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Difficulties accessing specialist care and the association with unmet health care needs among middle-aged and older Canadians

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ABSTRACT

Background

Canada's population is aging rapidly, with implications for the health care system, including increasing demand for specialist care. However, few studies have examined factors associated with specialist care use, difficulty accessing such care, and the relationship between access difficulties and unmet health care needs among middle-aged (45 to 64 years) and older (65 years or older) adults.

Data and methods

Data from the 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care were used to identify factors associated with specialist care use, difficulty accessing specialist care, and to examine the relationship between access difficulties and unmet health care needs. Drawing on a nationally representative sample of 23,473 Canadians aged 45 or older, multivariable logistic regression analyses were conducted separately for middle-aged and older adults.

Results

In 2024, 38.5% of Canadians aged 45 or older used specialist care, 27.8% experienced access difficulties, and 18.0% reported unmet health care needs. Older adults (65 years or older) were more likely than middle-aged adults (45 to 64 years) to use specialist care (42.9% versus 35.1%) but less likely to report difficulty accessing it (24.6% versus 30.2%). Having a greater number of chronic conditions or a disability was associated with both specialist care use and greater difficulty accessing specialist care among middle-aged and older adults. Experiencing difficulties accessing specialist care was strongly associated with a higher likelihood of having unmet health care needs among middle-aged (6.2 times) and older (14.0 times) adults.

Interpretation

The study underscores the importance of accounting for multiple factors, such as age, gender, immigrant status, multimorbidity, disability, and access to a primary health care provider, when examining access to care.

Keywords

Medical specialist, difficulties accessing care, seniors, health service use, social determinants, chronic conditions.

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What is already known on this subject?

- The use of health care services is associated with demographic, socioeconomic, geographic, and health-related factors.
- Women are more likely than men to use primary care, and they are also more likely to report chronic physical conditions and poor mental health, including depression and anxiety.
- Women are less likely than men to visit medical specialists but are more likely to experience difficulties accessing specialist care.
- Unmet health care needs among Canadians vary significantly by age, sex, and province. Common reasons include long wait times, lack of available services, and cost.

What does this study add?

- In 2024, 38.5% of Canadians aged 45 years or older (about 6.6 million people) used specialist care, 27.8% (about 4.5 million) experienced difficulties accessing specialist care, and 18.0% (about 3.0 million) reported having unmet health care needs.
- Older adults were more likely to use specialist care but were less likely to report difficulties accessing it, compared with middle-aged adults. Having a primary health care provider increased the likelihood of seeing a specialist and reduced the likelihood of experiencing access difficulties among both age groups.
- A higher number of chronic conditions or the presence of a disability was consistently associated with specialist care use and increased difficulty accessing specialist care among both age groups.
- Individuals reporting difficulty accessing primary or specialist care—or both—were more likely to report unmet health care needs than those who reported no difficulty.

Canada's population is aging rapidly, driven by lower birth rates, longer life expectancy, and the demographic shift associated with the baby boom generation (1946-1964 birth cohort). The share of older adults (aged 65 or older) within the total population is projected to increase from 18.9% in 2023 to between 21.9% and 32.3% by 2073.¹ Life expectancy among older adults continues to increase, and most report good health despite living with chronic conditions;² however, the prevalence of such conditions rises with age. Consequently, the number of Canadians living with chronic conditions or a disability is expected to rise.

Consistent with this trend, in 2023, 68.0% of older Canadians (about 5.0 million people) were living with multimorbidity (two or more chronic conditions)—67.4% among those aged 65 to 84, increasing to 74.1% for those aged 85 and older. Similarly, 15.3% of older Canadians (about 1.1 million people) reported having a disability—14.8% among those aged 65 to 84, rising to 21.0% for those aged 85 and older.³ The key challenge is whether the health care system is adequately prepared to meet the needs of an increasing population of older adults with chronic conditions or a disability.^{4,5}

Within this broad context, notable gender differences exist in health status and health care use among older Canadians. Older women are more likely than men to live with multimorbidity or a disability.⁶ Reflecting these differences in health needs, older

women tend to use primary health care services more frequently than men but are less likely to visit medical specialists.⁷

While access to primary care has been widely studied in Canada,⁸⁻¹² research on specialist care use is more limited. Specifically, few studies have examined specialist care use among middle-aged and older Canadians.^{7,13,14} Existing research has linked specialist care use to factors such as age, education, income, access to a regular doctor, health status, chronic conditions, and place of residence.^{7,14} Some studies have also examined barriers to accessing specialists and identified demographic, socioeconomic, health-status, and geographic factors.^{7,13} Nonetheless, to inform policy and program development, further research using a nationally representative sample is needed to identify multidimensional determinants of specialist care use and difficulties accessing specialist care among middle-aged (45 to 64 years) and older (65 years or older) Canadians. In addition, more detailed age-disaggregated analyses—particularly among older Canadians—and examinations of provincial variations are required to address gaps in the literature on specialist care use.

Difficulty accessing specialist care contributes to unmet health care needs.^{15,16} In 2022, an estimated 3.0 million Canadians aged 15 and older (9.2%) reported unmet health care needs, with substantial variation by age, sex, and province.¹⁷ Common reasons include long wait times, lack of available services, and

cost (e.g., costs related to prescription drugs and transportation).^{18,19} Yet, the extent to which difficulties accessing specialist health care contribute to unmet needs among middle-aged and older Canadians is unknown.

A life course perspective further underscores the importance of addressing this gap. Midlife is a pivotal period in the life course, as it is a time when many chronic conditions emerge and when promoting health and well-being can positively influence healthy aging.^{20,21} Guided by the life course approach,²² the United Nations Decade of Healthy Ageing: Plan of Action 2021 to 2030 emphasizes the importance of taking action at every stage of life—from early childhood through midlife to older age—so individuals can age as well as possible.²³ This approach highlights the value of examining middle-aged and older adults separately to identify factors associated with specialist care use to help inform health policy.

The primary objectives of this study were to assess the prevalence of, and factors associated with, specialist care use and difficulty accessing specialist care among middle-aged and older Canadians. An additional objective was to examine the association between difficulty accessing specialist care and unmet health care needs. Secondary objectives were to describe different aspects of specialist care use, including referral sources, reasons for initial consultation, and wait times between referral and consultation. Data from the 2024 Survey on Health Care Access and Experiences – Primary and Specialist Care (SHCAE-PSC) were used. The analysis was guided by Andersen's behavioural model of health services use,^{24,25} incorporating predisposing characteristics, enabling resources, and need factors. Findings from this study will provide new evidence of how these multidimensional factors are associated with specialist care use and access difficulties. They will also provide further insight into gender differences and the effects of wait times among middle-aged and older adults. A detailed description of the model's components is presented in the following section.

Methods

Data source

The 2024 SHCAE-PSC is a nationally representative cross-sectional survey that collected information on health care access and experiences from people living in private dwellings in the 10 provinces of Canada. Information was collected from individuals aged 18 and older by direct self-response via an online electronic questionnaire, with computer-assisted telephone interviews for non-responses. Individuals living on Indigenous reserves or Crown lands and those residing in institutions (e.g., health care facilities, prisons) were excluded from the survey. In total, 33,535 individuals were interviewed, and the response rate was 52.4%. Detailed survey methodology is available from Statistics Canada.²⁶

Study sample

The total analytical sample for this study was 23,473 Canadians aged 45 or older—12,390 middle-aged (45 to 64 years) and 11,083 older (65 years or older) adults—living in private dwellings in the 10 provinces of Canada.

Definitions

Specialist care use

Specialist care use was based on the yes or no question “During the past 12 months, did you consult a medical specialist for an initial consultation?” A medical specialist is a medical doctor certified to practise in a specific field (e.g., dermatologist, cardiologist).

Difficulty accessing specialist care

Difficulty accessing specialist care was categorized as dichotomous (yes or no) based on the question “In the past 12 months, did you ever experience any of the following difficulties getting the specialist care you needed?” Response categories included 12 types of difficulties (e.g., difficulty getting a referral, waiting too long between booking appointment and visit) and a category for those who did not experience any difficulties.

Unmet health care needs

Unmet health care needs were measured based on the yes or no question “During the past 12 months, was there ever a time when you felt that you needed health care, but you did not receive it?” Types of unmet care needs included treatment for new physical or mental health conditions, regular check-ups, injury care, medication and prescription refills, and other services.

Covariates

The selection of covariates was guided by Andersen's behavioural model of health services use and their availability in the SHCAE-PSC. Andersen's model was developed to understand health service use in relation to three domains: predisposing characteristics, enabling resources, and need-related factors.²⁵ Need-related factors (e.g., health status) influence service needs. Enabling resources include the availability of services and personnel, and the ability to access them. Predisposing characteristics reflect the tendency to use health care services.

Predisposing characteristics

Gender was categorized as men or women. Because of their small number (fewer than 10), non-binary people were excluded from the analysis. The age groups were middle-aged (45 to 64 years) and older (65 years or older) adults. Additional age groups were included for middle-aged adults (45 to 54 years and 55 to 64 years) and older adults (65 to 84 years and 85 years or

Table 1

Specialist care use for an initial consultation during the past 12 months among middle-aged and older Canadians (excluding territories), 2024

Characteristics	Prevalence of specialist care use						Adjusted odds ratio (AOR) of specialist care use					
	Middle-aged adults (45 to 64 years)			Older adults (65 years or older)			Middle-aged adults (45 to 64 years)			Older adults (65 years or older)		
	Percent	95% confidence interval		Percent	95% confidence interval		AOR	95% confidence interval		AOR	95% confidence interval	
		from	to		from	to		from	to		from	to
Gender												
Women	37.7 *	35.6	39.8	40.5 *	38.4	42.7	1.2 *	1.1	1.4	0.8 *	0.7	1.0
Men†	32.5	30.3	34.7	45.7 ‡	43.3	48.0	1.0	...	...	1.0	...	...
Middle-aged adults												
45 to 54 years†	32.4	30.2	34.7	...	...	...	1.0	...	...	...	...	...
55 to 64 years	37.6 *	35.6	39.7	...	...	...	1.1	1.0	1.3	...	...	...
Older adults												
65 to 84 years†	...	...	...	43.1	41.5	44.8	...	...	...	1.0	...	...
85 years or older	...	...	...	41.2	35.7	46.9	...	...	...	0.8	0.6	1.1
Living arrangements												
Living alone	35.8	32.3	39.5	39.8 *	37.1	42.5	0.9	0.7	1.1	0.8 *	0.7	1.0
Living with family or others†	35.0	33.3	36.7	44.2 ‡	42.2	46.2	1.0	...	...	1.0	...	...
Immigrant status												
Immigrant	34.6	31.8	37.5	44.2 ‡	40.7	47.7	1.0	0.8	1.2	1.0	0.9	1.2
Canadian-born individual†	35.4	33.7	37.1	42.5 ‡	40.7	44.3	1.0	...	...	1.0	...	...
Education												
Less than postsecondary†	34.4	31.5	37.5	40.3 ‡	37.9	42.7	1.0	...	...	1.0	...	...
Postsecondary	35.3	33.6	37.1	45.0 **	42.8	47.2	1.1	0.9	1.3	1.1	1.0	1.3
Total family income before taxes												
Lowest (quintile 1)†	33.8	29.9	38.0	40.4 ‡	37.3	43.6	1.0	...	...	1.0	...	...
Low-middle (quintile 2)	36.9	33.4	40.6	41.7 ‡	38.6	44.8	1.3 *	1.0	1.7	1.1	0.9	1.3
Middle (quintile 3)	34.6	31.1	38.2	43.3 ‡	39.8	46.8	1.2	0.9	1.6	1.1	0.9	1.4
High-middle (quintile 4)	36.6	33.4	39.8	47.9 **	43.6	52.2	1.3 *	1.0	1.7	1.5 *	1.2	1.9
Highest (quintile 5)	33.9	31.2	36.7	44.9 ‡	40.4	49.6	1.2	0.9	1.5	1.3 *	1.0	1.7
Has a primary health care provider												
Yes	37.1 *	35.4	38.8	43.8 **	42.1	45.4	1.6 *	1.3	1.9	1.3 *	1.0	1.6
No†	25.2	22.1	28.5	36.0 ‡	31.4	40.8	1.0	...	...	1.0	...	...
Perceived mental health												
Excellent, very good, or good†	33.6	32.0	35.2	42.3 ‡	40.7	44.0	1.0	...	...	1.0	...	...
Fair or poor	46.6 *	42.2	51.1	48.7 *	43.1	54.4	1.4 *	1.1	1.7	1.0	0.8	1.3
High stress in life												
Yes	38.2 *	35.2	41.2	50.5 **	45.5	55.5	1.0	0.9	1.2	1.2	1.0	1.5
No†	34.1	32.3	35.9	41.9 ‡	40.2	43.6	1.0	...	...	1.0	...	...
Number of chronic physical conditions												
None†	28.7	26.7	30.8	31.1	28.1	34.2	1.0	...	...	1.0	...	...
One	37.0 *	34.2	40.0	39.9 *	37.0	42.8	1.4 *	1.2	1.6	1.4 *	1.2	1.7
Two	46.0 *	41.6	50.6	46.3 *	43.0	49.6	1.9 *	1.5	2.4	1.9 *	1.5	2.3
Three	52.3 *	45.0	59.6	51.8 *	47.4	56.1	2.1 *	1.5	2.9	2.4 *	1.9	3.0
Four or more	59.2 *	50.7	67.3	62.7 *	57.7	67.4	2.7 *	1.8	4.0	3.4 *	2.6	4.5
Disability status												
Yes	50.3 *	46.1	54.6	54.0 *	50.3	57.6	1.6 *	1.3	2.0	1.4 *	1.1	1.7
No†	32.9	31.3	34.5	40.0 ‡	38.2	41.8	1.0	...	...	1.0	...	...
Place of residence												
Urban†	36.5	34.8	38.2	44.1 ‡	42.3	45.9	1.0	...	...	1.0	...	...
Rural	28.5 *	25.6	31.5	38.1 **	34.9	41.4	0.7 *	0.6	0.8	0.8	0.7	1.0
Province												
Newfoundland and Labrador	31.7 *	29.0	34.6	37.4 **	34.3	40.5	0.8 *	0.6	0.9	0.7 *	0.6	0.9
Prince Edward Island	27.4 *	24.8	30.2	32.4 **	29.9	35.0	0.8 *	0.6	0.9	0.6 *	0.5	0.7
Nova Scotia	29.9 *	27.2	32.8	32.6 *	29.7	35.7	0.8 *	0.6	0.9	0.6 *	0.5	0.7
New Brunswick	28.5 *	25.6	31.5	37.1 **	34.1	40.3	0.7 *	0.6	0.9	0.7 *	0.6	0.9
Quebec	35.9	32.9	39.0	42.3 ‡	39.0	45.6	1.1	0.9	1.3	1.0	0.8	1.2
Ontario†	37.4	34.3	40.6	46.6 ‡	43.3	49.9	1.0	...	...	1.0	...	...
Manitoba	32.5 *	29.4	35.8	37.5 **	34.0	41.1	0.8 *	0.6	0.9	0.6 *	0.5	0.8
Saskatchewan	28.9 *	26.2	31.8	36.7 **	33.7	39.8	0.7 *	0.5	0.8	0.7 *	0.5	0.8
Alberta	34.6	31.9	37.4	43.6 ‡	40.1	47.2	0.9	0.7	1.0	0.8	0.7	1.0
British Columbia	32.3 *	29.5	35.2	40.4 **	37.3	43.6	0.8	0.7	1.0	0.8 *	0.7	1.0

... not applicable

* significantly different from reference category ($p < 0.05$)

† reference category

‡ significantly different from middle-aged adults ($p < 0.05$)**Note:** In 2024, 6.6 million Canadians aged 45 years or older (38.5%) used specialist care for an initial consultation (35.1% among middle-aged adults and 42.9% among older adults).**Source:** Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

older). Living arrangements were categorized as living alone or living with family or others. Immigrant status was classified as immigrant (including non-permanent residents) or Canadian-born person, based on country of birth.

Enabling resources

Respondents' level of education was grouped as less than postsecondary or postsecondary. Total family income before taxes was divided into five categories: lowest (quintile 1), low-middle (quintile 2), middle (quintile 3), high-middle (quintile 4), and highest (quintile 5). Having a primary health care provider (yes or no) includes family doctors, general practitioners, or nurse practitioners.

Place of residence was categorized as rural (population less than 1,000) or urban (population of 1,000 or more). The 10 provinces of Canada were included as separate categories in the analysis.

Need-related factors

Self-rated mental health was coded as excellent, very good, or good, versus fair or poor, based on the question "In general, how is your mental health?"

The number of chronic physical conditions was classified into five categories (none, one, two, three, or four or more) based on 17 chronic conditions: asthma, lung condition (including chronic obstructive pulmonary disease), heart disease, diabetes, kidney disease, liver disease, high blood pressure, blood disorder, weakened immune system, neurological disorder, effects of a stroke, Alzheimer's disease or other dementia, cancer, arthritis, eye disease, urinary incontinence, and bowel disorder. These chronic conditions are expected to last or have already lasted six months or more and have been diagnosed by a health professional.

Table 2
Weighted percentage distribution of the most recent consultation with a medical specialist among middle-aged and older Canadians (excluding territories), 2024

Characteristics	Middle-aged adults (45 to 64 years)			Older adults (65 years or older)		
	Percent	95% confidence interval		Percent	95% confidence interval	
		from	to		from	to
Referred by						
Primary health care provider (a family doctor, general practitioner, or nurse practitioner)	68.3	65.9	70.7	64.0 *	61.5	66.3
Another specialist	14.8	13.0	16.8	17.5 *	15.6	19.5
Another health professional	8.1	6.8	9.6	8.1	6.8	9.5
Did not require a referral	8.8	7.5	10.3	10.5	9.0	12.2
Mode of consultation¹						
In person	89.2	87.6	90.7	89.2	87.5	90.6
Over the telephone (voice only)	8.2	6.9	9.6	9.1	7.8	10.6
Reason for initial consultation						
Heart condition or stroke	9.7	8.1	11.5	17.0 *	15.1	19.1
Cancer	6.1	4.9	7.6	8.9 *	7.6	10.4
Asthma or other breathing condition	3.2	2.4	4.2	3.8	3.0	4.8
Arthritis	5.0	4.0	6.3	5.5	4.4	6.8
Cataract or other eye condition	5.5	4.4	6.9	8.6 *	7.3	10.0
Skin condition	12.7	10.9	14.8	10.2 *	8.8	11.8
Urological or gynecological condition	15.9	13.8	18.2	8.3 *	6.9	9.9
Orthopaedic condition	11.3	9.6	13.2	11.3	9.6	13.1
Neurological condition	5.2	4.1	6.5	5.1	4.0	6.6
Other condition ²	25.4	23.1	27.8	21.4 *	19.4	23.6
Wait time between referral and initial consultation						
Less than one month	31.7	29.3	34.2	37.9 *	35.4	40.4
One month to less than three months	31.0	28.6	33.5	30.9	28.5	33.3
Three months to less than six months	16.8	14.9	18.8	16.4	14.6	18.4
Six months to less than a year	12.8	11.1	14.7	9.7 *	8.1	11.4
One year or more	7.7	6.5	9.2	5.2 *	4.3	6.3
Frequency of consultation with a medical specialist (in the past 12 months)						
Once	41.0	38.4	43.7	33.2 *	30.8	35.6
2 to 4 times	47.9	45.1	50.7	53.0 *	50.4	55.6
5 to 9 times	7.1	5.9	8.6	9.4 *	7.9	11.2
10 or more times	4.0	3.0	5.2	4.4	3.5	5.6

* significantly different from middle-aged adults ($p < 0.05$)

1. Percentages do not add up to 100.0%, as certain categories were suppressed for disclosure compliance.

2. Other conditions also include mental health conditions and diabetes.

Source: Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

Disability status was based on the yes or no question “Do you identify as a person with a disability?” High stress in life was based on the yes or no question “Thinking about the amount of stress in your life, how would you describe most of your days?” Responses of “quite a bit stressful” or “extremely stressful” were coded as high stress, whereas responses of “not at all stressful,” “not very stressful,” or “a bit stressful” were classified as not high stress.²⁷

Difficulty accessing health care services in the past 12 months was based on the questions “In the past 12 months, did you experience any of the following difficulties getting the non-urgent primary health care you needed?” and “In the past 12 months, did you ever experience any of the following difficulties getting the specialist care you needed?” A primary health care provider is a family doctor, general practitioner, or nurse practitioner. Four mutually exclusive categories were created: (1) no difficulty, (2) difficulty accessing primary health care only, (3) difficulty accessing specialist care only, and (4) difficulty accessing both primary health care and specialist care. This categorization enables the separation of difficulties specific to specialist care from those arising in primary care. Because unmet needs may stem from barriers in either domain, distinguishing these groups helps reduce confounding results and supports more accurate estimates of the association between specialist-care difficulties and unmet health care needs.

Analytical approach

Weighted percentages and cross-tabulations were generated to examine the three outcome variables, as well as other aspects of specialist care use, including referral sources, reasons for consultation, wait times, types of difficulties experienced accessing care, and coping strategies. Multivariable logistic regression was calibrated to identify factors associated with specialist care use, difficulty accessing specialist care, and unmet health care needs. Analyses were presented separately for middle-aged and older Canadians.

Descriptive estimates of specialist care use, difficulty accessing specialist care, and unmet health care needs were based on available case analysis, with an unequal number of cases across covariates. Logistic regression estimates were derived based on complete case analysis, with an equal number of cases across the covariates following list-wise deletion of missing cases. The percentages of missing cases across the covariates were very low (from 0.03% for immigrant status to 1.2% for number of chronic conditions).

Sampling weights were used to account for the survey design and non-response. Bootstrap weights were applied using SAS-callable SUDAAN 11.0.3 to account for the underestimation of standard errors.²⁸ The significance level was set at $p < 0.05$.

Results

Characteristics of the study population

The study population represents 17.2 million Canadians aged 45 years or older, of whom 57.2% are middle-aged adults and 42.8% are older adults. The percentage of women was higher among older adults than middle-aged adults, while the percentage of men was lower among older adults than middle-aged adults. Further details are provided in Appendix A.

Specialist care use

In 2024, 38.5% (95% confidence interval [CI]: 37.3 to 39.6) of Canadians aged 45 or older (about 6.6 million people) used specialist care for an initial consultation in the past 12 months. Use was higher among older adults (42.9%) than middle-aged adults (35.1%), even after adjusting for demographic, socioeconomic, geographic, and health-related factors (adjusted odds ratio [AOR]=1.2, 95% CI: 1.1 to 1.3) (not shown).

Among middle-aged adults, women (37.7%) were more likely to use specialist care than men (32.5%), whereas among older adults, women were less likely to do so. These differences persisted even after accounting for the selected covariates (Table 1). Specialist care use did not differ significantly between adults aged 45 to 54 and those aged 55 to 64, nor between adults aged 65 to 84 and those 85 years or older, after adjustment. Older adults living alone had lower odds of specialist care use than those living with others (AOR=0.8). Higher family income was associated with greater odds of specialist care for both age groups, with few exceptions.

Those with a primary health care provider were more likely than those without one to see a specialist, and this difference remained significant for middle-aged adults (1.6 times higher) and older adults (1.3 times higher) after adjustment. Having an increasing number of chronic physical conditions and having a disability were associated with higher odds of specialist care use for both age groups.

Geographic variation was evident: compared with Ontario, those living in Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, and Saskatchewan had lower odds of specialist care use for both age groups.

Specialist care use: Referral sources, mode of consultation, and wait times

Primary health care providers were the most common source of referral for initial consultations with a medical specialist, followed by another specialist, and another health professional, for both age groups. About 90.0% of the middle-aged and older adults consulted a medical specialist in person. The most common reasons for the initial consultation with a medical specialist included a heart condition or stroke, cancer, a skin

condition, a urological or gynecological condition, and an orthopaedic condition (Table 2).

About two-thirds of middle-aged adults and more than two-thirds of older adults waited less than three months between the referral and the initial consultation with a medical specialist (Table 2). Older adults were more likely to be satisfied with the wait time and less likely to be affected by the wait time (Chart 1). For most middle-aged and older adults, the effect of the wait time was worry, anxiety, or stress (Chart 2).

Difficulty in accessing specialist care

In 2024, 27.8% (95% CI: 26.7 to 28.9) of Canadians aged 45 or older—about 4.5 million people—reported difficulty accessing specialist care for an initial consultation. Older adults (24.6%) were less likely to experience difficulty than middle-aged adults (30.2%), even after adjusting for the covariates (AOR=0.8, 95% CI: 0.7 to 0.9) (not shown).

Among middle-aged adults, a higher percentage of women (33.4%) than men (26.9%) experienced difficulty—a difference that remained significant even after adjustment for the covariates (AOR=1.4) (Table 3). Difficulty accessing specialist care did not differ significantly between adults aged 45 to 54 and those aged 55 to 64. However, among older adults, those aged 85 or older were less likely to report difficulties accessing specialist care than those aged 65 to 84 (AOR=0.5). Immigrants were more likely than Canadian-born individuals to have experienced access difficulties (1.8 times higher among middle-aged adults and 1.4 times higher among older adults).

Individuals with a postsecondary education had higher odds of reporting difficulties accessing specialist care than those with less than a postsecondary education. Poor or fair mental health,

high stress, disability, and one or more chronic conditions were associated with higher odds of difficulties across both age groups. In contrast, having a primary care provider was protective (AOR=0.6 for middle-aged adults and AOR=0.5 for older adults).

Geographic differences were observed, with higher odds of difficulties in Quebec (AOR=1.3) and British Columbia (AOR=1.4) among middle-aged adults, and in British Columbia (AOR=1.3) among older adults, compared with Ontario.

Types of difficulty accessing specialist care and coping strategies

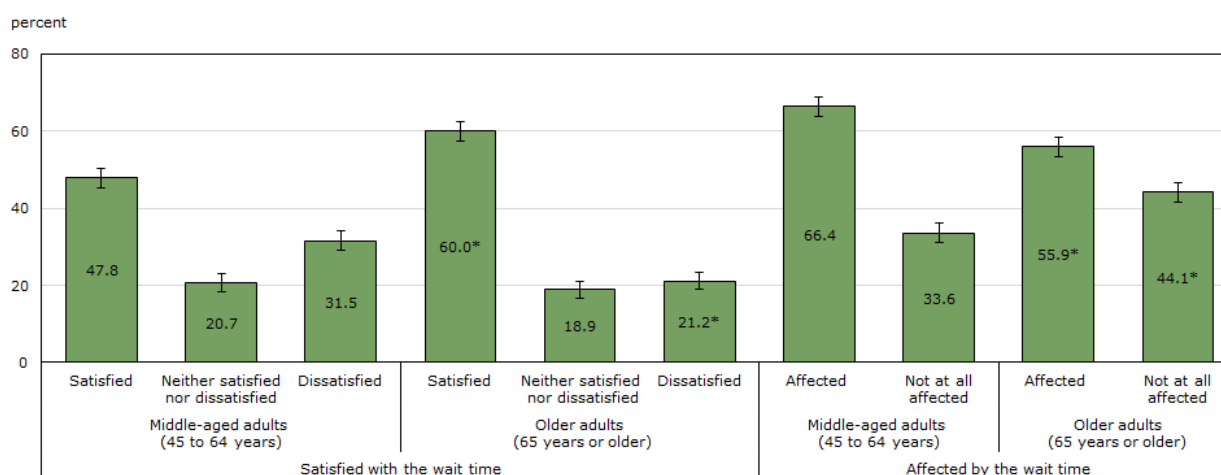
The top two difficulties experienced in accessing specialist care among middle-aged and older adults were difficulty getting an appointment and waiting too long between booking an appointment and the visit. Older adults were more likely than middle-aged adults to experience appointment cancellation or deferral, whereas middle-aged adults were more likely to report difficulty getting an appointment or obtaining a referral (Table 4).

Both middle-aged and older adults used various coping strategies to manage these difficulties, such as seeking medical care from a different health care professional or location (19.7% versus 17.7%), increasing the use of over-the-counter drugs (20.1% versus 17.3%), seeking medical information through the Internet (29.2% versus 19.9%), and seeking advice or care from family or friends (20.1% versus 16.9%).

Unmet health care needs

In 2024, 18.0% (95% CI: 17.1 to 19.0) of Canadians aged 45 or older (2.9 million people) reported having unmet health care

Chart 1
Satisfaction with wait time to consult with a medical specialist and effect of the wait time among middle-aged and older Canadians (excluding territories), 2024



* significantly different from middle-aged adults ($p < 0.05$)

Note: Vertical error bars represent the 95% confidence intervals.

Source: Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

needs (20.7% among middle-aged adults and 14.2% among older adults) (not shown). Among middle-aged adults, unmet health care needs were more likely for those who experienced difficulty accessing primary health care only (23.6%), specialist care only (27.3%), or both (54.4%) than for those reporting no difficulty. This pattern of unmet health care needs was similar among older adults (Table 5).

The higher likelihood of having unmet health care needs among those who experienced access difficulty persisted even after adjusting for the covariates. Among middle-aged adults, those who experienced difficulty accessing specialist care had 6.2 times the odds of having unmet health care needs than those who experienced no difficulty. Among older adults, those who experienced difficulty accessing specialist care had 14.0 times the odds of having unmet health care needs than those who experienced no difficulty.

Discussion

In 2024, 38.5% of Canadians aged 45 or older (about 6.6 million people) used specialist care, 27.8% (about 4.5 million) experienced difficulty accessing specialist care, and 18.0% (2.9 million) reported unmet health care needs. This study also shows that while specialist care use varies by predisposing, enabling, and need-related factors, access difficulties are widespread and associated with unmet health care needs.

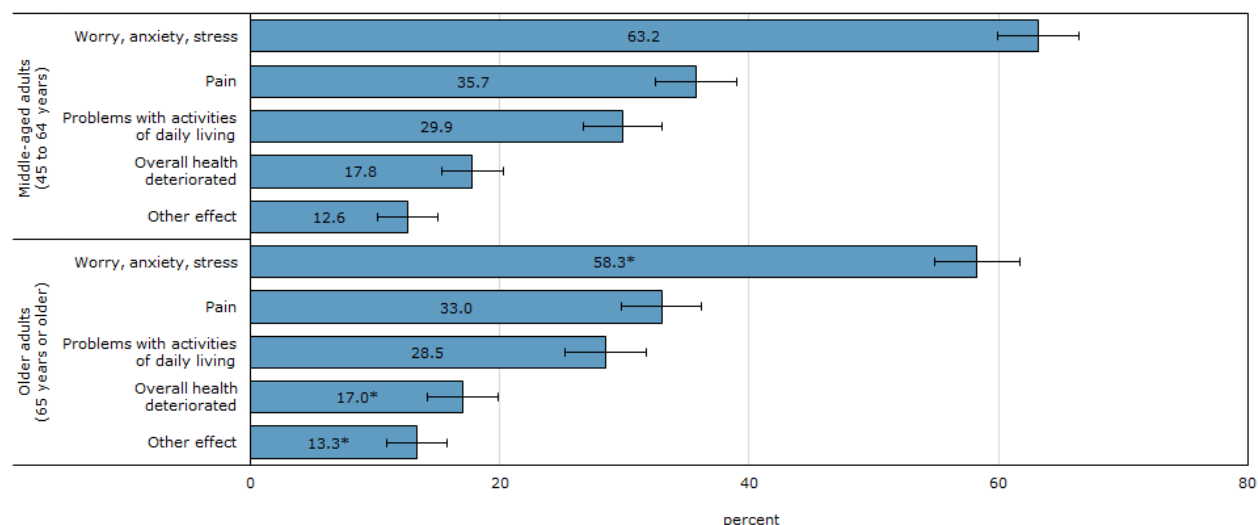
Among the predisposing characteristics, gender-specific patterns in specialist care use differed by age group. Among men, older adults were significantly more likely to use specialist care than middle-aged adults. This may be attributable to

differences in the patterns of chronic conditions (e.g., non-fatal versus life-threatening chronic conditions), leading to a greater need for specialist care.^{7,29} Among middle-aged adults, women were more likely than men to see a specialist, while the reverse was true among older adults. This difference persisted after controlling covariates. Further research could investigate whether age and gender differences in specialist care use reflect underlying patterns in health-seeking behaviour, referral practices, or differences in disease profiles between men and women as they age.

In this study, immigrants were no more or less likely than their Canadian-born counterparts to have used specialist care. However, consistent with many,^{13,30,31} but not all,¹⁴ earlier studies, immigrants were more likely to have experienced difficulties accessing such care. Previous studies have attributed disparities in accessing health care services among immigrants to language barriers, limited access to information, financial constraints, and cultural differences.³⁰⁻³² Future studies could examine the role of delivering culturally appropriate services and ensuring service availability in preferred modes of communication to improve immigrants' access to specialist care.

Regarding need-related factors, middle-aged and older adults living with multiple chronic conditions or a disability were more likely to use specialist care. This is consistent with previous studies.^{7,13,29,33} These individuals were also found to experience higher difficulties accessing specialist care, and this can result in lower life expectancy and worse health outcomes.³⁴ Individuals with disabilities are more susceptible to diverse

Chart 2
Effects of wait time for an initial consultation with a medical specialist among middle-aged and older Canadians (excluding territories), 2024



* significantly different from middle-aged adults ($p < 0.05$)

Note: Horizontal error bars represent the 95% confidence intervals.

Source: Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

Table 3
Difficulty accessing specialist care among middle-aged and older Canadians (excluding territories), 2024

Characteristics	Prevalence of difficulty accessing specialist care						Adjusted odds ratio (AOR) of difficulty accessing specialist care					
	Middle-aged adults (45 to 64 years)			Older adults (65 years or older)			Middle-aged adults (45 to 64 years)			Older adults (65 years or older)		
	Percent	95% confidence interval		Percent	95% confidence interval		AOR	95% confidence		AOR	95% confidence interval	
		from	to		from	to		from	to		from	to
Gender												
Women	33.4 *	31.4	35.4	24.2 †	22.4	26.2	1.4 *	1.2	1.6	1.1	0.9	1.2
Men†	26.9	24.8	29.1	25.0	22.8	27.2	1.0	...	...	1.0	...	...
Middle-aged adults												
45 to 54 years†	31.3	29.0	33.7	...	...	...	1.0	...	...	...	...	...
55 to 64 years	29.1	27.2	31.1	...	...	...	0.9	0.8	1.0	...	...	...
Older adults												
65 to 84 years†	...	...	...	25.3	23.8	26.9	...	...	...	1.0	...	...
85 years or older	...	...	...	17.1 *	13.4	21.6	...	...	...	0.5 *	0.7	0.7
Living arrangements												
Living alone	28.9	25.7	32.4	23.9 †	21.6	26.3	0.9 *	0.7	1.0	1.0	0.8	1.2
Living with family or others†	30.4	28.7	32.1	24.9 †	23.1	26.8	1.0	...	...	1.0	...	...
Immigrant status												
Immigrant	36.5 *	33.5	39.7	29.8 **	26.6	33.3	1.8 *	1.5	2.1	1.4 *	1.2	1.8
Canadian-born individual†	27.0	25.4	28.7	22.5 †	21.1	24.1	1.0	...	...	1.0	...	...
Education												
Less than postsecondary†	25.5	22.9	28.3	20.5 †	18.5	22.6	1.0	...	...	1.0	...	...
Postsecondary	31.8 *	30.0	33.7	27.7 **	25.6	29.8	1.3 *	1.1	1.6	1.4 *	1.2	1.6
Total family income before taxes												
Lowest (quintile 1)†	30.5	26.6	34.7	25.4 †	22.6	28.5	1.0	...	...	1.0	...	...
Low-middle (quintile 2)	30.0	26.5	33.8	21.1 **	18.8	23.7	1.1	0.8	1.4	0.9	0.7	1.1
Middle (quintile 3)	29.1	25.7	32.7	26.6	23.3	30.3	1.1	0.8	1.4	1.2	0.9	1.5
High-middle (quintile 4)	30.7	27.7	33.8	24.2 †	20.6	28.2	1.2	0.9	1.6	1.1	0.8	1.5
Highest (quintile 5)	30.4	27.8	33.2	28.1	24.0	32.6	1.3	1.0	1.6	1.2	0.9	1.7
Has a primary health care provider												
Yes	28.8 *	27.2	30.4	23.6 **	22.1	25.1	0.6 *	0.5	0.7	0.5 *	0.4	0.7
No†	37.4	33.6	41.3	32.5	27.7	37.6	1.0	...	...	1.0	...	...
Perceived mental health												
Excellent, very good, or good†	28.1	26.6	29.7	22.5 †	21.1	24.0	1.0	...	...	1.0	...	...
Fair or poor	45.3 *	40.7	50.0	44.5 *	38.7	50.5	1.5 *	1.2	1.9	1.8 *	1.4	2.3
High stress in life												
Yes	40.0 *	36.8	43.3	42.3 *	37.2	47.5	1.6 *	1.3	1.9	1.9 *	1.5	2.4
No†	26.6	25.0	28.3	22.1 †	20.7	23.6	1.0	...	...	1.0	...	...
Number of chronic physical conditions												
None†	26.5	24.4	28.7	15.3 †	13.1	17.9	1.0	...	...	1.0	...	...
One	30.7 *	28.0	33.5	23.5 **	21.1	26.1	1.3 *	1.1	1.6	1.7 *	1.4	2.2
Two	33.9 *	29.6	38.5	25.6 †	22.5	28.8	1.5 *	1.2	1.9	1.9 *	1.4	2.4
Three	45.7 *	38.8	52.7	29.6 †	25.7	33.8	2.3 *	1.6	3.2	2.3 *	1.7	3.1
Four or more	50.8 *	42.1	59.5	40.9 *	35.6	46.4	2.6 *	1.6	3.9	3.2 *	2.3	4.3
Disability status												
Yes	43.0 *	38.8	47.4	35.7 **	32.2	39.3	1.6 *	1.3	2.0	1.5 *	1.2	1.8
No†	28.3	26.8	29.9	21.6 †	20.1	23.2	1.0	...	...	1.0	...	...
Place of residence												
Urban†	30.4	28.8	32.1	24.7 †	23.1	26.5	1.0	...	...	1.0	...	...
Rural	29.0	25.8	32.4	23.9 †	20.9	27.1	1.1	0.9	1.4	1.1	0.9	1.3
Province												
Newfoundland and Labrador	30.5	27.6	33.5	27.1	24.3	30.1	1.2	1.0	1.6	1.1	0.9	1.4
Prince Edward Island	28.8	26.0	31.8	24.4 †	22.0	26.9	1.1	0.8	1.3	0.9	0.7	1.1
Nova Scotia	28.6	25.6	31.7	22.0 **	19.6	24.7	1.1	0.9	1.4	0.8	0.7	1.1
New Brunswick	26.9	23.9	30.1	22.0 **	19.4	24.8	1.0	0.8	1.3	0.9	0.7	1.2
Quebec	30.8	27.7	34.0	20.4 **	17.9	23.3	1.3 *	1.0	1.6	0.9	0.7	1.2
Ontario†	28.7	25.8	31.8	26.2	23.3	29.3	1.0	...	...	1.0	...	...
Manitoba	26.0	23.0	29.1	21.7 **	18.7	24.9	0.9	0.7	1.2	0.9	0.7	1.1
Saskatchewan	29.2	26.4	32.1	20.7 **	18.1	23.5	1.1	0.9	1.4	0.9	0.7	1.1
Alberta	29.9	27.1	32.8	24.7 †	21.6	28.0	1.1	0.9	1.3	0.9	0.7	1.2
British Columbia	35.9 *	32.8	39.2	29.2 †	26.2	32.3	1.4 *	1.2	1.8	1.3 *	1.0	1.6

... not applicable

* significantly different from reference category ($p < 0.05$)

† reference category

‡ significantly different from middle-aged adults ($p < 0.05$)**Note:** In 2024, 4.5 million Canadians aged 45 years or older (27.8%) experienced difficulty accessing specialist care for an initial consultation (30.2% among middle-aged adults and 24.6% among older adults).**Source:** Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

access difficulties, which can stem from multiple factors, including limited autonomy in making health decisions,³⁵ higher out-of-pocket costs (e.g., prescription medication, transport),³⁶ and insufficient training among health professionals.³⁷

Individuals with poor or fair mental health were also more likely to experience difficulties accessing specialist care across both age groups, consistent with previous studies.^{7,38,39} Several factors may contribute to these barriers, such as stigma,⁴⁰ long wait times,⁴¹ limited mental-health-specific referral pathways,⁴² and shortages of mental health care specialists.³⁹ Greater difficulty accessing specialist care among those with poorer mental health may further exacerbate the risk of lower use of mental health services, with adverse consequences for health and well-being.⁴³

Regarding enabling resources, middle-aged and older adults with a postsecondary education were more likely to report difficulties accessing specialist care. This may reflect their greater familiarity with the health care system, higher awareness of barriers, and greater willingness to report such difficulties.^{8,14} Higher family income was associated with a greater likelihood of specialist care use in both age groups, with few exceptions. The positive association may be explained by improved accessibility (e.g., ability to obtain referrals, travel costs) and affordability (e.g., having insurance coverage for drugs prescribed by specialists).^{7,44}

Having a primary health care provider increased the likelihood of seeing a specialist among middle-aged and older adults. In Canada's publicly funded health care system, a referral from a primary care provider is usually required to see a medical specialist, although specific procedures and exceptions can vary by province and type of service. This reflects the gatekeeping role primary health care providers play in making referrals and facilitating access to specialist care.^{45,46} Consistent with previous studies, having a primary health care provider also reduced the likelihood of experiencing access difficulties.^{13,14} By managing chronic conditions and coordinating referrals, primary health care providers support appropriate specialist use and improve appointment availability.^{47,48} Furthermore, they may help prevent the escalation of health issues that would otherwise necessitate specialist intervention.^{45,49} Recent studies have highlighted significant shortages of primary health care providers, particularly family physicians, in various parts of Canada, contributing to long wait times and difficulties accessing care.⁵⁰ Future research could examine how these shortages affect referral patterns and access to specialist care.

Most middle-aged and older adults were able to see a specialist within three months of referral, with older adults reporting greater satisfaction with wait times. However, two-thirds of middle-aged adults and over half of older adults experienced negative effects from waiting and adopted alternative coping strategies to manage difficulties in accessing specialist care,

Table 4
Types of difficulties experienced when accessing specialist care and coping strategies among middle-aged and older Canadians (excluding territories), 2024

Characteristics	Middle-aged adults (45 to 64 years)			Older adults (65 years or older)		
	Percent	95% confidence interval		Percent	95% confidence interval	
		from	to		from	to
Types of difficulties experienced¹						
Appointment cancelled or deferred	13.9	11.9	16.2	17.9 *	15.3	20.9
Difficulty getting an appointment	52.6	49.6	55.6	45.7 *	42.2	49.3
Difficulty getting a referral	18.6	16.4	21.1	14.3 *	11.8	17.3
Waited too long between booking appointment and visit	47.4	44.4	50.4	47.3	43.9	50.8
Did not get adequate information or advice	13.7	11.7	15.9	11.3	9.0	14.0
Overall health deteriorated	16.0	14.0	18.1	18.0	15.4	21.1
Service not available in the area	10.3	8.8	12.1	11.6	9.7	13.8
Other difficulties ²	8.8	7.4	10.4	12.8 *	10.5	15.5
Coping strategies¹						
Seek medical care from a different health care professional or location ³	19.7	17.5	22.2	17.7	15.0	20.7
Increase the use of over-the-counter drugs	20.1	17.9	22.6	17.3	14.6	20.3
Modify or extend current medication while waiting for care	12.0	10.3	14.0	13.6	11.4	16.3
Use traditional medicines	13.0	11.1	15.2	8.3 * ^E	6.3	11.0
Seek medical information through the Internet	29.2	26.6	31.9	19.9	17.2	22.9
Seek advice or care from family or friends	20.1	17.9	22.4	16.9	14.3	19.9
None of the above	39.0	35.8	42.2	45.6 *	42.3	48.9

* significantly different from middle-aged adults (45 to 64 years) ($p < 0.05$)

^E use with caution

1. Does not add up to 100% because of multiple responses.

2. Other difficulties include lack of availability of culturally appropriate health services, lack of Indigenous healing practices, services not available in preferred mode, and difficulties related to virtual care technology.

3. Among those who sought medical care elsewhere, 46.3% of middle-aged adults and 44.7% of older adults had to pay out-of-pocket.

Source: Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

Table 5

Odds ratios of unmet health care need among middle-aged and older Canadians (excluding territories), 2024

Characteristics	Prevalence of unmet health care needs						Adjusted odds ratio (AOR) of unmet health care needs					
	Middle-aged adults (45 to 64 years)			Older adults (65 years or older)			Middle-aged adults (45 to 64 years)			Older adults (65 years or older)		
	95% confidence interval			95% confidence interval			95% confidence interval			95% confidence interval		
	Percent	from	to	Percent	from	to	AOR	from	to	AOR	from	to
Experienced difficulty accessing health care												
No difficulty [†]	5.7	4.7	6.9	2.6 [‡]	2.0	3.4	1.0	...	...	1.0	...	...
Difficulty accessing primary health care only	23.6 [*]	20.1	27.5	20.9 [*]	17.0	25.3	4.7 [*]	3.4	6.5	8.7 [*]	6.0	12.8
Difficulty accessing specialist care only	27.3 [*]	22.5	32.6	26.0 [*]	21.5	31.0	6.2 [*]	4.4	8.8	14.0 [*]	9.4	20.7
Difficulty accessing primary health care and specialist care	54.4 [*]	50.9	57.8	50.8 [*]	46.4	55.1	17.4 [*]	13.2	22.9	34.2 [*]	24.4	47.9

... not applicable

[†] reference category^{*} significantly different from reference category ($p < 0.05$)[‡] significantly different from middle-aged adults ($p < 0.05$)

Notes: In 2024, 2.9 million Canadians aged 45 years or older (18.0%; 95% confidence interval: 17.1 to 19.0) had unmet health care needs (20.7% among middle-aged adults and 14.2% among older adults). Odds ratios were adjusted for gender, age, living arrangements, education, total family income before tax, having a primary health care provider, perceived mental health, high stress in life, number of chronic physical conditions, disability, place of residence, and province.

Source: Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

with potential adverse implications for their health and well-being.⁵¹ Future research could examine how these effects differ across chronic conditions and disability profiles among older Canadians.

These findings reflect the strong link between difficulty accessing specialist care and unmet needs, underscoring how access barriers may affect perceptions of the adequacy of care. Individuals reporting difficulty accessing primary or specialist care, and especially both, were significantly more likely to report having unmet needs than those who reported no difficulty, even after adjusting for covariates. Among older adults, difficulty accessing specialist care was associated with 14.0 times higher odds of unmet needs; when difficulties occurred in both primary and specialist care, the odds were 34.2 times higher. Unmet health care needs can lead to adverse health outcomes,⁵² reduced quality of life, and increased mortality.⁵³ Improving the accessibility and availability of primary and specialist services may help address these unmet health care needs among Canadians.

Strengths and limitations

A key strength of this study is its use of a large, nationally representative survey capturing the use of and difficulties accessing specialist care, separately for middle-aged and older adults. To the best of the authors' knowledge, this is the first analysis examining the association between difficulty accessing specialist care and unmet health care needs among Canadians. Additionally, this paper provides descriptive insights into referral sources, types of difficulties experienced, and coping strategies used. Another strength is the inclusion of all adults aged 45 or older, regardless of specialist care use in the past 12 months, yielding a broader study population than previous research.

However, this study has some limitations. Those living in the territories, on Indigenous reserves, and in institutional settings,

such as nursing homes and community care facilities for the elderly, were excluded. Consequently, the findings are not generalizable to these population groups. Measures of specialist use are self-reported and may be subject to recall or reporting bias. The analysis did not capture system-level factors, such as regional specialist supply, referral policy differences, or the availability of private medical care, and this may partly explain the observed disparities. While this study is representative, more than 60.0% of respondents were from Ontario and Quebec. Lastly, the data are cross-sectional, precluding causal inference.

Conclusion

Using a nationally representative, population-based sample, this study identified factors associated with specialist care use and difficulties in accessing specialist care and examined the relationship between access difficulties and unmet health care needs. Older adults were more likely than middle-aged adults to use specialist care and less likely to report difficulty accessing specialist care. Gender, immigrant status, family income, education, presence of multiple chronic conditions, high stress in life, disability, and having a primary care provider were associated with specialist care use and access difficulties, with few exceptions. Understanding these factors and barriers is essential to inform policies that support timely and equitable access to medical specialists. The findings underscore the needs of populations facing greater access barriers, including immigrants, individuals with disabilities or multiple chronic conditions, those with lower income, and those experiencing poor mental health. Future research could examine the health consequences of difficulties accessing specialist care among Canadians.

Appendix A

Weighted distribution of middle-aged and older Canadians by selected background characteristics (excluding territories), 2024

Characteristics	Middle-aged adults (45 to 64 years)				Older adults (65 years or older)			
	Number ('000)	Percent	95% confidence interval		Number ('000)	Percent	95% confidence interval	
			from	to			from	to
Gender								
Women	4,970	50.6	50.4	50.8	3,912	53.3 *	53.1	53.5
Men	4,851	49.4	49.2	49.6	3,430	46.7 *	46.5	46.9
Age group (in years)								
45 to 54	4,702	47.9	46.3	49.4	...	...	...	...
55 to 64	5,118	52.1	50.6	53.7	...	...	...	...
65 to 84	...	...	...	...	6,693	91.2	90.2	92.1
85 or older	...	...	...	...	648	8.8	7.9	9.8
Living arrangements								
Living alone	1,350	13.8	13.0	14.6	2,171	29.7 *	28.6	30.8
Living with family or others	8,451	86.2	85.4	87.0	5,145	70.3 *	69.2	71.4
Immigrant status								
Immigrant	3,233	32.9	31.4	34.5	2,042	27.8 *	26.3	29.4
Canadian-born individual	6,581	67.1	65.5	68.6	5,299	72.2 *	70.6	73.7
Education								
Less than postsecondary	2,562	26.1	24.8	27.5	3,149	43.0 *	41.3	44.6
Postsecondary	7,243	73.9	72.5	75.2	4,182	57.0 *	55.4	58.7
Total family income before taxes								
Lowest (quintile 1)	1,588	16.2	15.0	17.5	2,011	27.5 *	26.0	29.0
Low-middle (quintile 2)	1,691	17.2	16.1	18.4	1,990	27.2 *	25.8	28.7
Middle (quintile 3)	1,818	18.5	17.4	19.8	1,435	19.6	18.4	20.9
High-middle (quintile 4)	2,122	21.6	20.5	22.9	1,051	14.4 *	13.3	15.5
Highest (quintile 5)	2,583	26.4	25.0	27.7	830	11.3 *	10.4	12.3
Has a primary health care provider								
Yes	8,181	83.5	82.3	84.6	6,489	88.5 *	87.4	89.5
No	1,621	16.5	15.4	17.7	845	11.5 *	10.5	12.6
Perceived mental health								
Excellent, very good, or good	8,634	88.0	86.9	88.9	6,674	91.0 *	89.9	92.0
Fair or poor	1,182	12.0	11.1	13.1	664	9.0 *	8.0	10.1
High stress in life								
Yes	2,580	26.3	24.9	27.8	892	12.2 *	11.1	13.4
No	7,230	73.7	72.2	75.1	6,433	87.8 *	86.6	88.9
Number of chronic physical conditions								
None	5,089	52.8	51.3	54.4	1,811	24.9 *	23.6	26.4
One	2,686	27.9	26.5	29.3	2,188	30.1 *	28.7	31.6
Two	1,182	12.3	11.3	13.4	1,610	22.2 *	20.9	23.5
Three	408	4.2	3.7	4.9	927	12.8 *	11.8	13.8
Four or more	267	2.8	2.3	3.3	727	10.0 *	9.0	11.1
Disability status								
Yes	1,217	12.4	11.5	13.4	1,515	20.7 *	19.4	22.1
No	8,592	87.6	86.6	88.5	5,807	79.3 *	77.9	80.6
Place of residence								
Urban	8,151	83.0	81.9	84.1	5,946	81.0 *	79.8	82.1
Rural	1,669	17.0	15.9	18.1	1,395	19.0 *	17.9	20.2
Experienced difficulty accessing health care								
No difficulty	5,067	55.3	53.7	56.9	4,373	63.7 *	62.0	65.3
Difficulty accessing primary health care only	1,340	14.6	13.5	15.9	811	11.8 *	10.8	12.9
Difficulty accessing specialist care only	741	8.1	7.2	9.0	612	8.9	8.0	9.9
Difficulty accessing primary health care and specialist care	2,017	22.0	20.7	23.4	1,075	15.6 *	14.4	17.0
Province								
Newfoundland and Labrador	153	1.6	1.5	1.6	128	1.7 *	1.7	1.8
Prince Edward Island	44	0.4	0.4	0.4	35	0.5 *	0.5	0.5
Nova Scotia	270	2.8	2.7	2.8	227	3.1 *	3.1	3.1
New Brunswick	221	2.3	2.2	2.3	184	2.5 *	2.5	2.5
Quebec	2,241	22.8	22.7	22.9	1,775	24.2 *	23.9	24.4
Ontario	3,840	39.1	38.9	39.3	2,814	38.3 *	38.1	38.5
Manitoba	315	3.2	3.2	3.3	234	3.2	3.2	3.2
Saskatchewan	268	2.7	2.7	2.7	198	2.7	2.7	2.7
Alberta	1,129	11.5	11.4	11.6	699	9.5 *	9.4	9.6
British Columbia	1,338	13.6	13.6	13.7	1,048	14.3 *	14.2	14.4

... not applicable

* significantly different from middle-aged adults ($p < 0.05$)

Note: The study population represents 17.2 million Canadians aged 45 years or older (57.2% middle-aged adults and 42.8% older adults).

Source: Statistics Canada, Survey on Health Care Access and Experiences – Primary and Specialist Care, 2024.

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