Primary Care Needs OurCare

Introducing the OurCare Standard

The final report of the largest pan-Canadian conversation about the future of primary care

MAP Centre for Urban Health Solutions

ST. MICHAEL'S UNITY HEALTH TORONTO

MASSLBP

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Foreword

People in Canada are proud to have a health care system that delivers care based on need rather than the ability to pay. Universal access to timely, high-quality health care has been a core value of this country for decades.

Unfortunately, the reality today has failed to reach these lofty aspirations.

Too many people in Canada do not have access to primary care, the front door to the health care system.

The OurCare national survey, completed in fall 2022, estimated that more than one in five adults in Canada do not have a family doctor or nurse practitioner they can see regularly for care. Even those who do have a family doctor describe difficulties getting the care they need. The state of primary care has been deteriorating for years and the global COVID-19 pandemic added more challenges to an already stressed system.

It feels like we are at a crossroads. If we continue on the same path of patchwork reform, things will no doubt get worse. Tweaks to the system — adding small amounts of money to do the same thing — may make things a bit better for a few people in the short term. But it won't result in the meaningful transformation that is needed to ensure every person in Canada has the care they need, now and for generations to come.

Now is the time for bold reform in primary care — reform that should be centred on the values and priorities of those the system is meant to serve.

OurCare is the largest-ever initiative to engage the Canadian public about the future of primary care. Over the last 16 months, we've heard from thousands of people across Canada about their experiences of primary care as well as their values, priorities, and hopes for a better system.

We heard from people from all walks of life — young and old, new immigrants and those whose families have lived in Canada for generations, settlers and Indigenous Peoples, those with privilege and those who have been marginalized by the system, people living in big cities and those in rural areas, and people who have access to primary care and those who don't.

What's been remarkable is that despite differences in their backgrounds, perspectives, and life experiences, there is much common ground to be found.

Fundamentally, people want a future in which every person in Canada has access to high-quality primary care that meets their needs.

They want care that is both timely and based in a long-term relationship with a clinician or team. They want a system that is organized around wellness not sickness, where people are empowered to take charge of their health and can easily access their own health records. They want a system free from racism and discrimination, accessible regardless of income, language, ability or geography, and accountable to the communities the system is meant to serve.

In this report, we summarize the OurCare process, describe who we heard from, and share our key findings. We also introduce the OurCare Standard: six elements that summarize what people in Canada believe everyone should be able to expect from the primary care system.

The OurCare Standard presents a bold vision for the future of primary care in Canada. It's a vision that is centred on the values and priorities of patients and the public. We believe it's a vision that policy-makers, clinicians, health care administrators, researchers, and others can all agree on and use as a basis for change.
The time has come to guarantee high-quality primary care for every person living in Canada regardless of who they are or where they live.

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OurCare Principal Investigator

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Peter Macleod
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Executive Summary

OurCare is a national conversation with people in Canada about the future of primary care. Over 16 months, between September 2022 and December 2023, OurCare engaged nearly 10,000 people about their experiences with primary care and their values, ideas, and hopes for the future of that care. The conversation placed special emphasis on engaging people who have the greatest needs of care, face the greatest barriers to accessing care, and are most likely to be excluded from policy-making decisions about primary care.

OurCare had three phases:

1

National Survey

A National Survey, conducted in Fall 2022, heard from 9,279 respondents who answered questions on access to care, what matters most to them, use of walk-in clinics, virtual care, primary care teams, health records, and options for system redesign. The findings are publicly available at **data.ourcare.ca**.

2

Provincial Priorities Panels

Five Provincial Priorities Panels engaged a total of 159 people in deep dialogues about primary care in British Columbia, Manitoba, Ontario, Quebec, and Nova Scotia. For each panel, 29-35 members of the public were randomly selected to roughly match the demographics of the province. Together they spent 30-40 hours learning about primary care from experts and then deliberating in small groups to reach consensus on the values that should underlie the primary care system, the issues they wanted to see addressed, and recommendations for a better system. Each priorities panel culminated with a report written by the members of the public themselves. Their reports are available at **ourcare.ca**.

3

Community Roundtables

Ten community roundtables, two in each of the same five provinces, engaged a total of 192 participants from communities that are often excluded from policy conversations or consistently underserved by primary care systems, including First Nation, Inuit and Métis Peoples; African, Caribbean and Black communities; immigrants, refugees, migrant workers and other newcomers; LGBTQIA+ migrants; and people with disabilities. In each of these one-day focused dialogues, 14-24 participants shared experiences and challenges accessing primary care and articulated ideas for change. The findings from these community roundtables are available at **ourcare.ca**.

Key Themes

Throughout the three phases of OurCare, people in Canada told us what they've experienced, what they believe is right and fair, and what they expect from primary health care. In summary, participants expressed a need to transform primary care around the following themes:

Resolve the **attachment crisis**, whereby 22% of adults living in Canada do not have a family doctor or nurse practitioner they can see regularly, and many more struggle to access primary care in a way that serves their needs.

Expand **team-based primary care** to increase access to care, reduce clinician burnout, and enable a more holistic approach to care while also strengthening community involvement and oversight of care.

Enable **patient access to health records** while also guaranteeing privacy, data security, and portability of their records.

Expand **primary care coverage** to include dental care, eye care, prescription medications, physiotherapy, and mental health care, to support overall well-being.

Improve **accountability** in the health care system by strengthening community governance and oversight of primary care, facilitating more public education on patient rights and the value of primary care, and empowering patient advocacy organizations to support health system access and navigation as well as safeguard accountability on behalf of patients.

Bring a strong **equity focus** to ensure primary care meets everyone's needs and supports overall well-being; for example, by addressing racism and discrimination, providing language-concordant care, integrating Indigenous models of care, removing accessibility barriers, and partnering with community organizations to address the social determinants of health.

Expand **virtual care** that is publicly owned and accountable, integrated with in-person care, and improves accessibility and equity, for example, in rural and remote communities.

Grow the **primary care workforce** by accelerating the licensing of foreign-trained health care professionals, by training, recruiting, and retaining more people to work in primary care, and by creating a workforce more representative of the people it serves.

The OurCare Standard

Collectively, the data and recommendations from all phases of OurCare point towards a new approach to understanding and assessing the adequacy of primary care in Canada.

The OurCare Standard is a set of six central elements that together represent the collective aspirations of all people in Canada for a more sustainable, high-quality, and equitable system of primary care.

The OurCare Standard tells us what every person in Canada should expect from the primary care system. It also provides a framework for policy-makers and the public to compare different models of primary care and level up those models to realize better primary care for everyone living in Canada.

1. **Everyone** has a relationship with a primary care clinician who works with other health professionals in a publicly funded team.
2. **Everyone** receives ongoing care from their primary care team and can access them in a timely way.
3. **Everyone's** primary care team is connected to community and social services that together support their physical, mental and social well-being.
4. **Everyone** can access their health record online and share it with their clinicians.
5. **Everyone** receives culturally safe care that meets their needs from clinicians that represent the diversity of the communities they serve.
6. **Everyone** receives care from a primary care system that is accountable to the communities it serves.

Achieving the Standard

The OurCare Standard is an aspirational standard, but an attainable one. It will require many different actors — policy-makers, educators, clinicians, health care administrators, researchers and others — to take action. The steps they take may look different in different places.

Examples of key actions to achieve the OurCare Standard include:

- Guaranteeing access to primary care for everyone living in Canada;
- Increasing funding for primary care;
- Legislating requirements for electronic health record interoperability and patient access to their health data;
- Expanding community-governed, interprofessional primary care teams;
- Scaling up training capacity to increase the number of health professionals graduating with interest and competency in primary care;
- Reducing barriers to practice for internationally trained primary care clinicians;
- Enhancing curriculum, professional development, and practice standards to ensure all primary care professionals are trained to provide trauma-informed, anti-discriminatory, culturally safe, and gender-affirming care;
- Ensuring language-concordant care through consistent funding and use of language interpretation services; and
- Establishing systems for patient and public oversight of primary care.

In the OurCare Standard, policy-makers, clinicians, researchers, and the public at large will find both inspiration and clear guidance on how to transform primary care in Canada.

The vision is a system that ensures every person in Canada has access to primary care that serves their needs and abilities, supports their health and well-being, and delivers on the promises of equity and accessibility that underpin Canada's commitment to universal health care.

About Primary Care

What is Primary Care and how does it differ across the country?

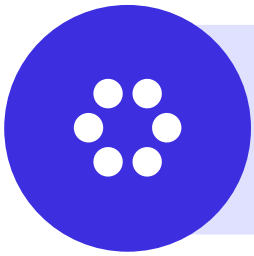
When it's working well, primary care is the front door to the health system. It's a place any patient should be able to turn to whether they have a new health concern or a chronic health condition like diabetes or asthma that needs ongoing care.

It's the entryway to other parts of the system, coordinating referrals to specialists. It helps people stay well by providing health advice and vaccinations to prevent illness, or organizing tests that catch disease early. It takes care of all parts of a person, physically and mentally, and puts each person's care needs in the context of their life, family and community.

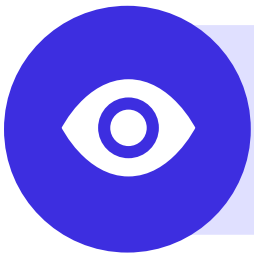
The 5 C's of Primary Care

Primary care is a model of care that supports the overall health and well-being of a population and ensures that everyone has equal access to health services. There are five core features of primary care, according to the World Health Organization:

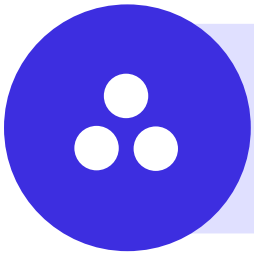
First Contact creates a strategic entry point for and improves access to health services.



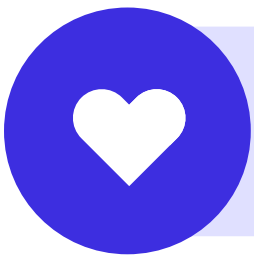
Continuity promotes the development of long-term personal relationships between a person and health professional or a team of providers.



Comprehensiveness ensures that a diverse range of promotive, protective, preventive, curative, rehabilitive, and palliative services are provided.



Coordination organizes services and care across levels of the health system and over time.



People-Centred care ensures that people have the education and support needed to make decisions and participate in their own care.

The World Health Organization's definition of prmary care can be accessed at
https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care

Most primary care in Canada is delivered by family physicians, most of whom are self-employed and run their own practices. Some physicians work on their own while others work in a group with other family physicians and other health professionals like nurses, nurse practitioners, social workers, and pharmacists, who may be paid directly by the physician or by the government.

14.5%
of people 12 and over in Canada did not have a regular primary care clinician in **2019**

In Canada, access to primary care has been an ongoing challenge. Even before the COVID-19 pandemic, in 2019, Statistics Canada estimated that about 14.5% of people in Canada age 12 and over did not have a regular primary care clinician[1]. There was a large variation by province from 9.4% in Ontario to 21.5% in Quebec reporting no regular primary care clinician. Results from the OurCare National Survey in the fall of 2022 suggest things have gotten worse, with 21.8% of adults nationwide reporting they did not have a regular primary care clinician, with the percentage ranging from 12.6% in Ontario to 30.8% in Quebec and 30.9% in Atlantic Canada.

21.8%
of people 12 and over in Canada did not have a regular primary care clinician in **2022**

The OurCare survey estimated that about five percent of adults in Canada identify a nurse practitioner as their regular primary care clinician. And some children receive primary care from a pediatrician. In other countries, people also receive primary care from a physician assistant, a growing field in Canada.

[1] Statistics Canada, 2020. "Primary health care providers 2019," Health Fact Sheets, Statistics Canada, Catlogue no. 82-625-X, October 22, 2020. https://www150.statcan.gc.ca/n1/pub/82-625-x/2020001/article/00004-eng.htm

Some trends influencing access to primary care include a declining proportion of medical students ranking family medicine as their first choice of specialty when applying to residency, many doctors approaching retirement age, and more doctors choosing to leave family practice after the pandemic[2]. Factors impacting the choice to practice family medicine range from relative pay, increasing practice costs (e.g. office rental), lack of practice support, large volume of paperwork, and difficulties finding coverage for vacation or leaves. Unfortunately, even those who have a primary care clinician often struggle to access their clinician in a timely manner. For example, the OurCare National Survey found that, among those with a primary care clinician, only 35% reported they could get a same or next day appointment when they needed care urgently.

Policy-makers and professional groups have known for more than two decades that the way family physicians are paid and organized is not in keeping with the needs of a growing, aging population or with medical and technological advancements. Provincial governments have tried to introduce reforms to modernize care but these have progressed differently across the country. For example, until the turn of the century, almost all family doctors were paid using a fee-for-service or pay-by-the-visit system. Some governments have tried to shift doctors to capitation payment, where they get paid per patient per year, or other types of payment like salary or a fee-per-hour. These new payments theoretically incentivize doctors to work differently, for example to address multiple problems in a visit, take more time to coordinate care, and proactively reach out to those who are overdue for care.

The percentage of family physicians paid fee-for-service varies by province from 46.5% in Ontario to 90.7% in Alberta[3]. There is also significant provincial variation in other aspects of primary care delivery and related resources including the total amount of health spending and number of family doctors per capita.

Many high-income countries have been able to provide better access to primary care than Canada does. In the Netherlands, Finland, and Norway, almost 100% of the population has access to regular, ongoing primary care[4]. These countries have chosen to make primary care a priority, guaranteeing access to care by automatically registering people to a physician or practice or by facilitating registration. On average, they also spend more money on primary care as a proportion of their total health budget.

[2] Mangin D, Premji K, Bayoumi I, et al. "Brief on Primary Care Part 2: Factors affecting primary care capacity in Ontario for pandemic response and recovery." Science Briefs of the Ontario COVID-19 Science Advisory Table. 2022;3(68). https://doi.org/10.47326/ocsat.2022.03.68.1.0

[3] Canadian Institute for Health Information. National Physician Database metadata. Available from: https://www.cihi.ca/en/nationalphysician-database-metadata

[4] Heba Shahaed et. al. 2023. "Primary care for all: lessons for Canada from peer countries with high primary care attachment," Canadian Medical Association Journal, 195 (47) E1628-E1636, December 4, 2023. https://www.cmaj.ca/content/195/47/E1628

What are the costs of inadequate primary care?

When people don't have access to high-quality primary care, everything else falls apart. People often have no choice but to turn to walk-in clinics or emergency departments for any new problem and to manage ongoing, chronic conditions.

Unfortunately, these settings often cannot meet their needs. Walk-in clinics and emergency departments are designed for quick visits focused on a new, urgent problem and aren't designed, for example, to provide ongoing follow-up for diabetes or depression, coordinate referrals for specialists or tests, or provide infants with routine vaccines and growth and development checks.

Some people have means to pay for private options that can provide primary care, including nurse practitioner clinics or virtual services that are not funded through provincial insurance plans — a situation that is unfair and particularly upsetting in a country that prides itself on people having access to care based on need and not the ability to pay. Others turn to family, friends, other countries, the internet — or forgo care altogether. When people delay or forgo care, their health can be irreversibly affected. It could mean a cancer not diagnosed in time to be treated, unmanaged depression that leads to suicide, or untreated high blood pressure that leads to a stroke or a heart attack.

When people can't access primary care, other parts of the health system are affected. For example, the 2023 annual report from the Office of the Auditor General of Ontario estimated that one in five emergency department visits were the result of lack of access to primary care — a huge strain on already overcrowded emergency departments which are struggling to retain staff and provide timely care. There are also wider effects. Without access to primary care, an individual's health issues can impact their ability to work, study or care for their loved ones, ultimately affecting our productivity, resilience and happiness as a society.

1 in 5

people in Canada do not have access to primary care

What are the benefits?

A large body of research, much of it led by the late Professor Barbara Starfield, has shown that countries with a strong primary care system have healthier populations, fewer differences in health between people (better equity), and lower health care costs[5].

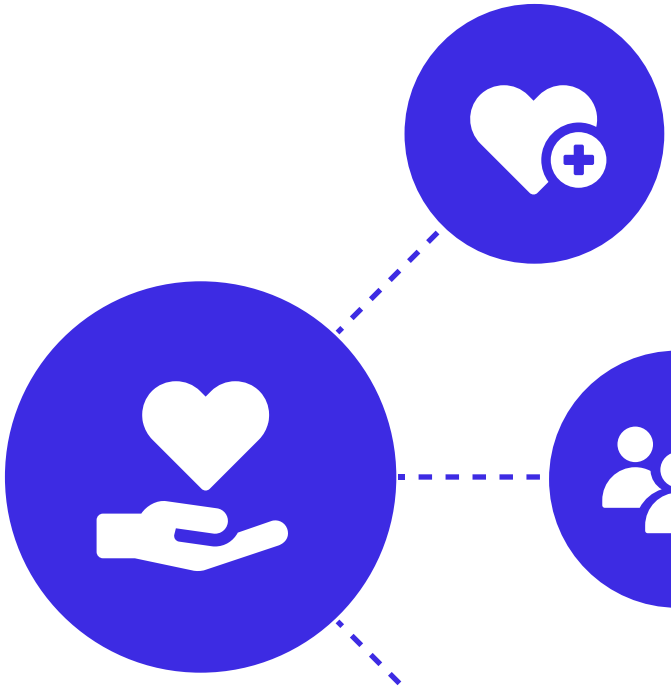
Related research from Dr. Sanjay Basu and colleagues in the US found that individuals in areas with more primary care doctors per capita had a higher life expectancy[6]. Dozens of studies have also found that having an ongoing relationship with one clinician who you see again and again over time — continuity in the relationship between an individual and doctor — has many benefits, including better health, decreased use of the health care system, lower health care costs and even lower death rates.

When people have access to high quality primary care, they have a home in the health care system — a place they and their families can turn to in order to keep well, and also in times of stress. High quality primary care means equitable, timely, patient-centred, relational care that is accessible for everyone. It means an entryway to other parts of the health system for further care. And it means care for the whole person, taking into account a patient's values and preferences, and supporting them in their journey of life, from birth to death and everything in between. They feel well physically, mentally and socially, and they are able to thrive, living life to their fullest potential.

[5] Barbara Starfield et. al. 2005. "Contributions of Primary Care to Health Systems and Health," The Milbank Quarterly, 2005 Sep; 83(3): 457–502. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

[6] Sanjay Basu et. al. 2019. "Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015," JAMA Internal Medicine, 2019;179(4):506-514. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393

Why Primary Care?



Better health outcomes for everyone

Fewer differences in health outcomes between people

Lower health care costs


DELL

The OurCare Process

What makes OurCare different?

In a world where policy decisions often remain distant from the people they serve and support, OurCare seeks to bridge the gap between the public and those whose privilege and duty it is to create a world-class health care system that works for everyone.

OurCare's mission is singular: to design a model for consulting people in Canada on what they think, know, need, and expect of primary health care, and to do it at a scale and scope not previously attempted anywhere in the world.

The OurCare methodology gathered valuable statistical data from the national survey to augment research and analysis of the state of primary care in Canada. More crucially, the methodology prioritized gathering the considered perspectives of individuals — the patients and families who use the health care system, and the communities who support them and whom they represent. Through well-tested, democratic methods of public consultation — priorities panels and community roundtables — we ensured the broad representation of Canada's diverse population in these important conversations. By employing techniques including deliberation, citizen-expert dialogue, and consensus-building, and by establishing relationships with dozens of community partners, organizers, and practitioners of primary care, OurCare has yielded new solutions for primary care transformation with unmatched rigour, depth, and clarity.

3 Phases of OurCare

1 National Survey, 9,279 people

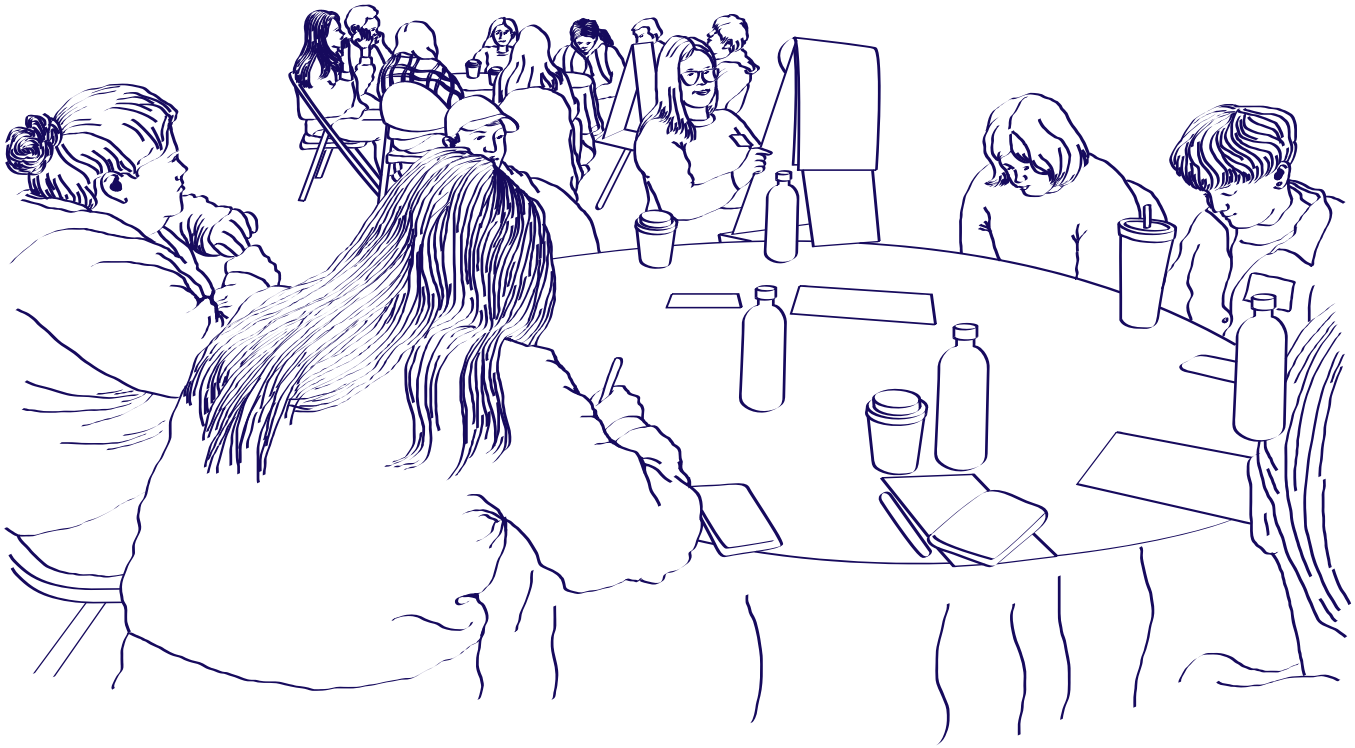
The OurCare national survey explored people's experiences, priorities and preferences for primary care.
Explore the results at **data.ourcare.ca**

5 Provincial Priorities Panels, 159 people

Each panel included 29-35 randomly selected residents from the province who spent 30 to 40 hours learning and deliberating about primary care.

10 Community Roundtables, 192 people

Each roundtable gathered 14-24 people from an equity-deserving community for a one-day session to identify specific needs and priorities for their group.



9,279

respondents
to a national public
survey

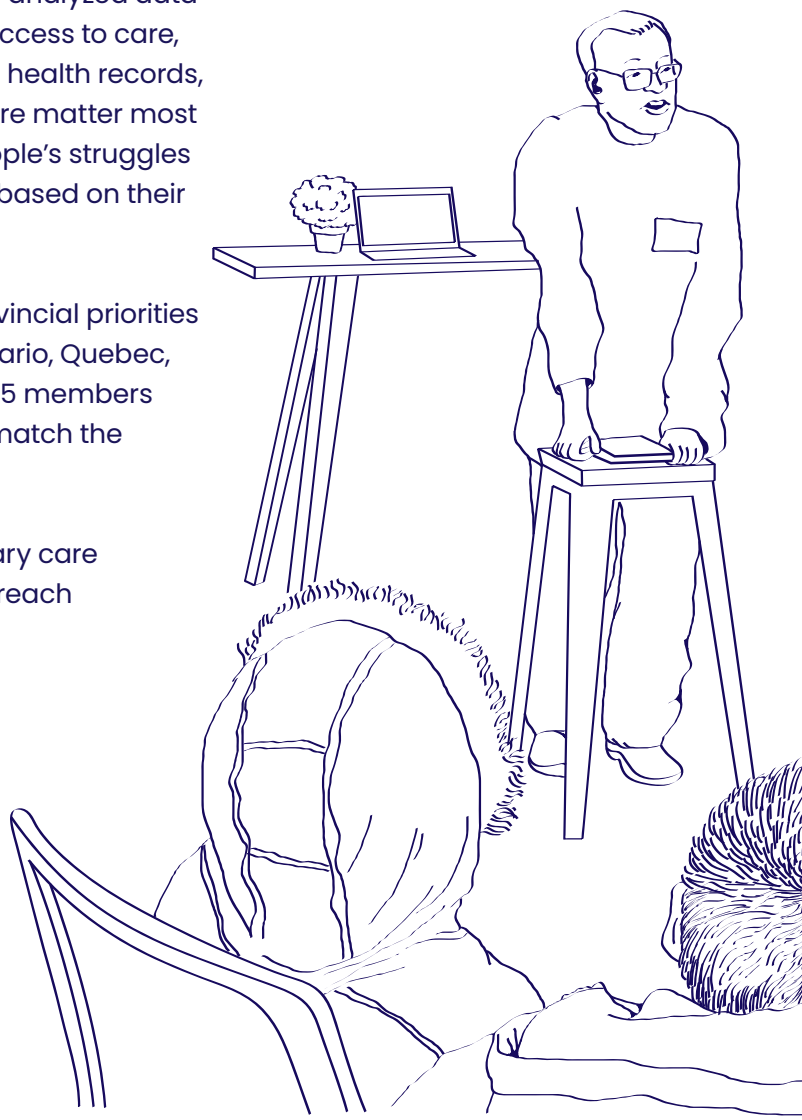
What we set out to learn, and the people we engaged

OurCare began with a national public survey that asked people in Canada to share their experiences and perspectives on primary care. The 15-minute electronic survey was open between September 20 and October 25, 2022 and was promoted through our collaborators, social media, opinion pieces and media features.

We also partnered with a national public opinion firm, Vox Pop Labs, who distributed the survey to its respondent panel. We analyzed data from 9,279 respondents who answered questions on access to care, use of walk-in clinics, virtual care, primary care teams, health records, options for system redesign and which elements of care matter most to them. The survey provided a broad snapshot of people's struggles to access care, their priorities, and how these differed based on their background and where they lived.

OurCare also engaged a total of 159 people in five provincial priorities panels, one in each of British Columbia, Manitoba, Ontario, Quebec, and Nova Scotia. Each priorities panel comprised 29-35 members of the public who were randomly selected to roughly match the demographics of the province.

Together they spent 30-40 hours learning about primary care from experts and then deliberating in small groups to reach consensus on the values that should underlie the primary care system, the issues they wanted to see addressed, and recommendations for a better system. Each priorities panel culminated with a report written by the members of the public themselves.



Panel membership included people of diverse age, gender, income level, race, geographical setting (rural and urban), length of residency in Canada, and self-reported health. They also included people with and without a family doctor. We deliberately sought to overrepresent residents that research suggests are underserved by the primary health care system, including Indigenous People, people who are racialized, people living with a lower income, and newcomers to Canada. Notably, almost one-third of the participants in the Manitoba Priorities Panel were First Nation, Inuit or Métis – an acknowledgement of the ongoing impact of colonialism and injustice on health care access and health outcomes for Indigenous Peoples in Canada.

192

people participated in 10 community roundtables across the country

Despite our attempts to include diverse voices in the national survey and priorities panels, we knew that there were voices missing. The third and final phase of OurCare focused on some of the most underserved and equity-deserving communities in Canada. We convened a total of 192 people in 10 community roundtables across the country, two in each of five provinces. These one-day focused dialogues, each with 14-24 people, aimed to give voice to communities that are often excluded from policy conversations or consistently underserved by primary care systems. We engaged with First Nation, Inuit and Métis people living on urban and related homelands; First Nation, Inuit and Métis youth; African, Caribbean and Black communities; immigrants, refugees, migrant workers and other newcomers; LGBTQIA+ migrants; and people with disabilities. The community roundtables were organized in partnership with local community organizations that had established relationships with these communities. To ensure inclusivity, several roundtables were conducted in three to five languages simultaneously.

Findings from the national survey, priorities panels, and community roundtables are available at **ourcare.ca**.

To support the learning and deliberation elements of the priorities panels and community roundtables, OurCare partnered with more than 75 experts and health care leaders to engage with participants in dialogue and knowledge-building. (To read bios of all guests and view presentations and videos, visit ourcare.ca.)

To support its work, OurCare convened five provincial advisory groups and two national advisory groups comprising primary care clinicians, researchers, health care administrators and representatives from colleges, universities, health professional associations, community organizations, patient groups, government agencies, health care organizations, provincial and regional health authorities, and Ministries of Health. More than 140 advisors volunteered their time and expertise to guide the OurCare initiative through its various processes and engagements, and we are grateful for their support. (See Advisory Groups on p. 62.)

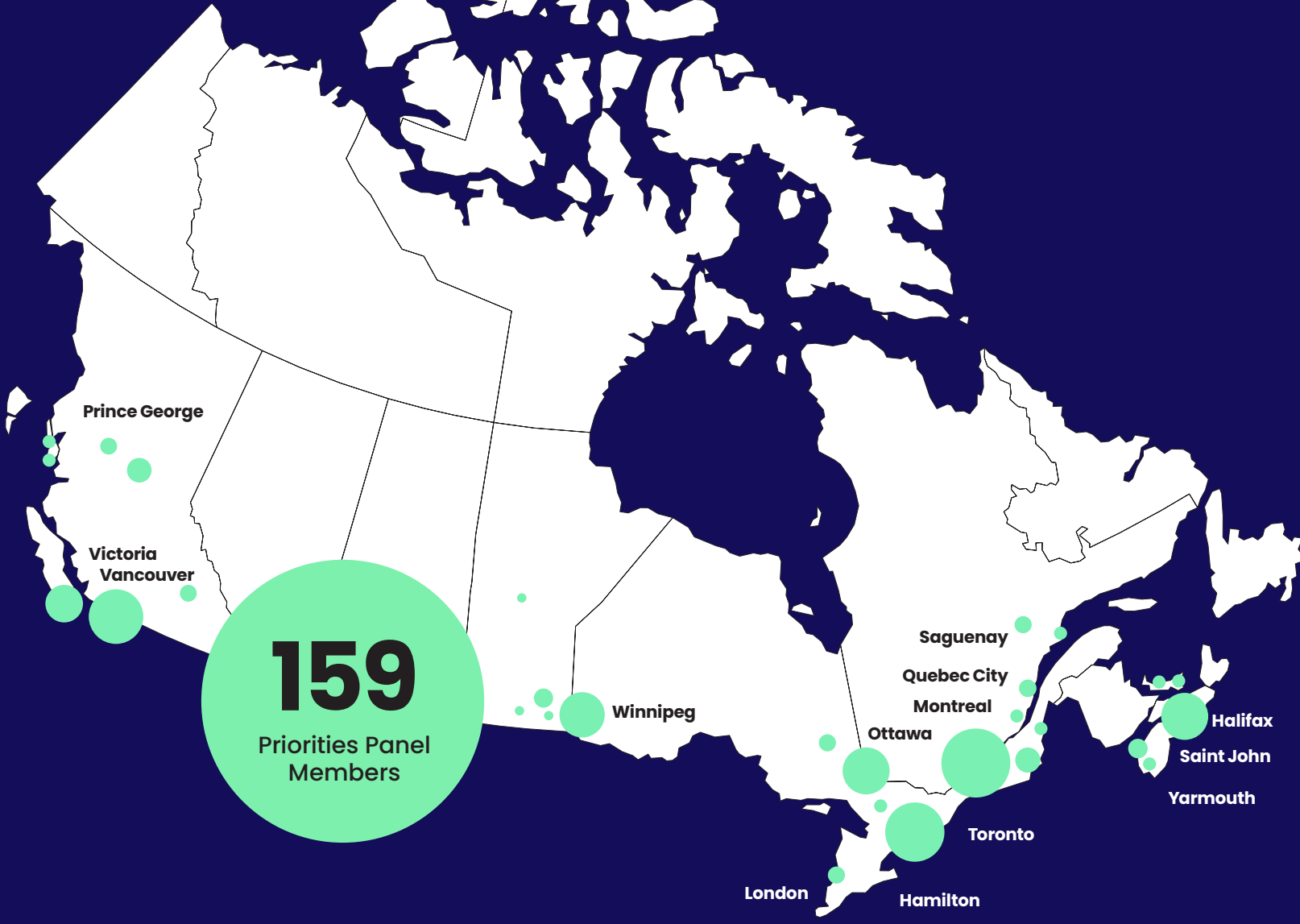
And while the OurCare process had its limitations, notably being unable to engage people living in the Territories or Indigenous communities on reserve, we strived at every stage to consider diversity and equity in each phase of the initiative.

140+

advisors volunteered their time and expertise to guide the OurCare initiative

75+

experts and health care leaders engaged with participants in panels and roundtables



16%
lived in Canada less than 10 years

41%
had difficulty paying monthly bills

8%
self-identified as First Nations, Métis, or Inuits

32%
self-identified as racialized

Age

11%	18 - 29 years
28%	30 - 44 years
35%	45 - 64 years
26%	65+ years

Gender

46%	Men
4%	Non-binary
50%	Women

192
Community Roundtable participants

OurCare Roundtables: Communities + Partners

Province	Communities	Languages	Partners
British Columbia	People Living with Disabilities	English	Disability Without Poverty
	Refugees, Migrant Workers, and other Newcomers	English, Tigrinya, Dari, Arabic, Spanish	Umbrella Multicultural Health Co-op
Manitoba	Indigenous Youth	English	Michael Redhead Champagne
	Refugees, Migrant Workers, and other Newcomers	English, Arabic, Ukrainian	Elmwood Community Resource Centre
Ontario	First Nation, Inuit, Métis, and Relatives living in Urban and Related Homelands	English	Indigenous Primary Health Care Council Well Living House
	African, Caribbean, and Black Ontarians	English, French	Black Physicians' Association of Ontario TAIBU Community Health Centre Durham Community Health Centre
Quebec	LGBTQIA+ Migrants	English, French, Arabic, Spanish	Clinique Mauve
	Low-income Residents, Newcomers, and Refugee Claimants	English, French	Afrique au Féminin
Nova Scotia	Refugee Claimants	English, Spanish, Haitian-Creole	Halifax Refugee Clinic
	African Nova Scotians	English	United Way Halifax

Why policy-makers should listen

People from across Canada have come together to speak with one voice about their hopes for a stronger, more equitable primary care system. It is incumbent upon all of us to listen to what they have to say.

Canada's vaunted public health care system can be truly world class only if it is designed by the people it is meant to serve: patients and the public. Too often, these voices are left out of conversations about reform. Too often, interest groups in health care become entrenched in their silos. Too often, policy-makers are unable to find the pulse of the public on issues that affect their health and well-being.

But there is a way forward. The perspectives of hundreds of people in priorities panels and community roundtables, and the data collected from thousands more through the OurCare national survey, show that there is consensus among diversity.

People from all across Canada are calling for change. Collectively, they spent roughly 10,000 hours sharing their experiences, learning from others, and articulating what they think primary care should look like. Despite the differences in their backgrounds, experiences and more, they agreed on key values and features of primary care that can be the foundation of reform. Their recommendations can help build a framework for a better system. Their vision, articulated so clearly in this report, can be a benchmark by which the health care system can judge its success in serving the public.

10,000

hours sharing experiences, learning from others, and deliberating on solutions

Findings at a Glance

The findings from the three phases of **OurCare** are summarized in 16 reports available at ourcare.ca. Here is a snapshot of what we heard.

National Survey

The national survey highlighted that more than one in five people in Canada do not have access to primary care and those who do still struggle to receive care in a timely way that meets their needs.

We learned there was large variation in access by region. We heard what people value most and that they are open to different ways of organizing care to ensure every person in Canada has access. Survey results, including how people with different backgrounds responded differently, are available at data.ourcare.ca.

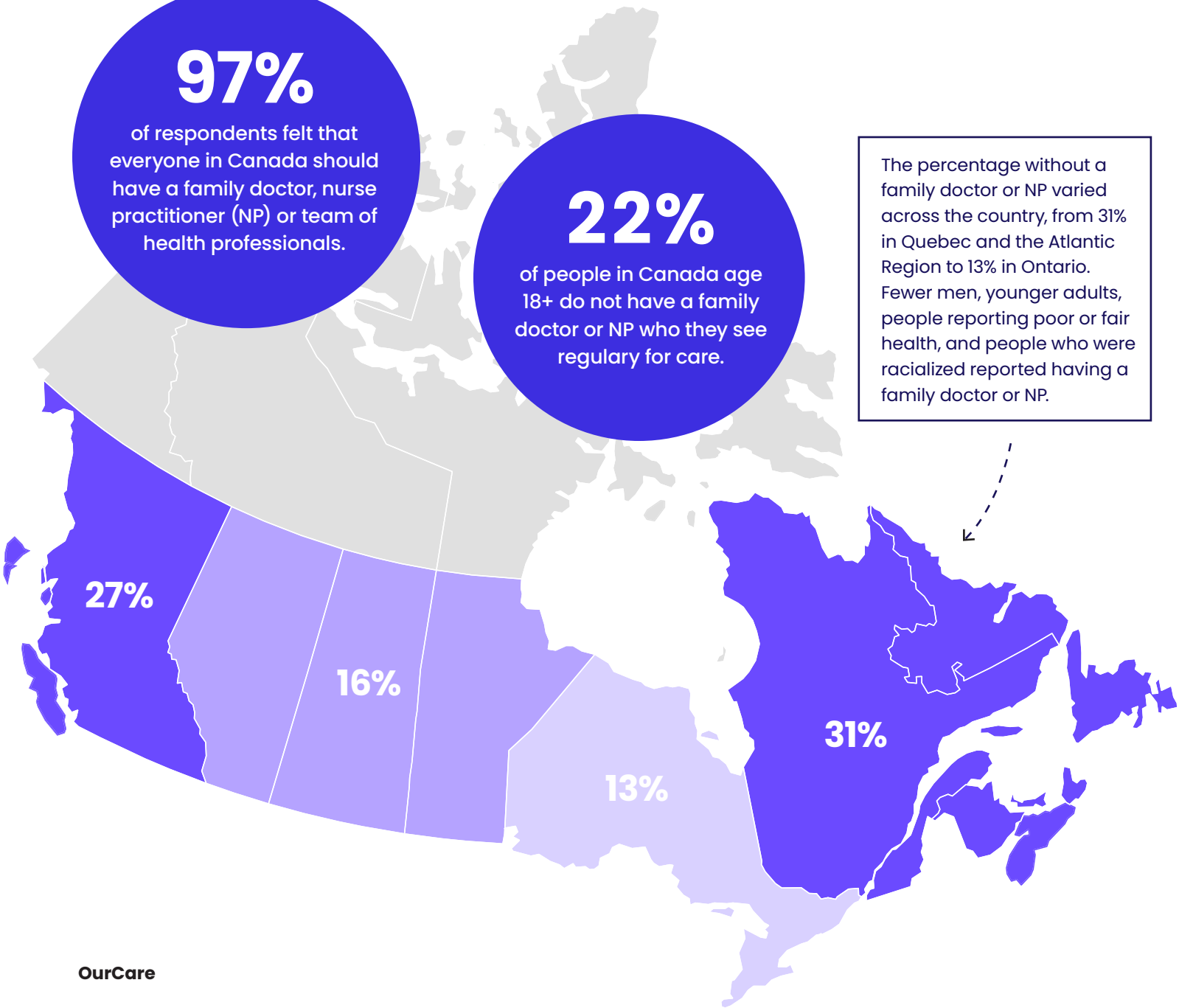
97%

of respondents felt that everyone in Canada should have a family doctor, nurse practitioner (NP) or team of health professionals.

22%

of people in Canada age 18+ do not have a family doctor or NP who they see regulary for care.

The percentage without a family doctor or NP varied across the country, from 31% in Quebec and the Atlantic Region to 13% in Ontario. Fewer men, younger adults, people reporting poor or fair health, and people who were racialized reported having a family doctor or NP.



Among those with a family doctor or NP:

35%

could book a same-day or next-day appointment with their primary care clinician for an urgent issue, but this varied across the country, from 23% in British Columbia and Atlantic Canada to 39% in Ontario.

25%

said they could always get care from another family doctor or NP in the practice when their own clinician was away.

36%

said their clinician's office offered care on weekends or outside 9am to 5pm on weekdays.

When people without a primary care clinician had a health problem that worried them but was not urgent, the top three places they reported getting care were an in-person walk-in clinic (50%), a virtual walk-in clinic (27%) or an emergency department (24%).

90%

of respondents said they would be comfortable getting support from another team member if their family doctor or NP recommended it, but among those with a primary care clinician, only

36%, 13%, 12% and **9%**

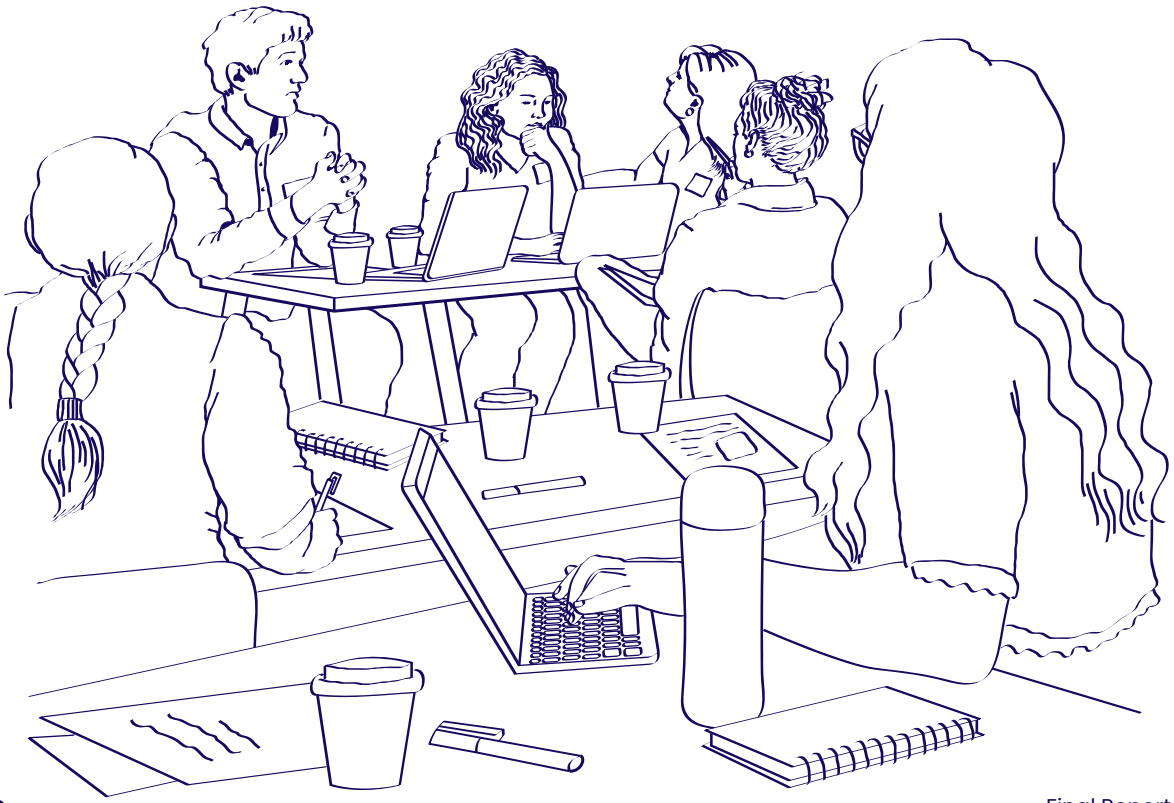
reported the practice had a nurse, dietitian, pharmacist or social worker, respectively.

The attributes of primary care most commonly reported as important were:
That my primary care clinician and the practice they work in:

- know me as a person and consider all the factors that affect my health (92%)
- make it easy for me to get care during the day (91%)
- are able to provide most of my care (88%)
- coordinate the care I get from multiple places (88%)
- stand up for me (87%)

When asked how they would like to receive care

- scheduled in-person appointments (92%)
- phone appointments (66%)
- and drop-in in-person appointments (54%)



People were open to new ways of working:

73%

agreed that teams of family doctors and NPs in Canada should have to **accept as a patient any person who lives in the neighbourhood near their office**.

91%

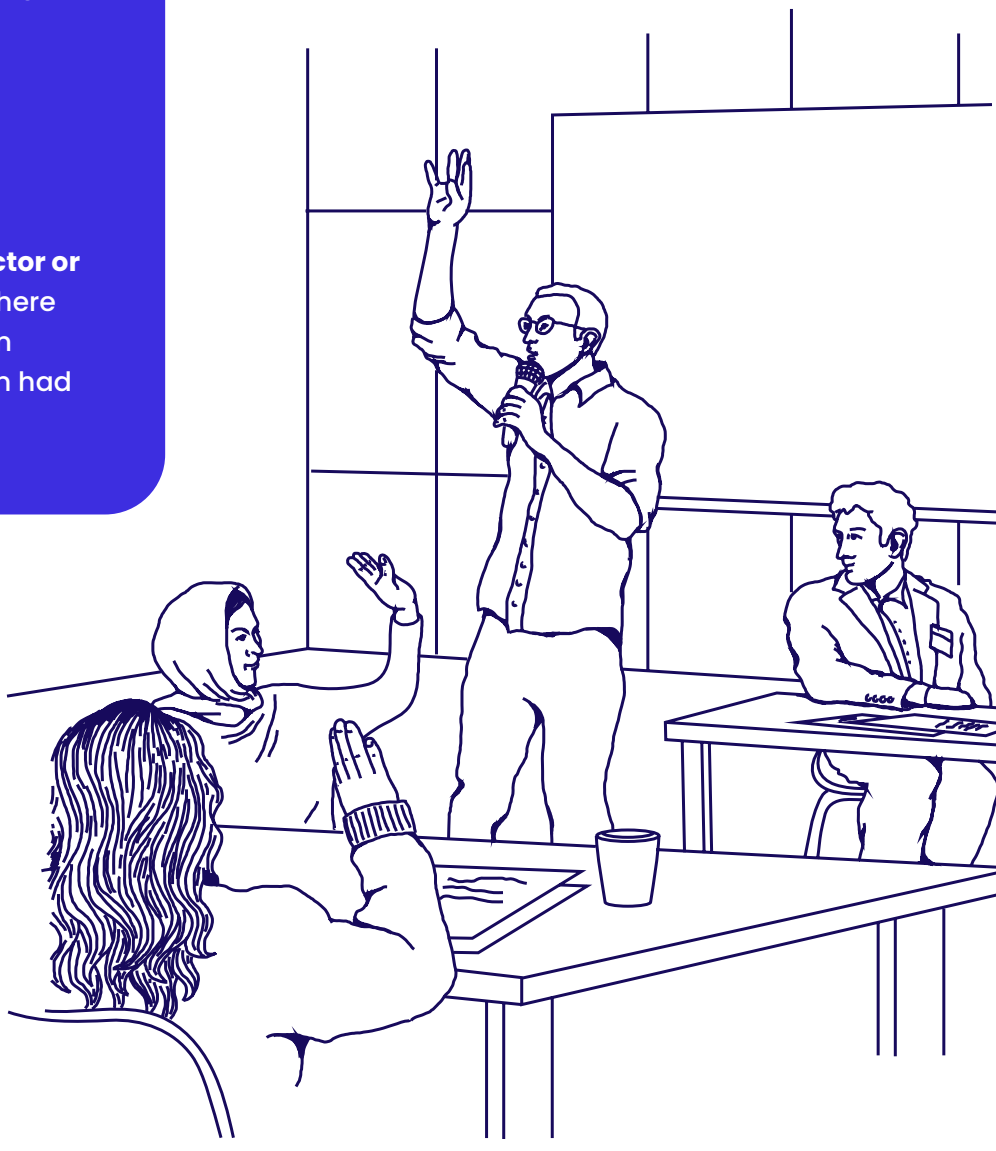
were somewhat or very willing to see the same NP consistently for most things except when the NP feels a doctor is needed.

76%

were willing to see any family doctor or NP in the practice in a scenario where they may not see the same person consistently but where that person had access to their records.

94%

of survey respondents said it was important to have one personal health record that all health professionals working in the province could see and use when providing care to that individual.



Provincial Priorities Panels

Each of the five provincial priorities panels brought together diverse members of the public. Despite this diversity, there was strong agreement within each provincial discussion and across all five provincial discussions.

Members of the public agreed that they wanted a primary care system that was accessible, holistic and wellness-oriented, accountable, equitable, empathic, patient-centred, sustainable, and universal. They also agreed on recommendations for a better system.

Full reports from each provincial priorities panel are available at **ourcare.ca**.

Scale team-based primary care for all

Expand team-based care to improve capacity in the system, reduce provider burnout and provide more holistic care. Start in areas of greatest need and scale existing community-governed models, such as Community Health Centres (CHCs) and ACCESS Centres, where different types of health professionals like nurses, social workers, and pharmacists work alongside doctors.

Move to a single patient-held health record

Ensure patients have easy access to their own health records. These should be available online in a manner that is private and secure and allows patients to share records with their clinicians and caregivers. Electronic health records should be interoperable to foster connectivity, portability and accessibility.

Act upstream

Primary care should address the social determinants of health and have stronger links with community agencies. Public coverage should be expanded to include mental health, vision, dental care, eye care, physical therapy, and medications.

Leverage virtual and mobile care

Virtual care should be integrated with in-person care and, in particular, used to enhance access in rural and remote communities. Government should ensure access to affordable, reliable internet and public infrastructure that enables people to access virtual care. Mobile care should be used to expand access to underserved communities.

Ensure diversity and inclusion in care delivery

Require training in cultural safety and humility and anti-discrimination. Facilitate barrier-free pathways to primary care professional education, especially among equity-deserving and Indigenous communities. Integrate Indigenous models of care.

Accelerate health professional recruitment and retention

Further the process for integrating internationally trained primary care professionals. Reduce the administrative burden faced by clinicians and improve their working conditions.

Strengthen patient empowerment

Strengthen community involvement in primary care policy, delivery, and measurement. Educate members of the public on their rights and the value of primary care and how to navigate the system. Measure and report on system performance.


OurCare
Ontario Primary Care
Priorities Panel

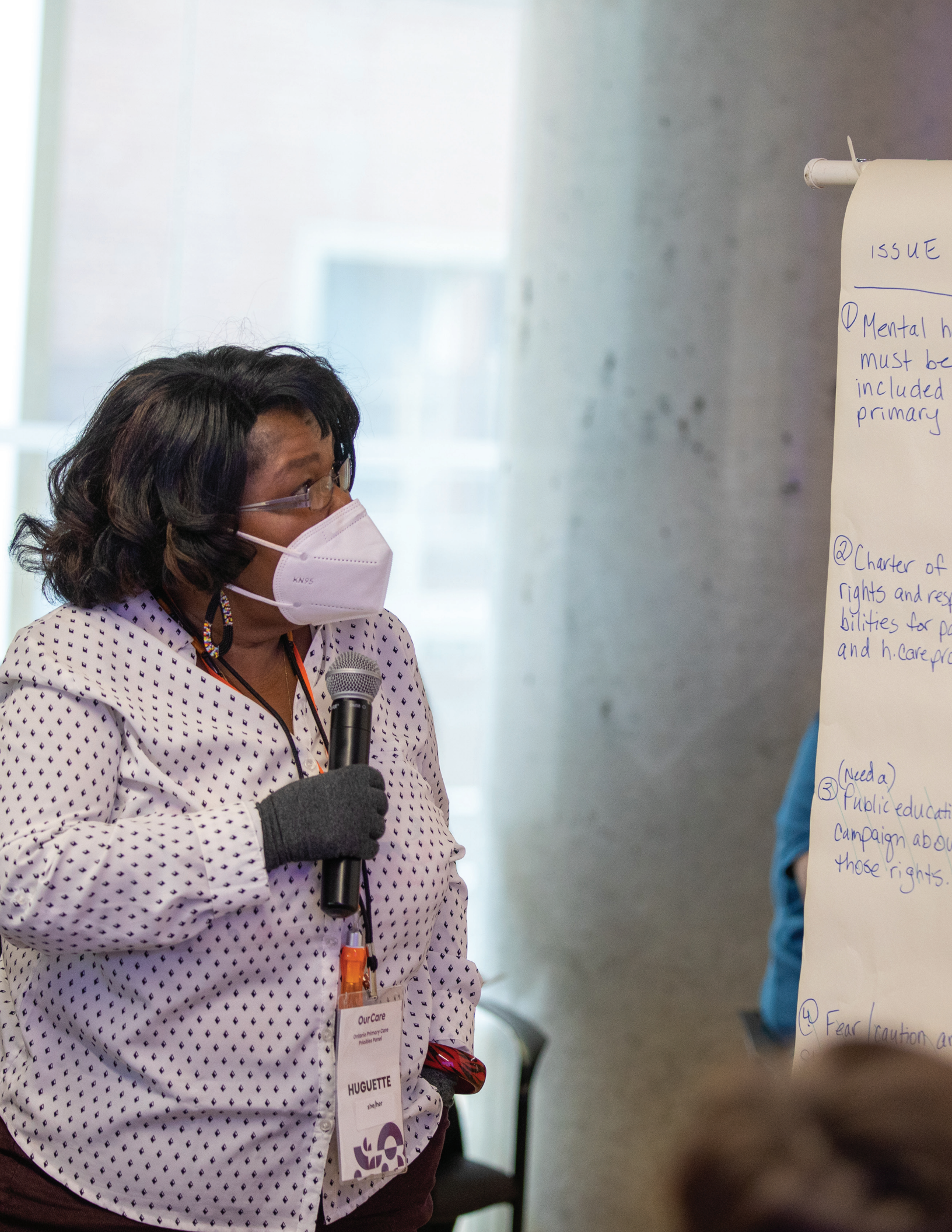
Community Roundtables

OurCare worked with local community partners to host 10 community roundtables (two in each province) with a total of 192 particpants.

Participants at the roundtables shared many experiences in common with those of the priorities panel members, including frustration with long wait times to get care, challenges navigating the system, and frustration at being unable to access their own health records. It was also clear that racism, ableism, xenophobia, transphobia and other forms of discrimination are common experiences that erode trust and prevent people from seeking care. For many, not having care in their spoken language was a significant barrier. Empowering individuals and communities was seen as central to improving the system. For example, First Nation, Inuit, and Métis participants reminded us that Indigenous models of care are culturally determined and have always worked. Full reports from the community roundtables are available at **ourcare.ca**.

Roundtable participants agreed with many of the recommendations put forward by the priorities panels, including:

- Expanding team-based care, particularly Community Health Centres and Indigenous Primary Health Care Organizations;
- Empowering patients to play an active role in their care and ensure they have access to their own health record;
- Addressing the social determinants of health, expand public coverage and remove financial barriers to care including access barriers related to the Interim Federal Health Program;
- Taking a holistic, wellness-oriented approach to care that considers spirituality, mental health, and sexuality, as well as physical health;
- Educating patients, including newcomers, on their rights and how to navigate the health care system; and
- Reducing barriers for foreign-trained health professionals to work in Canada and reducing barriers to pursuing medical education in Canada for people from equity-deserving communities.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① Mental h
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Public educati
campaign abou
those rights.
④ Fear / caution a
KN95
OurCare
Ontario Primary Care
Priorities Panel
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Community roundtable participants also highlighted many ideas for change in their discussions, including:

Addressing experiences of racism and discrimination in the health care system by mandating cultural safety and anti-oppression training in all care settings and ensuring the availability of standardized public recourse mechanisms for patients who experience racism and maltreatment;

Expanding the health workforce to reflect the diversity of the populations served and respect Indigenous self-determination. In addition to redressing instances of discrimination and historical injustice, representation in the health workforce can build trust with equity-deserving communities and ensure culturally safe, high-quality care;

Adopting an intersectional, gender-affirming, and anti-oppressive lens in the design of health care spaces to ensure that they are safe and accessible for all individuals, including those with disabilities and those who do not speak the dominant language;

Funding client-led, community-based care including care models that are responsive to and meet the unique needs and assets of First Nation, Inuit, and Métis peoples across urban, rural and remote geographies; and

Advancing Indigenous models of health and well-being that apply Indigenous approaches and practices such as relationship-centred care that empowers clients to take leadership in their own health and well-being.


OurCare
Howe Scottie Priorities
Panel on Primary Care

Introducing the OurCare Standard

In the national survey, priorities panels, and community roundtables, **OurCare** heard from people all across the country about what they expect a high-quality primary care system should look like.

We have distilled their work into a set of six elements which together represent their aspirations for a more sustainable, accessible, and equitable system of primary care. We call it the OurCare Standard.

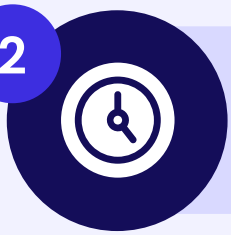
The **OurCare Standard** is a novel approach to understanding and assessing the adequacy of primary care in Canada. It is based on the analysis of hundreds of recommendations and thousands of data points, and has been reviewed by OurCare advisors and participants alike.

The OurCare Standard

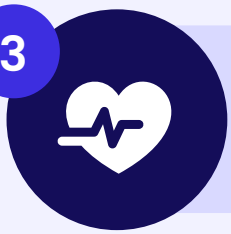
The **OurCare Standard** represents what every person living in Canada should be able to expect of the primary care they receive. And it provides a framework for comparing different models of primary care and levelling up those models to realize better primary care for everyone living in Canada.

1. 

Everyone has a relationship with a primary care clinician who works with other health professionals in a publicly funded team.

2. 

Everyone receives ongoing care from their primary care team and can access them in a timely way.

3. 

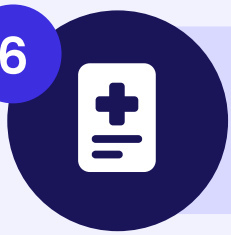
Everyone's primary care team is connected to community and social services that together support their physical, mental and social well-being.

4. 

Everyone can access their health record online and share it with their clinicians.

5. 

Everyone receives culturally safe care that meets their needs from clinicians that represent the diversity of the communities they serve.

6. 

Everyone receives care from a primary care system that is accountable to the communities it serves.

Understanding the OurCare Standard

1

The first element of the Standard affirms that everyone living in Canada has an ongoing relationship with a primary care clinician — whether a family doctor or nurse practitioner — and that this clinician should actively work with other health professionals in a team-based setting or network. It also affirms a key Canadian value: that health care should remain publicly funded and free at the point of access to all.

2

The second element of the Standard reminds us that high-quality primary care is relationship-centred and ongoing. While care may not always be with the individual's regular clinician, it should occur with another member of the clinician's team who has access to the patient's health records in order to ensure good continuity of care. This standard also asserts that everyone living in Canada should be able to access a member of their primary care team in a timely way, which includes availability in the evenings and weekends and options for both virtual and in-person care.

3

The third element of the Standard reflects the importance of all primary care teams developing active links to community and social services, and working in partnership with them to promote good health, prevent disease, and foster the well-being of the individual. People in Canada want a primary care system that is focused on wellness and not on sickness, which means care that is holistic, preventive, and addresses the social determinants of health.

4

The fourth element of the Standard asserts that everyone living in Canada should own and control access to their health record. This record should integrate each patient's history of health care consultations as well as all health data related to the patient, regardless of the health service provider. It should be available to patients as an integrated electronic record. The idea of an integrated, personal health record is a long-standing goal of many governments and health service providers in Canada. People in Canada remain emphatic that this goal should be achieved.

5

The fifth element of the Standard asserts that everyone is entitled to culturally safe care. This means that people feel respected and safe when they interact with the health care system and are supported to draw strength from their identity, culture, and community[7]. It means care that is free from racism and discrimination and accessible to people regardless of language or disability. Primary care should offer a full range of services that meet people's needs, including gender-affirming care, care for mental health and addictions, and Indigenous models of care. Culturally safe care requires more clinicians and care providers from traditionally underrepresented groups. Representation in the health workforce can help redress instances of discrimination and historical injustice, build trust with equity-deserving communities and ensure culturally safe, high-quality care.

6

The sixth element of the Standard asserts the importance of community accountability. This means that primary care systems across Canada should regularly and publicly report on their performance using standardized and comparable measures. It also means that primary care systems, including government and local teams, need to foster accountability by inviting community members to play a real role in their governance. One element of accountability is ensuring that primary care is funded at a level appropriate to community needs.

[7] "Cultural Safety: Supporting Increased cultural competency and safety throughout Northern Health," Indigenous Health BC, accessed 30 January 2024. https://www.indigenoushealthnh.ca/cultural-safety#cultural-safety

Achieving the OurCare Standard

The OurCare Standard is an aspirational standard, but an attainable one. Work is underway across the country to strengthen primary care systems. The OurCare Standard is intended to offer a common vision we can return to and track our collective progress. It represents what every person living in Canada should be able to expect of the primary care they receive, and recognizes that the steps needed to achieve this will look different in different places.

OurCare priorities panels articulated a series of recommendations specific to their provinces that may inform provincial action. At the same time, similar recommendations across provinces reflect that across the country, we face common challenges, and similar actions are needed to achieve the standard nationally. The actions which follow are not exhaustive, but reflect necessary steps to overcome shared challenges and realize peoples' aspirations for better primary care.

1 Everyone has a relationship with a primary care clinician who works with other health professionals in a publicly funded team.

This standard requires a commitment to guarantee access to primary care to all people in Canada and commensurate levels of funding from federal and provincial governments. It is notable that many countries have mechanisms to facilitate or automate connection to primary care and that the proportion of health spending on primary care is much lower in Canada (5.3%) compared to the OECD average (8.1%)[8].

This standard also requires coordinated efforts to ensure there are enough primary care clinicians to meet peoples' needs and that they can work together as a team to serve more people than one clinician could serve alone. These actions require collaboration between the federal government, provinces, and training institutions. **Actions include:**

- Scaling up training capacity to optimize interprofessional collaboration and increase the number of health professionals graduating with interest and competency in primary care.
- Reducing barriers to licensing and practice for internationally trained primary care clinicians

This standard also requires everyone planning primary care services to focus attention on the needs of people who are underserved. **Actions include:**

- Scaling up community-governed, interprofessional primary care teams that prioritize equity-deserving communities with low primary care attachment
- Achieving standards for clinic accessibility for people with disabilities
- Ensuring consistent funding and use of language interpretation services
- Focused federal-provincial collaboration to remove barriers that prevent newcomers and refugees from immediately accessing primary care services and health insurance

This standard also requires continued federal and provincial attention to public funding of services, including rigorous monitoring and enforcement of the Canada Health Act to ensure that people are not charged for medically necessary primary care services.

[8] OECD 2018. "Spending on Primary Care: First Estimates," December 2018, https://www.oecd.org/health/health-systems/Spending-on-Primary-Care-Policy-Brief-December-2018.pdf

2 Everyone receives ongoing care from their primary care team and can access them in a timely way.

In addition to the actions described above to expand access, this standard requires innovation in how care is accessed, to ensure care is timely, ongoing and delivered by someone who knows you and has access to your health record. **Actions include:**

- Investing in virtual care options integrated with in-person care, including related infrastructure to enhance access to primary care in rural and remote communities
- Facilitating collaboration between practices to provide shared after-hours care in a region
- Aligning incentives and supports to expand primary care teams that support ongoing, timely care and disincentivizing standalone urgent care options

3 Everyone's primary care team is connected to community and social services that together support their physical, mental and social well-being.

This standard requires developing and supporting links between health care, community, and social services, with attention to social determinants of health throughout primary care planning and delivery. **Actions include:**

- Restructuring funding and governance to integrate primary care clinics with local community and social services to address the social determinants of health
- Developing practice-level relationships with local community and social services organizations with a view to better addressing social determinants of health.

4 Everyone can access their health record online and share it with their clinicians.

This standard requires interoperability and integration of medical information alongside support for patient access. **Actions include:**

- Legislating requirements for electronic health record interoperability
- Ensuring that IT and electronic health record systems are interoperable and accessible to patients
- Supporting patient access to their own records at the practice level where possible

5 Everyone receives culturally safe care that meets their needs from clinicians that represent the diversity of the communities they serve.

This standard requires that primary care is equipped to deliver trauma-informed and culturally appropriate care in a manner that respects the fundamental dignity of the individual and their identity. No matter where people receive care, it must be free from racism and discrimination, and be accessible regardless of language or disability. **Actions include:**

- Enhancing curriculum, professional development offerings, and practice standards to ensure all primary care professionals are trained to provide trauma-informed, anti-discriminatory, culturally safe, and gender-affirming care, and a full range of services including mental health and addictions care.
- Involving community members in the governance of educational, training and credentialing institutions
- Increasing the diversity of trainees so that health care professionals in all fields better represent the populations served
- Increasing training opportunities for northern, remote, and rural residents and Indigenous communities

6 Everyone receives care from a primary care system that is accountable to the communities it serves.

This standard requires that people have the opportunity to participate in the governance of primary care systems. **Actions include:**

- Establishing systems for patient and public engagement and oversight at local, regional, and provincial/territorial levels
- Including ongoing community representation in primary care practice-level governance
- Enhancing curriculum, professional development offerings, and practice standards to ensure all primary care professionals have the knowledge and skills to work effectively in team-based models, and to engage patients and communities in practice governance
- Funding and implementing a health promotion campaign that provides the public with information to help them navigate the health care system and empowers them to stay healthy and manage common health concerns, with special attention to education for newcomers.

This standard also requires that everyone has access to transparent information about primary care system performance, and knows who they can contact when questions of accountability arise. **Actions include:**

- Establishing a Primary Care Charter of Rights and an ombudsperson who can receive patient complaints and provide independent oversight of the primary care system, including incidents of racism and discrimination
- Funding research that supports design, spread and evaluation of primary care reforms and innovations
- Establishing an Office of Primary Care Excellence at Health Canada to track primary care performance and invest in primary care transformation initiatives
- Adopting the OurCare Standard and reporting publicly on provincial and national compliance
- Continuing to fund the OurCare initiative in order to continue research and consultations with citizens to improve the primary care system in all provinces, territories and on First Nation reserves.

Conclusion

Over 16 months, **OurCare** unearthed common values, ideas, and solutions for primary care. From surveys and dialogue, from priorities panels and community roundtables, it was clear that despite differences in experience and background, there was so much that people in Canada agreed on.

The OurCare Standard is a distillation of all we heard. It should serve as a blueprint for policy-makers to guide needed transformation. It can serve as a benchmark for people in Canada by which they can judge how their care measures up.

Everyone in Canada should be able to access the primary care they need — the care they deserve — regardless of circumstance or ability.

People in Canada are clear about the primary care they want. Now it's up to us to make it happen.

OurCare People

OurCare is deeply grateful to the members of the public who took the time to share their experiences and ideas with us. We also want to recognize the important contributions of our national and provincial advisory group members, guest speakers, primary care leads, and community partners in shaping the work that led to this report. This final report is based on their contributions but has not been specifically endorsed by any of the individuals or organizations named below.

Provincial Priorities Panel Participants

A total of 159 volunteers randomly selected by civic lottery participated in OurCare's five provincial priorities panels. These individuals spent more than thirty hours together over several months learning about various facets and features of primary care, deliberating pros and cons, weighing priorities, and ultimately producing a public report including recommendations to policy-makers about how to make primary care more equitable and accessible for everyone. OurCare thanks them for their public service and commitment to improving primary care.

To read bios of all OurCare participants and guest speakers, visit **ourcare.ca**.

British Columbia

Rebecca Austin
Corrie Beltrame
Jane Bockman
Dana Boschman
Sabrina Brosnan
Debbie Chow
Elly Grabner
Micha Hogg
Benson Izunwanne
Ruby Jaggernath
Jasmine Javillo
Daman Kandola
Cole Keitamo
Jeanette Lim
Malika Lim
Jesse MacGregor
Donald Wesley March
Amy Mason
Ray McDonald
Mark Neath
Hendrik de Pagter
Jennifer Ramesch
Ken Raynor
Christine Sorensen
Bobbi Tatoosh
Joel Therrien
Hannah Wilson
Sandi Wilson
Eric Winter
Matthew Zhiss

Manitoba

Muhammad Aldhshan
Vibhuti Arya
Douglas Bartlett
Diane Beckett
Steven Black
Neelam Borrison
Harvey Brandt
Adriana Brydon
Mandy Buhler
Carolin Bund
Laurie Christianson
Jason Cook
Sandy Epp
Marti Ford
Karen Gabriel
Beth Glass
Andy Humphreys
Judi Janzen
Meenu Kapoor
Donna Kostiuk
Alain Louer
Laurel Martin
Paula Orecklin
Jean-Louis Pehe
Tomas Ponzilius
Greg Sametz
Alexander Watson
Chad Zolinski

Ontario

Mohammad Abu-Rshaid
George Babu
David Biagioni
Paul Cummings
Carolyn Curran
Roberta Della Picca
Renata Derege-Braga
Kevin Donaldson
Janne Donner
Tara Dwivedi
Kelsy Ervin
Rob Fleury
Cheryl Gabaret
Madelyn Gold
Matthew Gorman
Lee Herald
Mwenyemkuu Hussun
Jean-François Huguette
Kenneth Johnson
Edith Law
Peter Mazzucco
Joshua McCoy
Fiona McMurran
Eliscia McPhee
Shireen Noble
Tanya Ormerod
Peter Reid
Duane Stanley
G. Stegelmann
Miroslav Suta
Rebecca Szeto
Rajesh Talpade
Joseph Vincent
Alan Wolske
Amelia Zindros

Quebec

Chantal Bégin
Joëlle Bérubé
Kristian Clinton
Marie Michelle Dimanche
Donald Gilbert
Jorge Gonzalez
Sandra Gualtieri
Robin Guméry
Tara Hall
Gilbert Hoom
Lee Kalpin
Sara Kemp
Venise Landry
Martin Langevin
Philippe Latouche
José Mathieu
Darrow Maxis
Lucie Mayer
Laurent Millot
Peter Muir
Rosena Olivier
Julia Pagé-Daigneault
Pierrot Péladeau
Annia Pierre
Daniel Pinault
Evelyn Pitre
Valerie Pyke
Caroline Santos
Sébastien Sirois
Alexis-Paul St-Germain
Julie Yip

Nova Scotia

Abdul Anifowose
Selena Atwell
Jessica Bay
Cynthia Bazinet
Dominic Boyd
Mani Chakrabarty
Margaret-Ellen Disney
Darrell Gaudet
Carole Hill-Bojarski
Chika Iwuji
Vipan Kamboj
Deepti Limaye
Octavio Rafael López Villatoro
Foster Mackenzie
Reg Manzer
Bill McIntyre
Ben McVicker
Kirk Munroe
Jody Myers
Ernest Ng
Vel Oakes
Troy Pallo
Judy Porter
Aimee Redding
Darshana Saravanan
Sam Semark
Erica Smith
Marianne Smith
Keith Towse
Andrea Trask
Jordan Waterbury
Michael Westcott
Norman Wiegers
Heather Young

OurCare Primary Care Regional Leads

OurCare relied on a team of Primary Care Leads in each province to help guide programming, arrange guest speakers, and liaise with stakeholder groups, advisory groups, and media. Most critically, they provided insight and feedback on the series of reports of OurCare panels and roundtables. We thank them effusively for their tireless contributions to OurCare.

British Columbia

Dr. Goldis Mitra
Family Physician in North Vancouver; Executive, BC Family Doctors Clinical Assistant Professor, Department of Family Medicine, University of British Columbia

Manitoba

Dr. Mandy Buss
Indigenous Health Lead for Department of Family Medicine and Undergraduate Medical Education Course Director, Indigenous Health, Max Rady College of Medicine, University of Manitoba

Dr. Amanda Condon
Family Physician, Notre Dame de Lourdes; Associate Professor, Department of Family Medicine, Max Rady College of Medicine, University of Manitoba

Dr. Alan Katz
Family Physician and Health Services Researcher; Professor, Departments of Family Medicine and Community Health Sciences, Max Rady Faculty of Health Sciences, University of Manitoba

Quebec

Prof. Mylaine Breton
Associate Professor, Université de Sherbrooke, Longueuil Campus; Canada Research Chair in Clinical Governance of Primary Health Care

Dr. Neb Kovacina
Family Physician, St. Mary's Hospital, Montreal; Director, Quality Improvement, Department of Family Medicine, McGill University

Nova Scotia

Dr. Ruth Lavergne
Associate Professor, Department of Family Medicine, Dalhousie University; Tier II Canada Research Chair in Primary Care

Dr. Katherine Stringer
Family Physician, Spryfield Clinic, Dalhousie Family Medicine; Department Head, Department of Family Medicine, Dalhousie University

OurCare Guest Speakers

More than 75 guest speakers shared their expertise with members of the priorities panels and the community roundtables. We thank them for their generous gifts of time, insights, and commitment to engaging the public.

British Columbia

Estephanie Acebedo
Clinical Nurse Leader, Urgent and Primary Care Centre, Island Health, Victoria

Evan Tlesla Adams
Coast Salish Physician, Deputy Chief Medical Officer, First Nations Health Authority

Hayley Diakiw
Nurse Practitioner, Gorge Urgent and Primary Care Centre, Victoria

Davana Harlow
Registered Social Worker, Downtown Victoria Urgent and Primary Care Centre

Lindsay Hedden
Assistant Professor, Health Services Research, Simon Fraser University

Lindsay Mackay
Family Physician, Clinician-Scientist, Department of Family Medicine, UBC

Rita McCracken
Family Physician, Assistant Professor, Department of Family Practice, UBC

Gladys Mitchell
Business Owner, Sewing Entrepreneur

Tracy Monk
Family Physician, Faculty Lead, UBC Centre for Relationship Based Care

Birinder Narang
Clinical Assistant Professor, UBC, Medical Contributor, Global BC and CKNW 980

Christie Newton
Associate Head, Education and Engagement, UBC Department of Family Practice

Keir Peterson
Chief Medical Officer, TELUS Health

Thuy-Nga (Tia) Pham
Family Physician, Co-Medical Director, South Island Urgent and Primary Care Centres

André Picard
Health Reporter and Columnist, The Globe and Mail

Kathleen Ross
Family Physician, President, Canadian Medical Association

Alan Ruddiman
Rural Generalist Physician; Past President, Doctors of BC

Valerie St. John
Executive Director, BC Association of Community Health Centres (BCACHC)

Manitoba

Rafiq Andani
Associate Chief Medical Officer for Shared Health

Tara Clarke
Program Lead, Physician Extender Program, Ongomiizwin Health Services

Richard Cloutier
Journalist, 680 CJOB Winnipeg; Senior Reporter, Global News

Jeanette Edwards
Former Provincial Lead, System Integration and Quality Management; Former Interim Provincial Lead, Indigenous Health, Shared Health

Denis Fortier
Chief Medical Officer, Southern Health-Santé Sud; Retired Rural Family Physician

Eric Jacobsohn
Professor, Department of Anesthesiology, Pain and Perioperative Medicine, and Department of Internal Medicine, Max Rady College of Medicine, U of M; Associate Dean of Professionalism

Melanie MacKinnon
Head, Ongomiizwin – Indigenous Institute of Health and Healing, Faculty of Health Sciences, University of Manitoba

Trina Mathison
Site Chief Medical Officer, Dauphin Regional Health Centre; Medical Lead, CancerCare community program, Dauphin

Ainslie Mihalchuk
Assistant Registrar overseeing Quality, College of Physicians and Surgeons of Manitoba; Family Physician

Colleen Ottertail
Director Primary Care Clinic, Aboriginal Health & Wellness Centre of Winnipeg

Lanette Siragusa
Chief Executive Officer, Shared Health

Barb Wasilewski
Assistant Deputy Minister, Health Policy and Planning

Ian Whetter
Family Doctor; Medical Director, Ongomiizwin Health Services; Rady Faculty of Health Sciences, Co-lead of the Office of Community Engagement

Ontario

Ewan Affleck
Senior Medical Advisor - Health Informatics, College of Physicians & Surgeons of Alberta; Member of the Expert Advisory Group of the pan-Canadian Health Data Strategy

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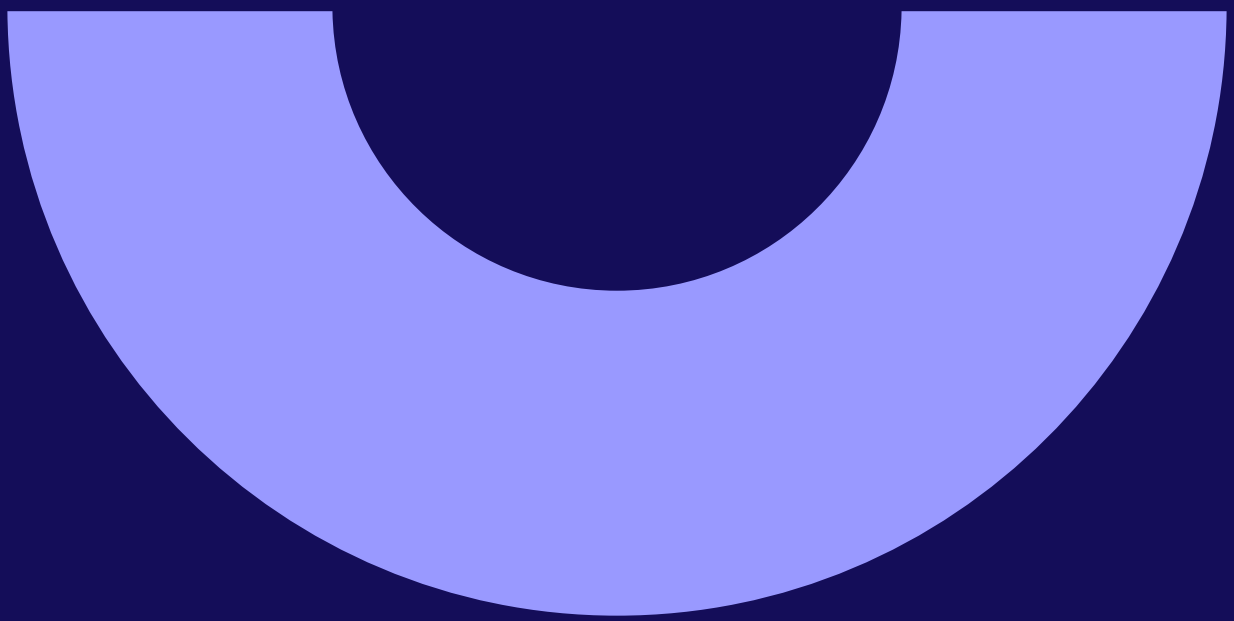

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MAP Centre for Urban Health Solutions
MAP Centre for Urban Solutions is a research centre dedicated to creating a healthier future for all. The centre has a focus on scientific excellence, rapid scale-up and long term community partnerships to improve health and lives in Canada. MAP is based at St. Michael's Hospital in Toronto.

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St. Michael's Hospital is a Catholic research and teaching hospital in downtown Toronto. The hospital is part of the Unity Health Toronto network of hospitals that includes Providence Healthcare and St. Joseph's Health Centre.

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MASS LBP is Canada's recognized leader in the design of deliberative processes that bridge the distance between citizens, stakeholders, and government. For more than a decade, MASS has been designing and executing innovative deliberative processes that help governments develop more effective policies by working together with their partners and communities.

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Staples Canada's Even the Odds Campaign
Staples and MAP have come together to create Even the Odds: an initiative to raise awareness of inequity in Canada and to help build vibrant, healthy communities. The partnership is based on the shared belief that everyone should have the opportunity to thrive. Even the Odds funds research and solutions to help make the future fair for everyone.
Learn more at staples.ca/eventheodds.
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