residency choices in the first iteration. Of these, 596 *only* wanted to pursue family medicine. Meanwhile, 1439 international medical graduates (IMGs) ranked family medicine as one of their preferred residency choices in the first iteration. 612 *only* wanted to pursue family medicine. **The current system only had capacity to place 1821 CMGs and IMGs, or 55%, of these aspiring family doctors.**

ⁱⁱⁱ Based on data the AFMC received from CaRMS concerning the 2025 R-1 match **the median number of trainees within a Family Medicine program was seven.** Therefore, we estimate that with 50 new sites multiplied by seven trainees this investment would result in an additional 350 Family Medicine physicians completing residency every year.

^{iv} The College of Family Physicians of Canada (CFPC) estimates that each family physician in Canada has an average of 1,351 patients. **Our conservative estimate is that each new family doctor would take 1,000 patients.**