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Racialized groups who have a regular health care provider: An overview

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Racialized groups who have a regular health care provider: An overview

by Mireille Vézina and Shikha Gupta

Overview of the study

The article examines the prevalence of having a regular health care provider (RHCP) among the seven largest racialized groups in Canada.¹ Specifically, using data from the 2024 Canadian Community Health Survey, the article shows how the proportion of people who have an RHCP differs between and within the racialized populations and the non-racialized and non-Indigenous population and how it varies across racialized groups based on demographic characteristics, such as gender, age, immigrant status, immigration period and provincial region.

- In 2024, a lower proportion of racialized people (79%) reported having an RHCP than their non-racialized, non-Indigenous counterparts (84%), although this difference does not consistently appear across sociodemographic characteristics. The Arab (71%), Latin American (72%), Southeast Asian (72%) and Black (73%) populations reported the lowest proportions, while the Filipino population reported the highest one (86%).
- Having an RHCP increases with age for both racialized and non-racialized, non-Indigenous people. In 2024, 66% of racialized individuals aged 18 to 34 had an RHCP, compared with 83% of those aged 35 to 49, 90% of those aged 50 to 64, and 95% of those aged 65 and older.
- Racialized people aged 18 to 34 (66%) had a lower proportion of individuals who had an RHCP than their non-racialized, non-Indigenous counterparts (78%). However, this pattern was different among older age groups. A similar proportion of racialized individuals aged 35 to 49 (83%) had an RHCP as non-racialized, non-Indigenous individuals of the same age (82%). Higher proportions were observed among racialized individuals aged 50 to 64 (90% versus 85% for their non-racialized, non-Indigenous counterparts) and 65 and older (95% versus 90%, respectively).
- Among racialized people, a higher proportion of established immigrants (89%) had an RHCP than recent immigrants (73%), Canadian-born people (83%) and Canadian-born non-racialized, non-Indigenous people (84%). Among racialized recent immigrants, the Filipino population (84%) had the highest proportion of people with an RHCP, while the Arab (60%) and Black (64%) populations had the lowest proportions.
- Racialized people living in the Atlantic provinces (45%) and Quebec (59%) were the least likely to report having an RHCP, while those living in Ontario were the most likely to report having such access (85%).

Introduction

Having a regular health care provider (RHCP)² can help prevent and safely treat common illnesses and chronic conditions. An RHCP refers to a health professional whom a person can routinely consult when seeking care or health advice.³ This broad category includes family doctors, as well as medical specialists, nurse practitioners and other health professionals.

In Canada, access to medically necessary health care is supported by fundamental rights and is an important value for all Canadians.⁴ Access to an RHCP is a [Government of](#)

[Canada shared health priority](#) and an indicator of [social inclusion](#). Among Canada's achievements, the country's health care system is one most Canadians—particularly racialized Canadians⁵—consider important.

However, having an RHCP, such as a family doctor, specialist or nurse practitioner, can be limited by demographic, personal and structural factors, such as the availability of services, wait times for a consultation and the distance from a person's home to the services offered.⁶

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Moreover, because of their generally younger age—especially recent immigrants (established in Canada for 10 years or less)—and higher likelihood of reporting their health status as very good or excellent,⁷ members of racialized groups may be less likely to seek regular health follow-ups or to be prioritized on a waitlist when resources are limited, compared with those with chronic conditions, severe health needs, or older age groups and children.

Given the growth of racialized populations in Canada, mainly driven by immigration,⁸ it is important to study the sociodemographic characteristics of those who reported having an RHCP to ensure the country's health care system remains accessible to all. Using data from the 2024 Canadian Community Health Survey (CCHS), this article examines the prevalence of having an RHCP among adults (i.e., aged 18 and older) in the seven largest racialized groups⁹ in Canada (South Asian, Chinese, Black, Filipino, Latin American, Arab and Southeast Asian). The study also looks at how the proportion of people with an RHCP differs within these groups, according to gender, age, immigrant status, immigration period and region of residence. Although the availability

of RHCPs varies across different regions of Canada, the article does not measure the influence of this factor in the prevalence of having an RHCP.

A companion study, "[Navigating health care: Regular health care provider access among recent immigrants, established immigrants and non-immigrants](#)," examines the prevalence of having an RHCP among immigrants and non-immigrants and how patterns vary across demographic and socioeconomic factors.

About 8 in 10 racialized adults have a regular health care provider

In 2024, about 8 in 10 racialized adults (79%) reported having an RHCP. By comparison, the proportion that reported having an RHCP was 84% among their non-racialized, non-Indigenous counterparts (Table 1).¹⁰ The proportion of adults who had an RHCP in 2024 was similar to that in 2023, both for the racialized population (80%) and for the non-racialized, non-Indigenous population (83%).

Of the seven largest racialized groups, the Filipino population (86%) had the highest proportion

of people with an RHCP in 2024. Meanwhile, the Arab (71%), Latin American (72%), Southeast Asian (72%) and Black (73%) populations had the lowest proportions of people with an RHCP and thus the largest percentage-point differences compared with the non-racialized, non-Indigenous population in Canada (84%).

Overall, racialized women (82%) were more likely to have an RHCP than their male counterparts (76%); however, the Black and South Asian populations were the only groups that showed a significant gender-based difference.

Black (66%) and Arab (70%) men populations had the lowest proportions of people with an RHCP. Among women, the lowest proportions were observed among the Arab (71%) and Southeast Asian (71%) populations. Conversely, the proportions observed among Filipino and Chinese men (85% and 79%, respectively) and among Filipino and Chinese women (87% and 86%, respectively) were similar to those observed among the non-racialized, non-Indigenous population (81% of men and 87% of women).

Table 1

Proportion of adults who have a regular health care provider, by racialized group and gender, population aged 18 and older, Canada, 2024

Racialized group	Total			Men+ (ref.)			Women+		
	Proportion	95% confidence interval		Proportion	95% confidence interval		Proportion	95% confidence interval	
		Lower limit	Upper limit		Lower limit	Upper limit		Lower limit	Upper limit
percent									
Total—Canada	83*	82	83	79*	78	80	86†	85	87
Total—racialized population	79*	77	81	76*	73	78	82*†	80	85
South Asian	80*	76	83	76	70	80	86†	81	90
Chinese	83	79	86	79	74	84	86	81	90
Black	73 *	68	77	66*	58	72	81*†	74	86

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Table 1

Proportion of adults who have a regular health care provider, by racialized group and gender, population aged 18 and older, Canada, 2024

Racialized group	Total			Men+ (ref.)			Women+		
	Proportion	95% confidence interval		Proportion	95% confidence interval		Proportion	95% confidence interval	
		Lower limit	Upper limit		Lower limit	Upper limit		Lower limit	Upper limit
percent									
Filipino	86	80	91	85 ^E	73	92	87	80	92
Arab	71*	63	77	70*	60	79	71*	60	80
Latin American	72*	64	79	72	60	81	73*	62	82
Southeast Asian	72*	62	81	74 ^E	59	84	71 ^{E*}	57	82
Non-racialized, non-Indigenous (ref.)	84	84	85	81	80	82	87 [†]	86	88

^E use with caution

* significantly different from the reference category (ref.) "non-racialized, non-Indigenous" ($p < 0.05$)

† significantly different from the reference category (ref.) "men+" ($p < 0.05$)

Notes: In this table, the concept of "racialized group" is derived directly from the concept of "visible minority." The *Employment Equity Act* defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour."

Indigenous people are not included in either the racialized population or the non-racialized population in the current analysis.

Given that the non-binary population is small, data aggregation to a two-category gender variable is sometimes necessary to protect the confidentiality of responses provided. In these cases, individuals in the "non-binary persons" category are distributed into the other two gender categories and are denoted by the "+" symbol.

Source: Statistics Canada, Canadian Community Health Survey, Annual Component, 2024.

The proportion of racialized adults who have a regular health care provider increases with age

In general, the risk of developing a chronic disease increases with age. According to 2024 CCHS data, younger adults were less likely to report chronic diseases compared with individuals aged 50 and older.¹¹ This pattern suggests that older adults, because of their greater and ongoing health care needs, are more likely to have more frequent medical follow-ups or receive priority treatment from an RHCP, particularly when resources are limited.¹²

Indeed, the results show that the proportion of the racialized individuals who reported having an RHCP increases with age. In 2024, 66% of racialized individuals aged 18 to 34 had an RHCP, compared with 95% of those aged 65 and older (Table 2). This same trend was also observed among the non-racialized, non-Indigenous

population; however, the gap between the younger and older individuals was less pronounced. For example, 78% of non-racialized, non-Indigenous people aged 18 to 34 had an RHCP, compared with 90% of those aged 65 and older.

Among the racialized population, individuals aged 18 to 34 not only have the lowest proportion of those with an RHCP, compared with older racialized groups, but they also show the largest gap (12 percentage points) relative to non-racialized, non-Indigenous people of the same age. However, this trend shifts in older age groups. Among those aged 35 to 49, similar proportions of racialized (83%) and non-racialized, non-Indigenous (82%) people reported having an RHCP. Furthermore, a higher proportion of racialized people than non-racialized, non-Indigenous people had an RHCP among those aged 50 to 64 (90% and 85%, respectively) and those aged 65 and older (95% and 90%, respectively). The higher rates among older

racialized groups may, however, reflect greater health needs or poorer health status as this population ages.

Among the racialized population, the differences between the younger and older age groups were more pronounced in some groups, namely the South Asian and Black populations. For example, 66% of South Asian populations aged 18 to 34 had an RHCP compared with 97% of South Asian individuals aged 65 and older, a difference of nearly 31 percentage points. By comparison, among the Filipino population, the gap between the youngest and oldest age groups was approximately 21 percentage points. Consistent with general trends, the Black (63%) and South Asian (66%) populations aged 18 to 34 had lower proportions of individuals with an RHCP compared with the non-racialized, non-Indigenous population of the same age group (78%).

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However, South Asian people aged 35 to 49 were more likely to have an RHCP than their

non-racialized, non-Indigenous counterparts. No differences were observed between non-racialized,

non-Indigenous and Black or South Asian individuals in the 50-to-64 and the 65-and-older age groups.

Table 2

Proportion of adults who have a regular health care provider, by racialized group and age, population aged 18 and older, Canada, 2024

Racialized group	Age group											
	18 to 34 years (ref.)			35 to 49 years			50 to 64 years			65 years and older		
	95% confidence interval			95% confidence interval			95% confidence interval			95% confidence interval		
	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit
	percent											
Total—Canada	73	72	75	82 [†]	81	83	86 [†]	85	87	91 [†]	90	92
Total—racialized population	66 [*]	62	69	83 [†]	81	85	90 ^{†*}	87	92	95 [†]	94	97
South Asian	66 [*]	59	72	90 ^{†*}	85	93	90 [†]	84	94	97 [†]	92	99
Chinese	67 [*]	59	75	86 [†]	80	90	91 [†]	85	95	95 [†]	92	97
Black	63 [*]	53	72	74 [*]	67	80	81 ^E	69	89	94 [†]	87	97
Filipino	76 ^E	60	87	88	81	92	97 ^{†*}	92	99	97 ^{E†}	90	99
Arab	55 ^{E*}	41	69	74	63	82	93 ^{E†}	83	97	F	F	F
Latin American	62 ^{E*}	45	76	71 ^E	58	81	88 ^{E†}	78	94	F	F	F
Southeast Asian	51 ^{E*}	35	67	81 ^{E†}	68	90	F	F	F	F	F	F
Non-racialized, non-Indigenous (ref.)	78	76	80	82 [†]	80	83	85 [†]	84	86	90 [†]	90	91

^E use with caution

^F too unreliable to be published

^{*} significantly different from the reference category (ref.) "non-racialized, non-Indigenous" ($p < 0.05$)

[†] significantly different from the reference category (ref.) "18 to 34 years" ($p < 0.05$)

Notes: In this table, the concept of "racialized group" is derived directly from the concept of "visible minority." The *Employment Equity Act* defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour."

Source: Statistics Canada, Canadian Community Health Survey, Annual Component, 2024.

Recent racialized immigrants are less likely to have a regular health care provider

In 2024, the majority of the racialized adult population in Canada was born outside the country (82%); 24% had recently immigrated to Canada (from 2014 to 2024), 49% were immigrants established before 2014 and 10% were non-permanent residents (NPRs) [Table A.1].

The scientific literature suggests,¹³ that many immigrants, including racialized individuals, arrive with better health profiles compared with the native-born population, partly because of selective migration and pre-migration health screenings. In the first 10 years after arriving in Canada, immigrants are generally

more likely than Canadian-born individuals (non-immigrants) to be healthier—a phenomenon often referred to as the "healthy immigrant effect"—and rate their health as generally very good or excellent.¹⁴ Because of their better health status and their larger share of younger individuals, immigrants (particularly recent immigrants) may thus perceive less need to seek ongoing consultations with an RHCP. In addition, prioritization and wait times when seeking certain types of RHCP depend on an individual's health condition¹⁵ and the availability of services. In some cases, older adults, young children and people with chronic conditions are prioritized when being assigned an RHCP, and more particularly a

family doctor. However, the healthy immigrant effect fades with time spent in the country.¹⁶

Among the racialized population, NPRs (32%) and recent immigrants (73%) were the least likely to have an RHCP (Table 3). Conversely, racialized immigrants established before 2014 had the highest rate, at 89%, which is higher than the rates observed among the non-racialized, non-Indigenous population born in Canada (84%) and the racialized population born in Canada (83%). Similar evidence that established immigrants often have access to an RHCP that is comparable to, or slightly better than, that of non-immigrants has been reported by previous national studies,^{17,18} even

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when accounting for racialized identity.¹⁹ This may reflect the greater familiarity of established immigrants with the health system over time; the higher proportion of older adults in this group; and the decline of the initial health advantages, which increases care needs.^{20,21}

Among recent racialized immigrants, the Filipino population (84%) had the highest proportion of people who had an RHCP, while the Arab (60%) and Black (64%) populations had the lowest. A lower proportion of recent immigrants with an RHCP was also observed when considering racialized groups separately. For example, the Arab (60%), Black (64%), South Asian (76%) and

Chinese (74%) populations who recently immigrated were 16 to 26 percentage points less likely to have an RHCP than their counterparts who immigrated before 2014 (Arab: 86%; Black: 88%; South Asian: 93%; Chinese: 90%).

The lower proportion of recent immigrants with an RHCP can be driven by factors such as their younger age and generally better health status, compared with established immigrants and the population born in Canada. Furthermore, language barriers, place of birth, region of residence in Canada and unfamiliarity with the health system are other factors that may have an influence. Further research on

financial challenges and limited social networks would also provide a better understanding of the differences between recent immigrants and established immigrants in the likelihood of having an RHCP.

The lower proportion of NPRs with an RHCP can be explained by the fact that they are admitted to Canada temporarily. The NPR population includes temporary foreign workers, international students and asylum claimants. Some NPRs are eligible for Canada's public health insurance under certain criteria, depending on the province or the territory they live in. This can affect their likelihood of reporting having an RHCP.

Table 3

Proportion of adults who have a regular health care provider, by racialized group and immigrant status, population aged 18 and older, Canada, 2024

Racialized group	Immigrant status											
	Non-immigrants			Immigrants admitted to Canada from 2014 to 2024			Immigrants admitted to Canada before 2014 (ref.)			Non-permanent residents		
	95% confidence interval			95% confidence interval			95% confidence interval			95% confidence interval		
	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit
	percent											
Total—Canada	84 [†]	83	85	71 [†]	67	74	89	88	91	36 [†]	29	43
Total—racialized population	83 [†]	79	87	73 [†]	69	76	89	87	91	32 [†]	25	41
South Asian	84	74	91	76 [†]	68	82	93	90	95	F [‡]	26	54
Chinese	78 [†]	68	86	74 [†]	63	83	90	86	92	F [†]	19	51
Black	81	70	88	64 [†]	54	72	88	83	93	F [†]	14	42
Filipino	F	F	F	84 ^{E*}	72	91	90 ^E	78	95	F [†]	10	48
Arab	F	F	F	60 ^{E†}	46	73	86	77	92	F [*]	2	27
Latin American	F	F	F	F	F	F	81	70	89	F [†]	13	44
Southeast Asian	F	F	F	F	F	F	90 ^E	82	95	F [†]	6	43
Non-racialized, non-Indigenous (ref.)	84	84	85	59	49	69	90	88	91	47 [†]	32	62

^E use with caution

F too unreliable to be published

* significantly different from the reference category (ref.) "non-racialized, non-Indigenous" ($p < 0.05$)

† significantly different from the reference category (ref.) "immigrants admitted to Canada before 2014" ($p < 0.05$)

Notes: In this table, the concept of "racialized group" is derived directly from the concept of "visible minority." The *Employment Equity Act* defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour."

Indigenous people are not included in either the racialized population or the non-racialized population in the current analysis.

Source: Statistics Canada, Canadian Community Health Survey, Annual Component, 2024.

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Racialized populations in the Atlantic provinces and Quebec are the least likely to report having a regular health care provider

Aside from age and immigrant status, the proportion of racialized individuals who reported having an RHCP also varied by geographical region, reflecting the existence of other structural factors that can also play a role, such as the availability of services and resources. In 2024, the proportion of racialized individuals who had an RHCP was lowest in the Atlantic provinces (45%) and Quebec (59%) and highest in Ontario (85%) [Table 4]. These variations across the country are relatively consistent with the general trend for the overall adult population in Canada.

Racialized individuals living in the Atlantic provinces, Quebec and Ontario were less likely to have an RHCP than their non-racialized,

non-Indigenous counterparts, while there were no significant differences between the two groups in the Prairies and British Columbia. The gap between the racialized and non-racialized, non-Indigenous populations was highest in the Atlantic provinces (35 percentage points), followed by Quebec (19 percentage points).

In Ontario, although racialized individuals (85%) were less likely than their non-racialized, non-Indigenous counterparts (91%) to have an RHCP, the proportion of racialized individuals (85%) with an RHCP was similar to that of the overall Canadian population (83%) and the overall non-racialized, non-Indigenous population (84%).

Despite disparities across the country in terms of having an RHCP, the proportions of racialized individuals who have an RHCP still increase with age and vary by immigrant status and period of

immigration in every province. The different patterns observed regarding the gap with the non-racialized, non-Indigenous population are the same as those presented in the first two sections (data not shown).

Across all provinces, the majority of racialized individuals aged 18 to 34 did not have an RHCP; this proportion ranged from 52% in Quebec to 69% in British Columbia. By comparison, the proportion of non-racialized, non-Indigenous people aged 18 to 34 who did not have an RHCP was 45% or less in each province (Table 5). Please note that these results do not account for variations that may exist within the geographical regions and provinces at the census metropolitan area scale. For example, the proportion of people who have an RHCP could vary by metropolitan area because of greater availability and capacity for offering services.

Table 4

Proportion of adults who have a regular health care provider, by racialized group and geographical region, population aged 18 and older, Canada, 2024

Racialized group	Geographical region								
	Ontario (ref.)			Atlantic provinces			Quebec		
	95% confidence interval			95% confidence interval			95% confidence interval		
	Lower limit Upper limit			Lower limit Upper limit			Lower limit Upper limit		
	Proportion			Proportion			Proportion		
	percent								
Total—Canada	89	87	90	77 [†]	75	79	74 [†]	73	76
Total—racialized population	85 [*]	83	88	45 ^{*†}	36	55	59 ^{*†}	54	64
South Asian	82 [*]	78	86	F	F	F	F	F	F
Chinese	88	83	92	F	F	F	F	F	F
Black	86	80	91	F	F	F	54 ^{*†}	45	63
Filipino	89 ^E	75	96	x	x	x	F	F	F
Arab	88 ^E	76	94	x	x	x	55 ^{*†}	44	65
Latin American	85 ^E	73	92	x	x	x	66 ^E	52	77
Southeast Asian	81 ^E	66	91	x	x	x	F	F	F
Non-racialized, non-Indigenous (ref.)	91	90	92	80 [†]	78	82	78 [†]	76	79

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Table 4

Proportion of adults who have a regular health care provider, by racialized group and geographical region, population aged 18 and older, Canada, 2024

Racialized group	Geographical region					
	Prairies			British Columbia		
	95% confidence interval			95% confidence interval		
	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit
	percent					
Total—Canada	84[†]	82	85	80[†]	78	82
Total—racialized population	82	77	86	77[†]	73	81
South Asian	85	76	91	79	69	86
Chinese	81	71	88	80	74	85
Black	85	76	91	F	F	F
Filipino	88	78	93	86 ^E	73	94
Arab	F	F	F	x	x	x
Latin American	F	F	F	F	F	F
Southeast Asian	F	F	F	F	F	F
Non-racialized, non-Indigenous (ref.)	85 [†]	83	86	82 [†]	79	84

x suppressed to meet the confidentiality requirements of the *Statistics Act*

^E use with caution

F too unreliable to be published

* significantly different from the reference category (ref.) "non-racialized, non-Indigenous" ($p < 0.05$)

† significantly different from the reference category (ref.) "Ontario" ($p < 0.05$)

Notes: In this table, the concept of "racialized group" is derived directly from the concept of "visible minority." The *Employment Equity Act* defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour."

Source: Statistics Canada, Canadian Community Health Survey, Annual Component, 2024.

Table 5

Proportion of adults aged 18 to 34 who do not have a regular health care provider, by racialized status and geographical region, Canada, 2024

Region	Racialized			Non-racialized, non-Indigenous (ref.)		
	95% confidence interval			95% confidence interval		
	Lower limit			Lower limit		
	Proportion	Lower limit	Upper limit	Proportion	Lower limit	Upper limit
	percent					
Atlantic provinces	63*	51	73	29	24	35
Quebec	52*	45	60	26	23	30
Ontario	68*	61	74	35	30	41
Prairies	67*	57	75	45	39	50
British Columbia	69*	60	76	41	35	47

* significantly different from the reference category (ref.) "non-racialized, non-Indigenous" ($p < 0.05$)

Notes: In this table, the concept of "racialized group" is derived directly from the concept of "visible minority." The *Employment Equity Act* defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour."

Source: Statistics Canada, Canadian Community Health Survey, Annual Component, 2024.

Conclusion

The findings of this study revealed that, overall, a lower proportion of racialized people reported having an RHCP compared with their non-racialized, non-Indigenous counterparts. However, those results were more nuanced when disaggregating by selected characteristics such as age, immigrant status and region of residence. For example, when comparing by immigrant status, the proportions of people with an RHCP were similar or higher among racialized individuals compared with non-racialized, non-Indigenous individuals for the Canadian-born, established immigrant and recent immigrant populations.

Among racialized groups, lower proportions of younger individuals, recent immigrants, and those living in the Atlantic provinces or Quebec had an RHCP. Some groups had lower rates than others. For example, younger racialized populations and recent Arab and Black immigrants recorded the lowest rates.

However, the differences between the racialized and the non-racialized, non-Indigenous populations for younger individuals shifted among older groups. Overall, higher proportions of individuals in older racialized groups had an RHCP than their non-racialized, non-Indigenous counterparts.

As for other racialized groups with the highest proportions of people reporting having an RHCP, such as

Filipino people, the high proportions observed could be influenced by the fact that some groups had higher proportions of women working in the health care and social assistance sector compared with other racialized groups. More information about the geographical location of an RHCP and type of insurance available would help explain the higher proportions of individuals who have an RHCP observed among certain groups, such as Filipinos born outside Canada and immigrants overall. Other unknowns relevant to racialized groups include whether services are received in person or virtually and the type of service received. Additional information on these topics would help to better understand the characteristics of the health care providers that racialized people regularly consult.

Moreover, having an RHCP does not mean that it is necessarily easy to access services when needed. For example, some appointments can be difficult to obtain in the short term. Information on the ease of accessing an RHCP when a consultation is needed would help to understand some of the challenges faced.

Lastly, cultural beliefs, health literacy, and experiences of systemic barriers or discrimination within the health care system can influence health-seeking behaviours, further affecting perceptions of necessity for continuous care.²² For example, racialized populations can

experience discrimination when trying to find an RHCP,^{23,24} which can affect their trust in the health care system and their use of health care services when needed.²⁵ The cost of certain specialized services, access to prescription drug insurance coverage²⁶ and official language proficiency²⁷ are other barriers racialized populations may face.

Therefore, the combination of demographic factors and broader social determinants of health plays a key role in shaping access to and use of regular health care among racialized populations in Canada.

Research on services offered in census metropolitan areas, knowledge of the predominant official language and knowledge of the Canadian health care system could also help understand the barriers faced by racialized groups who are less likely to have an RHCP in Canada. Additional research controlling for age structure could show how this factor contributes to the observed gap in the proportion of people with an RHCP between racialized people and non-racialized, non-Indigenous people.

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Appendix

Table A.1
Demographic characteristics, by racialized group, population aged 18 and older, Canada, 2024

Characteristics	Total— Canada	Non- racialized, non- Indigenous (ref.)	Total— racialized population	South Asian	Chinese	Black	Filipino	Arab	Latin American	Southeast Asian
					percent					
Total—Canada	100	100	100	100	100	100	100	100	100	100
Gender										
Men+	50	49	52*	58*	47	52	44	60*	55	49
Women+	50	51	48*	42*	53	48	56	40*	45	51
Age group										
18 to 34 years	29	25	39*	44*	31*	39*	34*	39*	38*	25*
35 to 49 years	25	22	31*	30*	29*	35*	35*	38*	34*	22
50 to 64 years	23	25	19*	17*	24	17*	21	17*	21	25
65 years and older	23	29	11*	9*	16*	10*	9*	6*	8*	29*
Immigrant status										
Non-immigrants	70	89	18*	14*	20*	22*	16*	16*	16*	89*
Immigrants admitted to Canada from 2014 to 2024	8	1	24*	28*	16*	32*	23*	28*	19*	1*
Immigrants admitted to Canada before 2014	20	9	49*	44*	60*	36*	57*	44*	50*	9*
Non-permanent residents	3	1	10*	14*	4*	10*	5*	12*	14*	1*
Region										
Atlantic provinces	7	9	2*	2*	2*	3*	2*	3*	1*	9*
Quebec	22	26	14*	5*	7*	36*	6*	43*	27	26
Ontario	40	35	52*	64*	48*	43*	43*	42*	48*	35
Prairies	18	18	14*	15*	10*	15	30*	10*	13	18
British Columbia	14	13	18*	15	35*	3*	19	3*	11	13

* significantly different from the reference category (ref.) "non-racialized, non-Indigenous" ($p < 0.05$)

Notes: In this table, the concept of "racialized group" is derived directly from the concept of "visible minority." The *Employment Equity Act* defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour."

Indigenous people are not included in either the racialized population or the non-racialized population in the current analysis.

Given that the non-binary population is small, data aggregation to a two-category gender variable is sometimes necessary to protect the confidentiality of responses provided. In these cases, individuals in the "non-binary persons" category are distributed into the other two gender categories and are denoted by the "+" symbol.

Source: Statistics Canada, Canadian Community Health Survey, Annual Component, 2024.

Data sources, methods and definitions

This analysis is based on data from the 2024 Canadian Community Health Survey (CCHS). The sample is representative of the Canadian population aged 18 and older living in the provinces.²⁸ The percentages of the indicators are calculated by excluding non-response records or missing data from the denominator. The racialized population in the survey represents 8,085 individuals and 25% of the Canadian adult population.

Most of the results for racialized groups presented are available in the following two tables:

[Table 13-10-0880-01 Health indicators by visible minority and selected sociodemographic characteristics: Canada excluding territories, annual estimates.](#)

[Table 13-10-0881-01 Health indicators by visible minority and selected sociodemographic characteristics: Canada and geographical regions of Canada excluding territories, annual estimates.](#)

Access to a regular health care provider

In the CCHS, “regular health care provider” refers to a health care professional a person regularly consults when they need care or advice about their health. This can include a family doctor, a medical specialist, a nurse practitioner or another professional.²⁹

In the 2024 CCHS, a single question on regular health care providers (RHCPs) was asked, which can be used to establish whether an individual regularly consults one health professional and, if yes, which type of health professional is regularly consulted. No additional details are available on this topic. For example, it is unknown in which country the health care provider is generally consulted, whether the consultation is generally done in person or virtually, or whether the cost of the service received is covered by health care insurance.

Non-response records and missing data are excluded from the denominator when calculating the proportions of individuals with access to an RHCP.

The [Survey on Health Care Access and Experiences – Primary and Specialist Care](#) (SHCAE-PSC) is another survey that collects information on the population reporting having an RHCP.

In the SHCAE-PSC, an **RHCP** is a health professional that a person regularly consults when they need care or advice about their health. This can include a family doctor or general practitioner, a medical specialist, a nurse practitioner, or another health professional.

Although the CCHS and SHCAE-PSC use slightly different wording to define an RHCP, both operationalize the concept similarly, including family doctors and general practitioners, nurse practitioners, medical specialists and other health professionals. However, because of minor differences in question wording and survey context, estimates of RHCP access from the two surveys should not be considered fully comparable.

Racialized group

The concept of “racialized group” is derived directly from the “[visible minority](#)” variable in the Census of Population. “Visible minority” refers to whether a person is a visible minority or

not, as defined by the *Employment Equity Act*. The *Employment Equity Act* defines visible minorities as “persons, other than Aboriginal people, who are non-Caucasian in race or non-white in colour.” The visible minority population comprises the following groups: South Asian, Chinese, Black, Filipino, Arab, Latin American, Southeast Asian, West Asian, Korean and Japanese.

In this article, the seven largest visible minority groups are analyzed. Given the small sample sizes for the West Asian, Korean, Japanese, visible minority not included elsewhere and multiple visible minorities categories in the CCHS, they are included in the total of the visible minority population (labelled the total of the racialized population) but not presented in this article because of data quality or to meet the confidentiality requirements of the *Statistics Act*.

Given the smaller sample size of some racialized groups in the CCHS, results for specific racialized groups should be interpreted with some caution. The results presented in this analysis apply to the 2024 CCHS, but different results may be observed in other iterations of the survey, based on the sample size of each racialized group.

Indigenous people are not included among the racialized population or the non-racialized, non-Indigenous population in the current analysis.

Gender

Gender refers to an individual’s personal and social identity as a man, woman or non-binary person (a person who is not exclusively a man or a woman).

Given that the non-binary population is small, data aggregation to a two-category gender variable is sometimes necessary to protect the confidentiality of responses provided. In these cases, individuals in the “non-binary persons” category are distributed into the other two gender categories. Unless otherwise indicated in the text, the category “men” includes men and some non-binary persons, while the category “women” includes women and some non-binary persons.

Immigrants

Immigrant refers to a person who is, or who has ever been, a landed immigrant or permanent resident. Such a person has been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this group.

Recent immigrant refers to a person who obtained Canadian permanent residency 10 years earlier or less. **Established immigrant** refers to a person who has had Canadian permanent residency for more than 10 years. **Non-immigrant** refers to a person who is a Canadian citizen by birth.

Non-permanent residents

Non-permanent resident (NPR) refers to a person from another country who lives in Canada temporarily.³⁰ The NPR population includes temporary foreign workers, international students and asylum claimants who seek refugee protection in Canada.

Notes

1. As identified in the *Employment Equity Act*.
2. An RHCP refers to any health professional that a person routinely consults when seeking care or health advice. This broad category includes primary health care providers, as well as medical specialists and other health professionals. The RHCP indicator differs from primary health care provider, which is limited to family doctors, general practitioners and nurse practitioners. Caution should be exercised when comparing these indicators, because their definitions and scopes are not equivalent.
3. The Survey on Health Care Access and Experiences – Primary and Specialist Care (SHCAE-PSC) is another survey that collects information on the population reporting having an RHCP. However, the measure of an RHCP in the SHCAE-PSC differs from that used in the Canadian Community Health Survey. This may affect the comparability of estimates between these data sources.
4. Government of Canada (2026).
5. Statistics Canada (2021a).
6. Clarke (2016).
7. Statistics Canada. (2025a) and (2025b).
8. Statistics Canada (2022).
9. This classification of racialized groups is based on the population group question in Statistics Canada's Census of Population and social surveys, including the CCHS. For more information on the indicators and concepts, see the Data sources, methods and definitions section.
10. The proportion of people who had access to an RHCP was similar in the previous year, 2023, among racialized groups (80%) and the non-racialized, non-Indigenous population (83%). Thus, the gap between the two populations was also observed and similar in 2023.
11. Statistics Canada (2025b).
12. Public Health Agency of Canada (2017).
13. Lu and Ng (2019).
14. Statistics Canada (2025a).
15. Breton et al. (2017).
16. Fuller-Thomson et al. (2011); McDonald and Kennedy (2004).
17. Degelman and Herman (2016).
18. Ssendikaddiwa et al. (2023).
19. Lin and Fang (2023).
20. Subedi and Rosenberg (2014).
21. Muggah et al. (2012).
22. Tsai and Ghahari, (2023).
23. Husbands et al. (2022).
24. Mahabir et al., (2021).
25. Husbands et al. (2022).
26. Statistics Canada (2024).
27. Al Shamsi et al. (2020).
28. For more information, see Statistics Canada (2023).
29. In the 2023 CCHS, this indicator was based on the following question: "Which of the following health care providers do you regularly consult with?"
30. Statistics Canada (2021b).

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