Comparative Analysis of Healthcare Workforce, Funding, and Geographic Access in Alberta and Canada

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Introduction and Background

Healthcare accessibility depends on the strength of the system that supports it. Hospitals, clinics, and emergency services can only function effectively when there are enough trained professionals and when funding is stable. Workforce availability and financial planning are therefore central to understanding whether people can receive timely and appropriate care.

Canada's healthcare system is publicly funded, but access and capacity still vary sharply across provinces. Alberta is a useful case because it combines rapid population growth, a relatively younger population profile, strong urban centres, and large rural distances. CIHI reports that Alberta's population reached about 4.89 million in 2024 and is projected to grow faster than any province over the long run, while the rural share of its population was 16.5% in 2024. That growth matters because it increases demand for workers, hospital capacity, and geographically distributed services.

This report focuses on three linked dimensions of healthcare access: workforce capacity, funding, and distance or travel-related access to care. The main question is not only how much Alberta and Canada spend, but whether staffing levels and care locations are keeping pace with demand. Across Canada, workforce shortages remain a major pressure point. CIHI reports 99,555 physicians in Canada in 2024, or 241 per 100,000 population, while the rate of family physicians fell from 124 per 100,000 in 2022 to 119 in 2024. CIHI also reports that direct-care RN supply fell from 67.9 to 66.8 per 10,000 population between 2020 and 2024.

Data Sources and Metrics

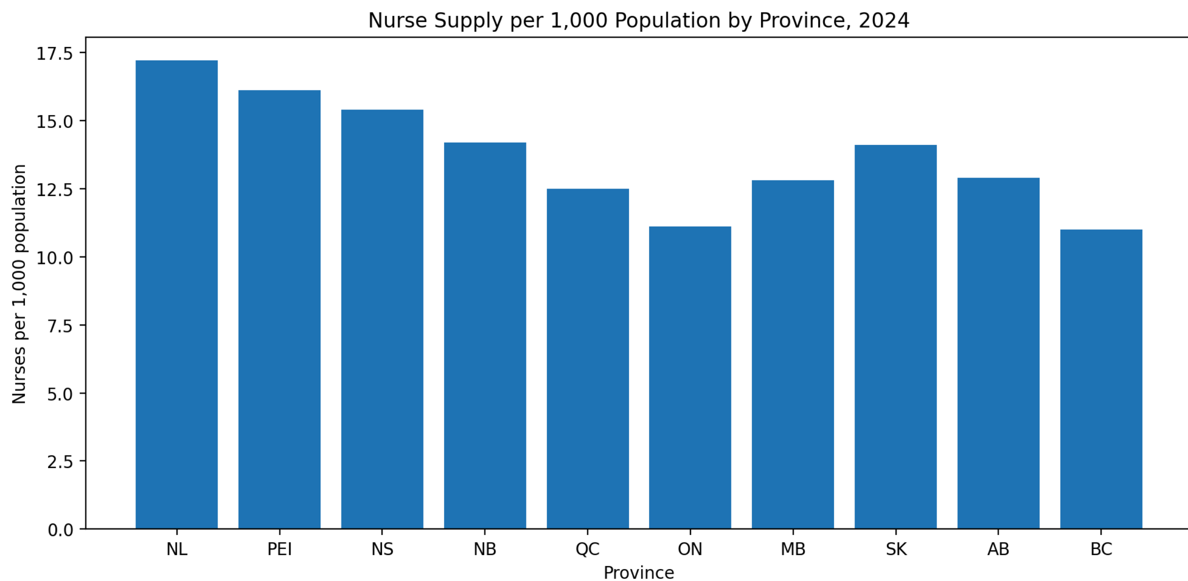
This analysis uses recent official Canadian sources. Workforce comparisons rely mainly on CIHI's Health System Context Series for nursing and rural family medicine, along with CIHI physician and nurse summary pages. Funding comparisons use CIHI's 2024 Health Expenditure Data in Brief. Geographic access uses Statistics Canada's Spatial Access Measures 2024 Update Report for healthcare-facility access within 90 minutes by public transit, and CIHI's 2024 travel burden analysis for inpatient hospital care.

The report compares provinces on four practical metrics: supply of nurses per 1,000 population, nursing overtime, total health expenditure per capita, and access to a healthcare facility within 90 minutes. For hospital-specific distance burden, it adds CIHI's travel burden results, which show how often patients face high or very high travel burdens for inpatient care.

1. Workforce Analysis

1.1 Nursing supply

Canada's nursing supply was 12.1 nurses per 1,000 population in 2024. Alberta stood at 12.9, above the national average, but below Newfoundland and Labrador at 17.2, Prince Edward Island at 16.1, and Nova Scotia at 15.4. Ontario and British Columbia were lower at 11.1 and 11.0 respectively. This suggests Alberta is not among the weakest provinces in nurse supply, but it is also not among the strongest performers.

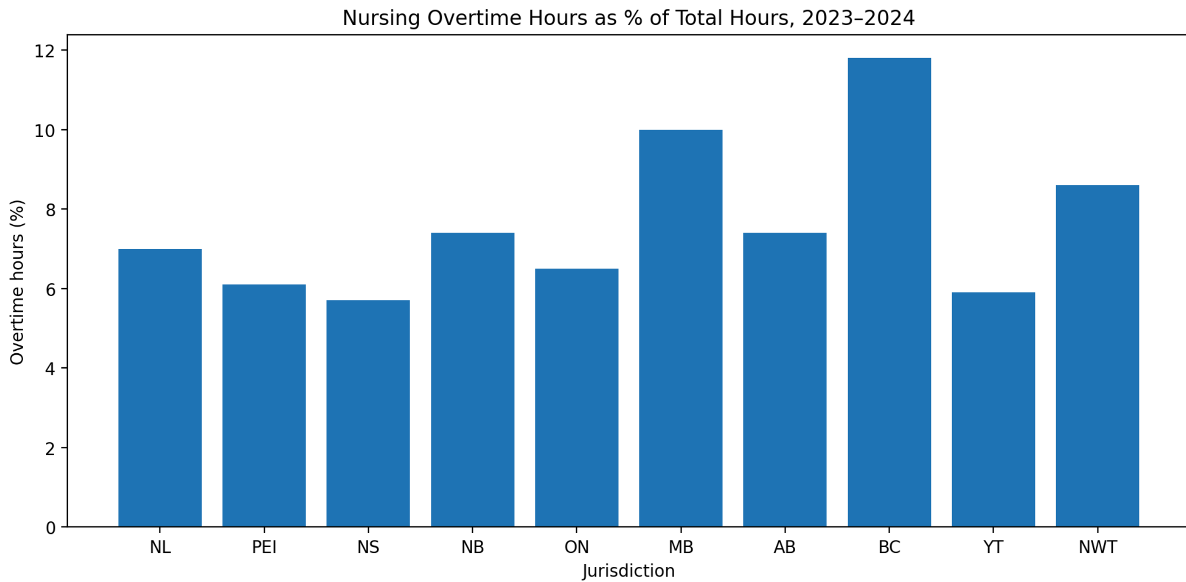


Nurse Supply per 1,000 Population by Province

1.2 Workforce pressure and overtime

Headcount alone does not show the full picture. Overtime is a better signal of strain in daily operations. CIHI shows that overtime hours in 2023–2024 were 7.9% nationally and 7.4% in Alberta. Alberta was therefore slightly below the Canada figure, but still under meaningful pressure. British Columbia was much higher at 11.8%, and Manitoba was 10.0%, while Nova Scotia was lower at 5.7%. This pattern suggests that Alberta's workforce pressure is real, but not as extreme as in some western and central jurisdictions.

Provinces such as British Columbia and Manitoba show significantly higher overtime percentages, indicating greater staffing strain and reliance on extended work hours to meet service demand. Alberta remains close to the national average, suggesting moderate pressure compared to other regions. This pattern reflects underlying workforce distribution challenges, where insufficient staffing levels lead to increased workload on existing personnel, potentially affecting service quality and long-term workforce sustainability.



Nursing Overtime Hours as % of Total Hours.

1.3 Rural family physician access

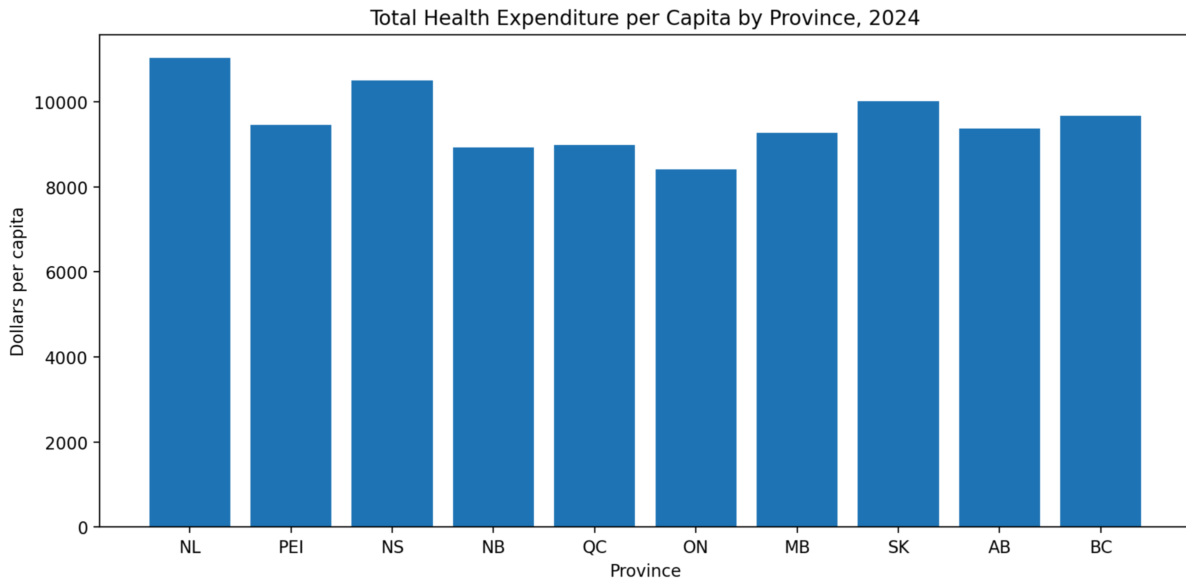
Because much of Alberta's access problem is geographic, rural primary care matters a lot. CIHI reports that Alberta had 89.9 rural family medicine physicians per 100,000 rural population in 2024, below the Canada rural average of 94.3. Alberta also trails British Columbia at 121.8, Quebec at 109.6, and Nova Scotia at 111.3. This matters because weak rural physician supply can increase downstream hospital use and increase the need to travel for care.

A second rural signal comes from hospital use. CIHI reports Alberta's rural age-sex-standardized hospitalization rate at 9.66 per 100 residents in 2024–2025, versus 6.93 for urban Alberta. Nationally, the comparable rates were 8.74 rural and 6.75 urban. The higher rural hospitalization rate may reflect greater illness burden, reduced access to timely community care, or stronger reliance on hospitals where other nearby services are limited.

2. Funding Analysis

Health spending in Canada reached $372.0 billion in 2024, or $9,053.5 per person, and 71.0% of total spending came from the public sector. Hospitals remained the largest spending category at 25.8% of total health spending, while physicians accounted for 13.3%. This shows that the system is still heavily structured around core institutional and clinical delivery.

At the provincial level, Alberta's total health expenditure per capita was $9,370 in 2024. That is above Ontario at $8,405, Quebec at $8,984, and New Brunswick at $8,922, but below British Columbia at $9,673, Saskatchewan at $10,018, Nova Scotia at $10,505, and Newfoundland and Labrador at $11,030. So Alberta is a mid-to-upper spender, but not an outlier when compared with other provinces.



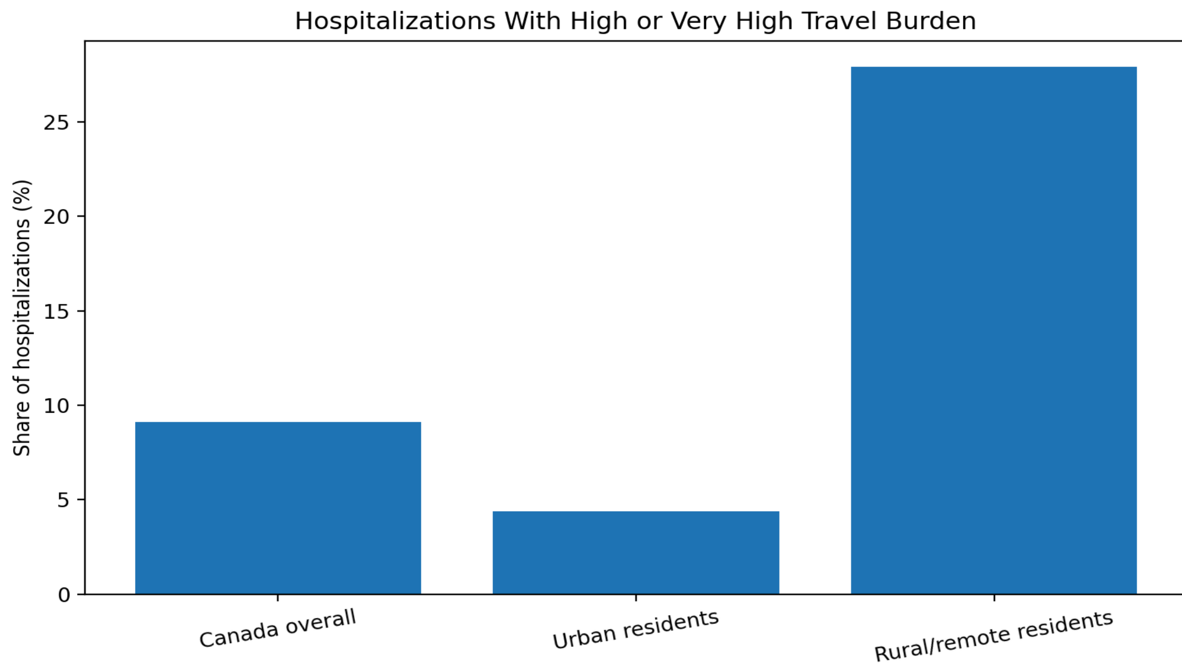
Total Health Expenditure per Capita by Province

Funding trends inside Alberta also show an important tension. CIHI's Alberta profile reports that provincial health spending rose from 4.5% of GDP in 2005–2006 to 6.3% in 2025–2026, still the lowest share in Canada, and total government health spending reached $30.5 billion. CIHI also reports that Alberta had the smallest increase in hospital spending per capita between 2015 and 2025, rising from $1,948 to $2,248, while Canada rose from $1,580 to $2,262. In other words, Alberta is spending more in total, but hospital spending growth has been comparatively restrained.

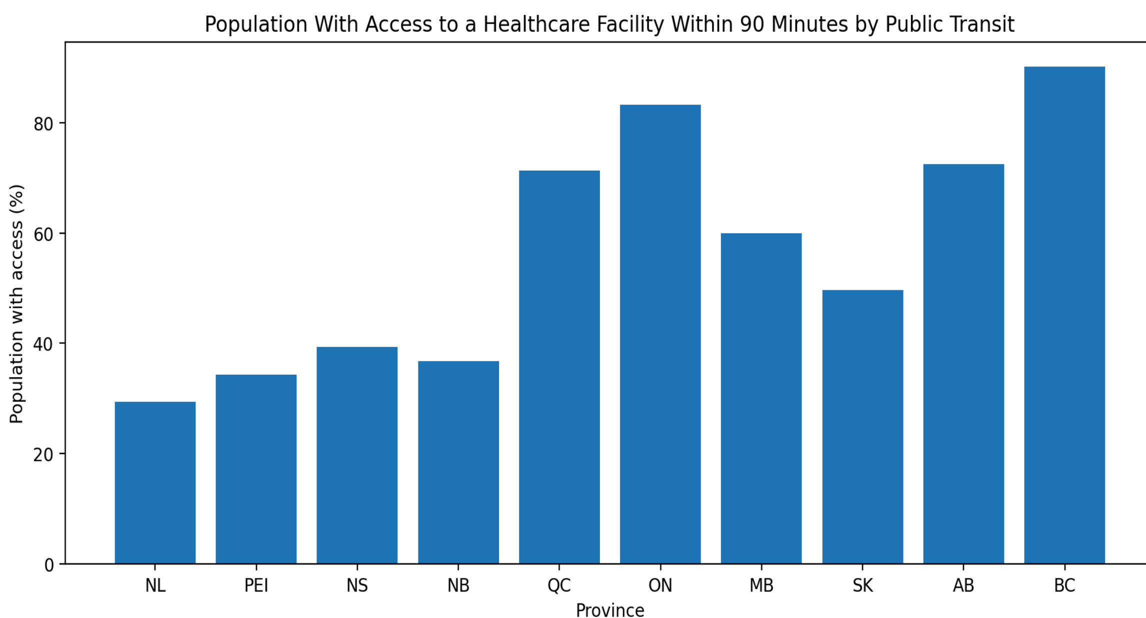
This creates an important policy interpretation. A province can spend above the national per-capita average and still face access problems if population growth, rural service distribution, and workforce availability rise faster than effective service capacity. Alberta appears to fit that pattern.

3. Distance to Hospital and Geographic Access

Distance is one of the clearest structural barriers in Canadian healthcare. CIHI's travel burden analysis found that 9.1% of hospital patients in Canada had high or very high travel burden, representing more than 250,000 hospitalizations annually. The burden was far worse for rural and remote residents, where 27.9% of hospitalizations had high or very high travel burden, compared with 4.4% for urban residents. CIHI also notes that more than 20,000 patients per year in the high-burden group had no road connection between home and hospital.



At the province and territory level, CIHI reports that Ontario and Quebec had the lowest share of patients with high or very high travel burden, at 5.8%, while Nunavut was dramatically higher at 82.9%. CIHI describes this as a fourteen-fold difference across Canada, largely driven by geography, sparse road networks, and limited local service availability. For a broader access comparison, Statistics Canada reports the share of the population that can reach a healthcare facility within 90 minutes by public transit during off-peak hours. Nationally, the figure was 75.1%. Alberta was at 72.5%, slightly below Canada overall. Ontario was much higher at 83.2% and British Columbia at 90.2%, while Newfoundland and Labrador was only 29.4%. These differences show that access is not only about funding or worker counts. Network design, settlement patterns, and where facilities are located matter a great deal.



Population With Access to a Healthcare Facility Within 90 Minutes by Public Transit

This metric is not the same as direct hospital distance, but it is still useful because it captures practical service accessibility at scale. When read together with CIHI's hospital travel-burden results, it shows a consistent national pattern: places with weaker geographic access are more likely to impose a larger care burden on patients. Alberta sits close to the national average on transit-based access, but its large rural geography means that hospital travel challenges are still a serious issue, especially outside Calgary and Edmonton.

Integrated Interpretation

The most important finding is that workforce, funding, and distance are not separate issues. They interact. A province may spend reasonably well on paper, but if rural physician supply is thin and services remain concentrated in urban areas, patients travel farther and hospitals absorb pressure that could have been handled earlier or closer to home. Alberta shows signs of this interaction. Its nurse supply is above the national average, but rural family physician supply is below the Canada rural benchmark, and rural hospitalization rates are materially higher than urban rates.

There is also a workforce-capacity signal inside hospitals. Alberta's hospital full-time-equivalent rate fell from 14.5 to 13.9 per 1,000 population between 2014–2015 and 2023–2024, while Canada rose from 13.7 to 14.8. That means Alberta's hospital staffing capacity per person moved in the opposite direction of the national trend. If population growth continues to outpace workforce growth, funding alone will not resolve access pressure. Finally, Alberta's position is best described as mixed rather than weak or strong. It is not a low-spending province in per-capita terms. It is not among the most constrained provinces on nurse supply. But it also does not lead on rural physician availability, and it faces a large-distance service environment that makes care delivery harder than in provinces with denser settlement patterns. That is why Alberta's access challenge is fundamentally structural.

Conclusion

The evidence suggests three main conclusions. First, healthcare workforce availability remains one of the strongest constraints on access, especially outside urban centres. Second, higher spending does not automatically translate into better access when population growth and service geography work against system capacity. Third, distance to care remains one of the most important hidden barriers in Canada, and it affects rural and remote residents far more than urban populations.

For Alberta, the policy implication is clear. Future improvements will likely depend less on broad spending increases alone and more on targeted action: strengthening rural family medicine, stabilizing the nursing workforce, protecting hospital staffing capacity per capita, and expanding decentralized care options that reduce travel burden. In short, the Alberta case shows that a healthcare system can be relatively well funded and still face significant access inequities if workforce distribution and care geography are not addressed together.

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