

OurCare | NosSoins

Quebec
Priorities
Panel on
Primary Care:
New perspectives and
possibilities for primary care
in Canada

*A report written by
members of the public*

November 2023

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A word from *Institut du Nouveau Monde*



Malorie Flon
General Director,
Institut du Nouveau Monde

This report is a testament to the work of 31 Quebecers who volunteered their time to participate on this panel addressing priorities for the future of primary care in Quebec. Collectively, they invested 930 hours in the process. The result? Six key priorities and 34 recommendations for the future.

This group of citizens had no specific expertise in primary care. Through the project, these individuals took the time to learn that high quality primary care*, is comprehensive, coordinated, continuous, and is the first point of contact to the health care system for patients. They also took time to study the issues and challenges facing the current system, and to hear a diversity of perspectives in order to formulate their own ideas for improving the health and well-being of the population. Through their deliberations, they demonstrated their ability to grasp complex issues and define public policy choices and priorities based on shared values.

I would like to express my gratitude to the people who have devoted their time and energy to this panel. Their contributions are a call to action for policymakers and other health and social care stakeholders, who we hope

will hear and seek to embody these priorities.

The work accomplished by the priorities panel also reminds us that our choices in health and social services are not based solely on technical and operational knowledge, but also on considerations rooted in a vision of human health and in collective principles and values.

I would also like to thank the members of the advisory committee who helped us build a program adapted to the Quebec context, as well as our guest speakers and funders: Tara Kiran, Neb Kovacina and Mylaine Breton, as well as the MASS LBP team for their trust and contribution during this process.



Malorie Flon, General Manager

* See the **glossary** at the end of the report for a description of some of the terms used.

What policymakers should know



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The world's best-performing health care systems rely on well-coordinated, accessible primary care. Yet primary care is in the midst of an unprecedented crisis. **More than two million Quebecers have no assigned family doctor or nurse practitioner.** When it comes to primary care access, we are among the worst-performing provinces in Canada, which is among the worst-performing developed countries.

The challenges faced by patients navigating the health care system and primary care are manifold. Primary care is often episodic, fragmented, and lacking in continuity. People find themselves without the tools to understand the system and with limited access to their health information, even if they have a regular family doctor.

Access to care is particularly difficult in the context of a human resources crisis. Recruitment and retention remain major challenges for the current system. What's more, family doctors are retiring earlier and earlier, or leaving the public system to work in the private sector in greater numbers than ever before.

To solve these fundamental problems, we need to think differently. With the OurCare project, we want to give a voice to members of the public who aren't usually present when decisions are made in order to **support improvements that are based on the values and expectations of the people the system is meant to serve.**

This report summarizes the expectations and recommendations of 31 members of the public who live in Quebec – people from all regions of the province, at different stages of life, from different social backgrounds. **They spent 30 hours together, learning from experts in the field and deliberating together to reach a consensus on how to improve primary care.**

Fundamentally, the public members believed every person living in Quebec should have access to high-quality primary care—a place that you turned to first when you have a problem and where care is coordinated among different parts of the system. They believed people in Quebec should expect care that takes into account and addresses the whole person and care that is grounded in a relationship over time.

How can that care become a reality? What do we need to consider when designing such a system? They outlined core values, key challenges and recommendations for what “better” looks like.

EQUITY

The members of the citizen panel reiterated the importance of **equity** in a universal, public health care system. They firmly believe that everyone in Quebec should receive the care they need, regardless of background, socio-economic status, place of residence, or mental or physical ability. There is no doubt that primary care plays an essential role in reducing social inequalities in health.

The challenges identified are the excessive rigidity and centralization of our system, which affects innovation and the flexibility needed to adapt to the populations we serve. Members were also concerned about the growing presence of private health services, which compete for resources with the public system and can worsen access for vulnerable members of the population. Finally, members of the

public identified the need to study systemic factors that affect health and may create health-related inequalities (i.e., social determinants of health).

Recommendations:

Protect the public system and **extend public coverage** to treatments of all medical conditions.

Prohibit advertising campaigns that favour the private sector over the public sector.

Develop **public education and communication tools** including information on how the system works, services offered, and the rights of users.

EMPOWERMENT AND RESPECT

Members of the citizen panel support the values of **empowerment and respect**. Members of the public remind us of the undeniable contribution patients make to their own care, and the panel wants them to be better equipped to play a central role in such care. They recognize the ability of communities, patients, and their families to rally together and collaborate with clinicians.

Recommendations:

Provide patients **access to their medical information**, including personal medical records, to improve collaboration among health care teams.

Offer **health education campaigns** for communities who face difficulties in service accessibility.

Encourage **public involvement in decision-making** regarding primary care.

ACCESSIBILITY

We also stress the importance of **accessible care**. Access to primary care within an appropriate time frame according to the urgency of the clinical situation is an essential component of high-performing health care systems. Challenges to providing timely access identified by citizen panel members include the difficulty of attracting and retaining human resources and the lack of team-based models.

Recommendations:

Reduce time spent by clinicians on low-value administrative tasks to **free up time for clinical tasks**, continuing education, and quality improvement.

Offer greater autonomy to health care professionals other than physicians in order to facilitate access to care and services.

Facilitate the **integration of foreign-trained professionals**.

PREVENTION AND A HOLISTIC APPROACH

Members of the panel also value a **preventative and holistic approach** to primary care. Prevention and education are seen as fundamental to improving the health of the population. Physicians are not the only practitioners capable of meeting patient health care needs. Primary care must include all health professionals.

Recommendations:

Include **prevention-based teaching and health promotion** in medical training curricula.

Increase **funding for primary care research** and knowledge sharing with the public.

Consider **holistic health** as an approach better adapted to the population.

EFFECTIVENESS

Finally, members emphasized that an important value of the system is **effectiveness, based on continuity of care and collaboration with patients**, and not just on the timeliness or volume of activities. Citizens would like to see greater accountability for quality care within the system and among professionals. Panel members have identified challenges to effective and accountable care, such as a lack of innovative models to ensure continuity of care, the hospital-centric model of the current system, and centralized governance that does not measure quality of care optimally.

Recommendations:

Promote team-based collaboration to ensure continuity of timely, high-quality care.

In collaboration with the public, **define and track population health indicators** to better identify system performance.

Ensure **accountability of health care professionals** to service users.

On May 26, 2023, the members of the OurCare Quebec panel presented their recommendations for a better system to provincial primary care stakeholders. Their values and recommendations resonated with the audience.

The work done by the citizen panel was a good demonstration of the **public's desire to participate in decisions regarding the future of primary care**. By having access to information, expert opinions, and an environment conducive to reflection, members were able to agree on a common vision for a better system. We thank them again for their generosity.

It is now up to us, decision-makers and health professionals, to publish and act upon the values and expectations of the population we serve!



Prof. Mylaine Breton
Co-leader of OurCare Quebec



Dr. Neb Kovacina
Co-leader of OurCare Quebec



Dr. Tara Kiran
OurCare Principal Investigator





Quebec Priorities Panel At-a-Glance

The OurCare Quebec Priorities Panel brought together 31 residents, randomly selected to roughly reflect the demographics of the province, with an emphasis on underserved communities. They spent about 30 hours listening to experts and deliberating together to come up with recommendations on what a better primary care system should look like. OurCare is also organizing priorities panels in Ontario, British Columbia, Nova Scotia and Manitoba. The reports are written by members of the public. For more information, visit OurCare.ca/PrioritiesPanels.

Quebec Priorities Panel At-a-Glance

31 members
15 speakers
30 program hours
31 recommendations

Members' Values

- Equity •
- Accessibility •
- Effectiveness •
- Preventive and holistic approach •
- Empowerment •
- Respect •

Recommendation Highlights:

Recognize systemic issues affecting health

- Prioritize and respect the right to independence of people, particularly those with visible and invisible disabilities, by providing them with assistance, such as better home care;
- Develop tools to explain how the system works, the services available and users' rights;
- Provide ongoing training for healthcare workers to prevent discrimination.

Attract and retain primary care professionals

- Create optimal and inclusive workplaces for new generations of employees;
- Provide administrative support to practitioners to enable them to devote more time to practice, continuing education and the quality of their work;
- Improve recognition of diplomas acquired outside Quebec and develop initiatives aimed at integrating foreign workers.

Flexibility and innovation

- Promote a more holistic approach to health, in particular by improving the training of doctors in prevention and health promotion;
- Ensure that patients have access to their personal medical records, in order to improve collaboration with their healthcare team;
- Give greater autonomy and latitude to healthcare professionals other than doctors.

The problems we want solved

Little recognition of the systemic issues affecting the health of the population •
Difficulty attracting and retaining health care professionals •
Lack of flexibility and innovation •
Lack of interdisciplinary models •
Health system governance is too centralised •
Growing presence of the private and for-profit sector is undermining the robustness of the public sector •

Recommendation Highlights (cont'd):

Team-based care

- Ensure that primary care providers foster an institutional culture that takes account of the social determinants of health and ensure good continuity of care;
- Promote and encourage better interdisciplinary collaboration between healthcare providers and community services.

Decentralize governance

- Ensure that health and social service organizations include a sufficient number of places reserved for the public on their boards of directors;
- Create a people's committee with a mandate to monitor and make recommendations on legislative and government activities relating to health care and the production of information on the health of the population;
- Define population health indicators, in collaboration with citizens and beneficiaries, in order to gain a better understanding of the performance of health system programmes and services.

Protect and promote the public system

- Protect and extend the coverage to all medical treatments in order to improve accessibility and equity of services;
- Define a better legal framework for overseeing private for-profit practice, so as not to undermine access to healthcare services covered by the public system;
- Limit the scope for development of the entrepreneurial model in health and social services.



Understanding the panel process

Objectives of the Priorities Panel on Primary Care

A Priorities Panel is made up of randomly selected citizens who volunteer to examine and discuss a complex social and political challenge. Such a panel is generally made up of between 36 and 48 people, and strives to prioritize fairness and wide representation by favouring an equitable and diversified demographic composition. Participants aim to represent all Quebec residents as faithfully as possible.

The mandate of the Quebec Priorities Panel on Primary Care was to examine various approaches that could strengthen the primary care system in Quebec. Discussions also focused on identifying measures that governments and health care providers should implement to ensure that all Quebecers have access to equitable, high-quality primary care. At the end of the deliberative process, panel members' objective is to reach consensus on a series of recommendations that can be forwarded to governments, professional associations, and society at large. The discussion sessions were guided by four key questions:

1. What do Quebecers expect from the primary care system?
2. What aspects of a high-quality primary care system should be prioritized according to these expectations?
3. How can we provide better care for equity-seeking patients and reduce disparities in access to care?
4. What is the role of for-profit primary care in Quebec?

Following five information and discussion sessions, panel members produced a report containing their recommendations. This report can be found in the [The Members' Report of the OurCare Quebec Priorities Panel on Primary Care](#) section of this document.

What is a Civic Lottery?

A civic lottery is a balanced way of selecting the members of a priorities panel. It is based on a form of sortition that uses a randomized selection process to recruit panelists from a pool of volunteers that have indicated their interest in serving on the panel. The result is a group of volunteers that broadly matches the demographics of the jurisdiction it represents.

Panel snapshot

31 members

In order to represent the needs of the Quebec population as accurately as possible while including the viewpoints of individuals who may be less often heard in public debate, the random selection of participants included a deliberate over-representation of equity-deserving groups¹, including: members of racialized communities, lower-income populations, and people who have been residents of Canada for less than ten years. 31 people made up the Quebec panel. The two tables below present a portrait of the members according to various characteristics.

Panel members by selected characteristics

Gender²:

17 - Women
14 - Men

Age:

3 - 18-29 years old
9 - 30-44 years old
10 - 45-64 years old
9 - 65+ years old

Members who identify as Indigenous: 1

Members who identify as part of a racialized group: 9

Members who have been in Canada less than 10 years: 6

Members with income trouble: 12

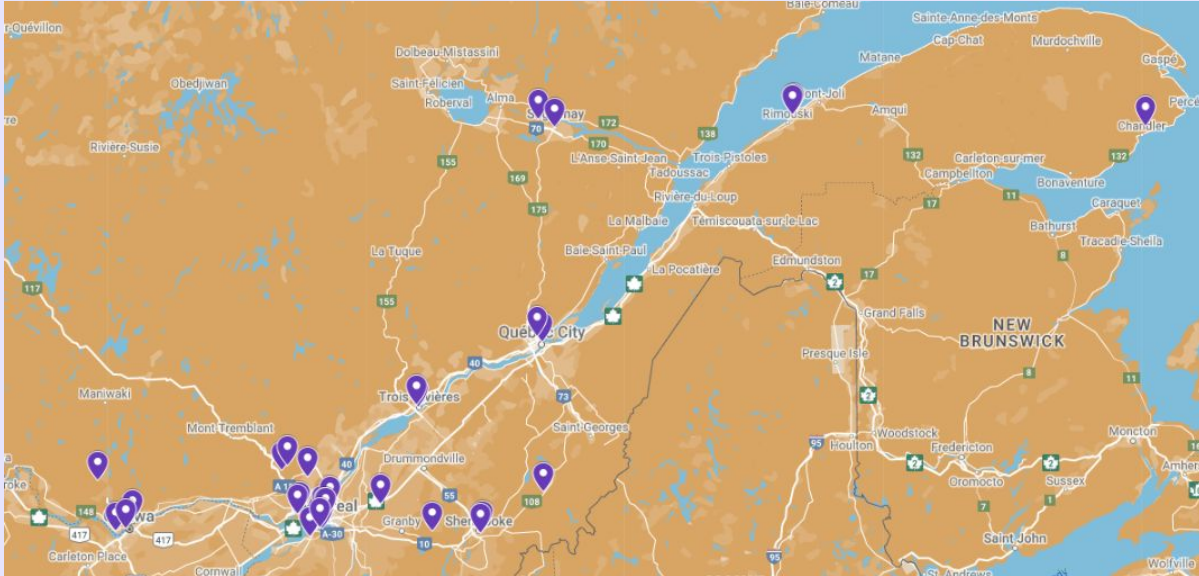
Members without primary care attachment³: 12

¹ Participants were asked, "Do you have trouble paying your bills at the end of the month?"

² "Women" refers to cisgender and transgender women. "Men" refers to cisgender and transgender men.

³ For attachment to primary care, participants were asked, "Do you currently have a family doctor or nurse practitioner that you see regularly?"

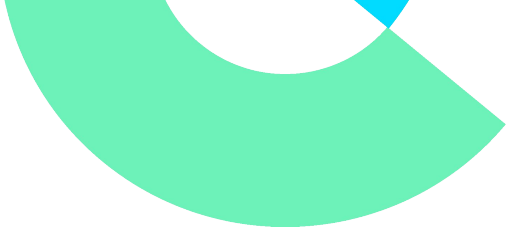
Geographical distribution of panel members



- 18 - Urban centres (Laval, Montréal, Montérégie, Capitale-Nationale)
- 9 - Centre-South (Estrie, Mauricie)
- 3 - St. Laurent (Bas-Saint-Laurent, Gaspésie-Îles-de-la-Madeleine)
- 1 - North (Laurentides, Outaouais, Saguenay-Lac-Saint-Jean)



The Members' Report of the OurCare **Quebec** Priorities Panel on Primary Care



At the end of the five sessions held by the Priorities Panel on Primary Care, members were invited to write a report outlining their most critical challenges, values, and recommendations. The following report presents the results of the Panel's five sessions.

Who we are and why we volunteered

We are citizen volunteers from different backgrounds, representing a diversity of beliefs, gender identities, sexual orientations, cultures, ethnicities, abilities, and ages. We strive to represent the entire population of Quebec, from all corners of the province, in both urban and rural areas. We are all living with a deteriorating health care system. This decline began several decades ago and has accelerated with each change of government.

Whether out of disagreement with the status quo, concern for improvement, protest, or conviction, we all want our voices to be heard and considered by our authorities. We are conscious of the privilege we have to express ourselves here, and we do so keeping in mind those who can not. While we do not speak on behalf of others, we have taken them into account throughout the process. Quebec's primary care system is in

crisis. It is crucial that our recommendations be acted upon urgently.

What we see and what we learned

Primary care is the cornerstone of the health and social services system. According to a recent national survey, 31% of adults in Quebec over the age of 18 do not have a dedicated health care professional.*

Quebec needs more effective primary care through team-based work. With a projected shortage of over 2,000 primary care physicians in the coming years, which will accentuate needs in other areas such as education and administration, we will be forced to reallocate resources and better support the role of doctors. Educational and training needs will require practicing physicians be assigned to teaching in addition to or in place of clinical practice, which, in turn, will have an impact on various medical professions and modify the services they are able to offer. The next five years will be particularly difficult if better optimization of health human resources is not implemented.

* OurCare. "Survey Data Explorer", 2022.
<https://data.ourcare.ca/all-questions>.

Educational and training needs will require practicing physicians be assigned to teaching in addition to or in place of clinical practice, which, in turn, will have an impact on various medical professions and modify the services they are able to offer. The next five years will be particularly difficult if better optimization of health human resources is not implemented.

During our sessions, we were made aware of social determinants of health and equity barriers existing within our own health care system. For example, residents of communities in Northern Quebec must be regularly transported and treated in the south of the province because the region lacks specialist health care services and appropriate clinics and resources. The financial costs and mortality rates associated with transporting residents across the province for examination and treatment have been increasing over time.

We were also briefed on different points of view concerning for-profit health care services. Currently, a lack of oversight in for-profit services is having a negative impact on reliability within the health care system. Barriers to accessing public front-line care are creating a shift towards paid health care services. Access to essential health care

should be free under our public health care plan.

We believe that solutions exist to optimize the use of our financial, administrative, and human resources within our health care system, notably through better use of home care. These solutions must be flexible responses adapted to the various realities and complex and diverse needs of the Quebec population. Optimizing resources will lead to better staff retention and enhance the impact of various health care professions by making better use of their different areas of expertise.

We met with health and social care professionals who are ready and willing to work together to create and implement innovative practices and models. Nonetheless, bureaucratic, legislative, and political constraints are holding back the adoption and implementation of such models across the health care system.

We understand that current and future practices and decisions must be based on studies that allow us to better understand, among other things, the impact of laws and policies on the health of the Quebec population.

The challenges we want solved

The challenges related to primary care that we have identified through our deliberation are:

1. **There is little recognition of the systemic issues affecting population health.** Our health care system does not seem to prioritize the overall well-being – in all its dimensions – of its users. Respect for the multi-faceted, integrated nature of care is essential, and requires recognition and consideration of systemic issues affecting users' health. A better understanding of systemic issues also entails valuing people's different socio-cultural realities.
2. **Difficulty attracting and retaining health care professionals.** Labour shortages in health care and social services are exacerbated by forced overtime, poor work environments, burnout and poor health among clinicians, and a lack of recognition. We see rigidity and a lack of collaboration within the system at many levels. What's more, recognition of foreign qualifications is complicated and takes too long, which does nothing to remedy the labour shortage.
3. **Lack of flexibility and innovation in the health care system.** The health care system is not efficient. The circulation and management of information is inadequate and technologically outdated, which negatively impacts the effectiveness of communication between decision-makers, health care professionals, and users of health care services. Those who administer the health system are not sufficiently informed about the on-the-ground realities of care provision, and measurements of the success of these services do not take user feedback into account. In particular, it's hard to understand why medical information isn't shared easily and quickly between Quebecers and the professionals who care for them. The system is cumbersome and resistant to change. This severely hampers creativity in the search for innovative solutions.
4. **There aren't enough interdisciplinary models to**

meet patients' expectations for speed and continuity of care. The hospital-centrism of the health care system does not take sufficient account of social determinants of health to ensure the delivery of quality care in Quebec. For example, home care is difficult to obtain, inconsistent, and not promoted as a viable option to expand equity and inclusion in health care. Nor is there a vision, action plan, or legislation for preventative health, which negatively influences the overall health of the population. Furthermore, the quality of care and time devoted to patient consultation are negatively affected by the system's current approach, in which family doctors are placed at the center of administrative action: performing certain diagnostic tests, approval of prescriptions by other specialists, or follow-up on insurance claims are tasks that end up in the hands of doctors when they could be assigned to others. This approach prevents other health professionals from providing care to individuals.

5. **Governance of health care institutions is too centralized.**

The current organization of public health care is overly centralized and opaque, creating a complex system that is difficult to understand, bureaucratic, protocol-driven, and prejudicial. It leaves little room for accountability, since decisions are made at too great a distance from users. A strong health care system will have a flexible organizational model that is capable of adapting to the realities and needs of the environment in which it is located.

Decentralized governance would give greater autonomy to professionals and communities to implement innovative and appropriate solutions, and accountability would be clearer and more direct. Government support for local governance and public involvement in identifying collective needs, priorities, and solutions is essential.

6. **The growing presence of the private, for-profit sector is undermining the robustness of the public sector.** We are seeing a growing presence of private, for-profit primary care services. This has the effect of reducing the pool of human resources available to the public sector and increases

inequities in access to care for those unable to pay out-of-pocket for health and social services. Also, this sector does not always provide follow-up care for people with more complex medical problems, which in turn increases pressure on the public health care system.





Our Values

Here are the values we believe should guide decision-making priorities and solutions for better primary care in Quebec.

Equity

Equity means that every person — regardless of their origin, history, circumstances, or characteristics, — can access quality care. All barriers to fair, empathetic care must be understood intersectionally and eliminated. Intersectionality indicates that specific health problems and care given are shaped by gender, culture, income, language, and other factors. In order to understand and improve health care intersectionally, everyone must be prepared to learn about their own personal prejudices, both conscious and unconscious.

Equity should not be confused with equality. Equity is important because it means that a greater proportion of the population is included, and that different communities receive distinct solutions, tools, and programs that take into account their unique reality.

The system must adapt to the person, not the other way around.

Accessibility

Accessibility means access to primary health care services for all by eliminating all structural, infrastructural (facilities and equipment), cultural, and financial barriers to care. Improving accessibility entails reducing silos between care professionals and decentralizing the role of doctors to rapidly mobilize other health professionals. It also requires improving the communication of essential information and the sharing of knowledge between patients, care providers, and institutions.

Accessibility also means protecting the free nature of our public health care system.

Effectiveness

Effectiveness is about doing things right, doing what's necessary, and focusing on what's most important: patients' long-term well-being. The primary responsibility of the health care system and its practitioners is to provide each patient with the highest possible quality of care. To achieve this, health care professionals must actively listen to the patient and their experiences, asking insightful questions. A reciprocal conversation will enable them to initiate more appropriate, health-promoting actions.

Effectiveness can also include an optimal allocation of resources, as well as preventing incomplete interventions and their consequences. A lack of continuity in care can worsen a patient's condition, forcing them to return to the health care system.

To strengthen effectiveness, we need to find ways to encourage system and practitioner accountability for the desired outcome of a patient intervention. Doctors and health care professionals need to have a definition of effective treatment that is consistent with that of patients.

In the end, you don't have to be fast to be effective. Slowing down has its merits.

Preventive and holistic approach

A preventive, holistic approach recognizes the value of social services as a complement to medicine and is concerned with a person's well-being as a whole, without compartmentalizing their problems. A holistic approach places the individual within their environment and studies the relationship between the two. Prevention and education are emphasized in this approach in order to avoid serious problems in the future.


This whole-person approach is local in scale, and aims to be more sensitive to people's context and less protocol-driven. The physician is not the only person capable of responding to a patient's health needs. Primary care must include professionals who have been historically marginalized by the health care system, and patients must be referred to professionals and services who can help them with what they really need

Empowerment

Empowering the population must be a goal of the health care system. The aim is to ensure that patients acquire the autonomy and skills they need to effectively take care of their health, to actively participate in their own care, and to create a positive impact on their families and communities. The right information and tools can empower people to take charge of their health. Government must facilitate this knowledge sharing to better inform citizens and support them in identifying their needs and the care they require.

Respect

Respect is a value that defines the relationship between practitioners and patients. Respecting people means listening to and taking



seriously their knowledge, experience, and life history. The value of respect also recognizes the ability of communities – and the patients and families within them – to mobilize and care for themselves with health practitioners as collaborators.





Recommendations

Here are the recommendations we would like to put forward to guide decisions concerning primary care in Quebec.

Priority 1: Improve recognition of systemic issues affecting the health of individuals

- 1.1 We recommend that the Ministère de la Santé et des Services Sociaux (the Minister of Health and Social Services, MSSS) respect and prioritize individuals' right to independence, particularly those with visible and non-visible disabilities, by providing them with assistance, such as better home care, and supporting their successful integration into the community. Supporting the autonomy of people with disabilities ensures a healthier, more independent life.
- 1.2 We recommend that the MSSS, in collaboration with various civil society stakeholders and communications professionals, develop tools to clearly explain how to navigate the public health and social services system, offer information about available services, and clearly define the rights of users. Examples of such tools include an official website, public awareness messages and campaigns distributed by communication agencies, and an interactive document similar to Canada's Food Guide. These tools must also be updated regularly.
- 1.3 We recommend that mandatory, ongoing training be offered to health and social services workers addressing all types of discrimination in order to increase equity of care. Training should cover racism, sexual and gender discrimination, transphobia and homophobia, glossophobia, ageism, medical violence, homelessness, mental health stigma, cultural, religious and linguistic differences, and so on.
- 1.4 We recommend that the MSSS conduct a scientific and objective study on the underlying causes of homelessness and the intangible factors that lead people experiencing homelessness and/or living in shelters to seek emergency care. The factors that bring people to the emergency room

include, but are not limited to: mental health conditions such as depression, anxiety, suicidal ideation and attempts, self-harm and others. Free of ideology, the study should take into account shelter residents' experiences with medical care before, during, and after homelessness; language and migration policies; distrust of the health care system; and people's ability to understand their own situation. The results of these studies should be easily accessible and free of charge to the general public.

Priority 2: Attract and retain primary care professionals

- 2.1 We recommend that primary care employers, including the provincial government, create welcoming and inclusive workplaces by recognizing the needs and expectations of new generations of employees and adapting job requirements and working conditions to this new reality.
- 2.2 We recommend that all levels of government, labour unions, and primary care employers and employees work together to attract and retain workers through greater flexibility and better working conditions. For example, in collaboration with professional associations, they could introduce a substitute system for absent doctors or those on leave; abolish mandatory overtime; reorganize schedules according to true availability and staff interests and preferences; and create floating teams.

We also suggest leveling out the current hierarchical structure of health care by, among other steps, simplifying bureaucracy; encouraging collaboration among workers to foster innovation, including administrative assistants on the medical team; promoting horizontal management for shared decision-making; and consulting stakeholders on the obstacles to fulfilling their roles.

- 2.3. We recommend that the MSSS and health and social service systems provide administrative support to practitioners, enabling them to devote more time to medical practice, continuing education, and quality patient care. Examples of administrative support and tools include standardizing and simplifying internal and external documentation (e.g., employment and insurance forms), creating new administrative assistant positions,

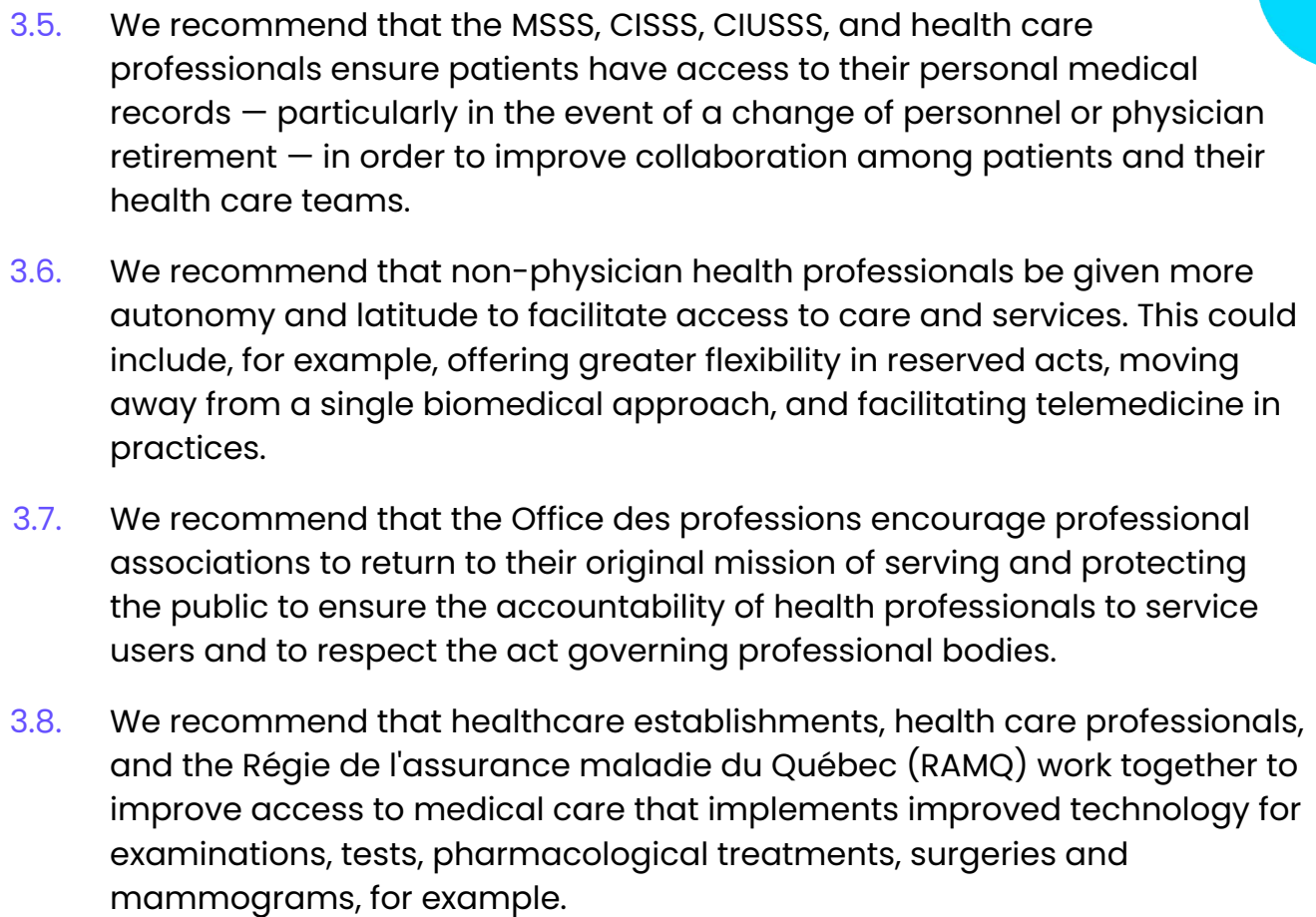
evaluating current management methods, and assessing the possibility of introducing a single medical record platform for the entire province. As a result, practitioners would experience less stress at work and have more time for patient care.

- 2.4. We recommend that the Ministère de l'Enseignement supérieur work in collaboration with medical professional associations and regulatory bodies to expand the labour pool by recognizing degrees acquired outside Quebec. Examples of initiatives aimed at integrating foreign workers into the primary care sector could include establishing training programs, issuing provisional or limited work permits, offering supervised internships, and promoting better sharing of knowledge and skills among health and social service practitioners.

Priority 3: Pivot towards a more flexible and innovative system

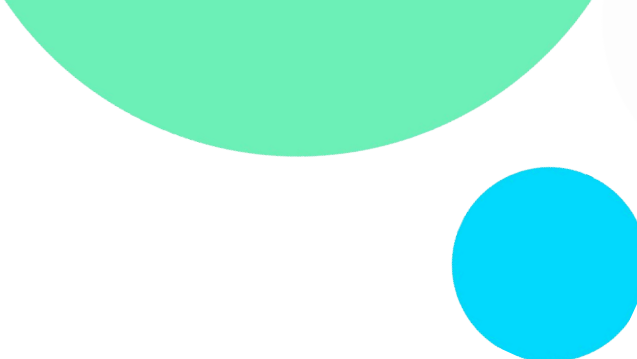
- 3.1. We recommend that a holistic approach to health be considered more seriously for the Quebec population. This way, patient autonomy would be respected: health care would avoid privileging medical prescriptions over other treatments that take into account a patient's physical, mental, emotional, social, familial, cultural, and spiritual health.
- 3.2. We recommend that the provincial and federal governments fund primary care research proportional to its importance, as well as funding information sharing and public education on health system navigation and care management. Knowledge gained from primary care research must be made public and distributed to all stakeholders.
- 3.3. We recommend that the Ministère de l'Enseignement supérieur and university faculties revise medical curricula to include courses in health promotion and prevention, including nutrition, from the first year of university.
- 3.4. We recommend that the MSSS, the Centres intégrés de santé et de services sociaux (CISSS) and the Centres intégrés universitaires de santé et de services sociaux (CIUSSS) facilitate the implementation of new data management and sharing policies, specifying the responsibilities of institutions and physicians. In addition, medical information must remain confidential but be easily accessible and understandable for patients and care teams.



- 
- 3.5. We recommend that the MSSS, CISSS, CIUSSS, and health care professionals ensure patients have access to their personal medical records – particularly in the event of a change of personnel or physician retirement – in order to improve collaboration among patients and their health care teams.
 - 3.6. We recommend that non-physician health professionals be given more autonomy and latitude to facilitate access to care and services. This could include, for example, offering greater flexibility in reserved acts, moving away from a single biomedical approach, and facilitating telemedicine in practices.
 - 3.7. We recommend that the Office des professions encourage professional associations to return to their original mission of serving and protecting the public to ensure the accountability of health professionals to service users and to respect the act governing professional bodies.
 - 3.8. We recommend that healthcare establishments, health care professionals, and the Régie de l'assurance maladie du Québec (RAMQ) work together to improve access to medical care that implements improved technology for examinations, tests, pharmacological treatments, surgeries and mammograms, for example.


Priority 4: Leverage a team-based approach to facilitate timely and continuous care


- 4.1. We recommend that primary care providers foster an institutional culture that recognizes social determinants of health, acts in the best interest of all individuals, and promotes continuous care for all.
- 4.2. We recommend that MSSS and clinicians promote better collaboration between primary care and community services to address recurring health problems and crisis situations, and thus ensure timely and continuous care.
- 4.3. We recommend that front-line organizations across Quebec improve access to care by offering group information sessions and education campaigns on how to navigate the system, particularly for underserved communities; people with specific health conditions, such as chronic pain



or newly diagnosed conditions; and others with unmet social needs, such as those experiencing homelessness. Education can also be therapeutic for communities. It can be delivered through a variety of means, such as face-to-face or virtual sessions, as well as media advertising.

Priority 5: Decentralize and improve governance of health and social services

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- 5.1. We recommend that all health care establishments – from the regional level of care delivery, such as CISSS-CIUSSS, to the local level, such as local community service centers (CLSCs) and family medicine groups (FMGs) – reserve at least 30% of seats on their boards of directors for members of the public and service users.
 - 5.2. We recommend that the Quebec National Assembly pass a law creating a people's committee with a mandate to monitor and submit recommendations on legislative and governmental activities relating to health care services and the production of information on population health population, regardless of the ministry or agency responsible for these activities. This people's committee should resemble a representative jury of citizens who are chosen at random but representative of the population, and should be independent and accountable to the National Assembly, like the Ombudsman. This people's committee should have the means to, among other things, understand the realities of all categories of the population.
 - 5.3. We recommend that provincial and municipal elected officials in Quebec, as well as all potential candidates, undergo mandatory training on intersectional feminism and systemic discrimination such as ageism, glossophobia, sexism, racism, language discrimination, mental health stigma, and ableism. Elected officials must be properly equipped to develop and implement more inclusive policies. Further, training on implementing these policies must be created and implemented by professionals with recognized expertise in their field and extensive, direct experience with relevant situations.

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- 5.4. We recommend that the Quebec government, local governments, health and social service institutions, and political parties commit to involving the public in decisions that affect front-line care in order to respect their voice and take their opinions fully into account.
 - 5.5. We recommend that researchers, members of the public, and health professionals work together to define population health indicators to better identify the performance of health system programs and services at all geographical and administrative levels, from national to local.
 - 5.6. We recommend that the provincial government ensure that user organizations, community health and social service agencies, and the public can participate in health care studies and service and program performance assessment, as well as equipping these groups to produce their own independent studies.
 - 5.7. We recommend that the Quebec government ensures well-coordinated public services, with decentralized decision-making and more cross-functional management.


Priority 6: Oversee for-profit private practice and promote the public system

- 6.1. We recommend that the provincial government protect and extend public coverage to all medical treatments in order to improve accessibility and equity of services, as well as to provide better patient care. For example, optometric services would be covered, as would hearing aids and assistive listening devices, dental care, and ambulance costs. The costs of alternative treatment plans to medication, such as yoga classes, would also be covered.
- 6.2. We recommend that the government regulate the supply of private, for-profit health care services. An improved legal framework is needed to oversee private, for-profit practice so as not to undermine access to health care services through the public system.
- 6.3. We recommend that the provincial government prohibit advertising campaigns that disadvantage public health care in favour of the private sector, as well as taking steps to promote healthy, inclusive and public

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health practices that are accessible to the entire population, without discrimination.

- 6.4. We recommend that the provincial government limit the growth of the “entrepreneurial model” in health and social services in Quebec, so as not to undermine a public, universal, and equitable health and social services system. This model is neither compatible with nor acceptable in a publicly-funded health care system.
- 6.5. We recommend that the MSSS supervise the pricing of private, for-profit health care establishments, and that these establishments be required to inform the public about the real costs of treatments and procedures.
- 6.6. We recommend that the Quebec government require private insurers to also cover pre-existing and more complex medical conditions.



OurCare Priorities Panel Program

The process was spread over five sessions. The first two were held online over Zoom, on Saturdays April 22 and May 6, 2023. The other three sessions were held in Montreal on May 26, 27, and 28, 2023. During these sessions, panel members met 15 experts who informed them about different aspects of primary health care in Quebec and other jurisdictions and gave them the opportunity to ask questions. They also took part in group discussions guided by facilitators from the Institut du Nouveau Monde (INM). Here are some details of the sessions in which members participated.

Session 1: Saturday, April 22 Virtual

The first session enabled panel members to familiarize themselves with the panel process and with the primary health care system in Quebec. Panel members were welcomed by Émilie Hervieux and Malorie Flon, who took turns moderating at various times during the process. Dr. Tara Kiran, principal investigator and project initiator for OurCare, along with Dr. Nebojsa Kovacina and Pre Mylaine Breton, co-leaders of the project in Quebec, then welcomed the participants. The objectives of this first meeting were to present the group's mandate, understand how the deliberative process works, and initiate reflection on the values that should define the primary care experience in Quebec. Members also took part in two presentations. The first provided an initial overview of primary care with Dr. Marie-Dominique Beaulieu, Professor Emeritus in the Department of Family Medicine and Emergency Medicine at the University of Montréal.¹ The second lecture, presented by Dr. Nebojsa Kovacina, family physician and director of the Continuous Quality Improvement (CQI) program in McGill University's Department of Family Medicine,

¹ A more complete biography of each speaker can be found in the [Guest Speakers](#) section.

focused on the results of the national survey conducted during the first phase of the OurCare initiative.

Session 2: Saturday, May 6 Virtual


In the second session, participants heard from experts on primary care models in Quebec and around the world, and on access to health care for equity-seeking groups. The first presentation on different models of primary care was given by Dr. Mylaine Breton, full professor in the Department of Community Health Sciences at the University of Sherbrooke and co-leader of the OurCare project in Quebec. Dr. Isabelle Leblanc, a family physician working in primary care, then introduced the concepts of equity and injustice in health care and social determinants of health. This presentation was followed by a discussion among three guest speakers who spoke about various challenges that certain population groups face in accessing primary health care. The discussion included: Marie-Claire Rufagari, coordinator of of the training component of the Table de concertation des organismes au service des personnes réfugiées et immigrantes

(TCRI); Dr. Geneviève Auclair, primary care physician at the Inuulitsivik Health Centre in Nunavik; and Lesley Hill, former Commissioner of the Special Commission on Children's Rights and Youth Protection. Panel members were then assigned to break-out groups to work together to identify essential and high-priority features of primary care systems, and to continue discussions on the values that should define the primary care experience in Quebec.

Session 3: Friday, May 26 Montreal

During this first face-to-face session, members finalized definitions of the values identified in the first two sessions and attended a presentation by Dr. Nebojsa Kovacina on the types of services that make up Quebec primary care: public non-profit organizations, services that obtain public funding but are delivered in a for-profit model, and those that are delivered in a for profit model and paid for privately. This presentation was followed by a discussion among three experts on the role of for-profit services in Quebec's primary care system: Patrick Déry, assistant editor at Options politiques; Dr. Isabelle Leblanc, a primary care physician;





and Dr. Nadia Sourial, professor in the Department of Management, Evaluation and Health Policy at the University of Montréal's School of Public Health.

**Session 4:
Saturday, May 27
Montreal**

The aim of this session was to encourage members to elaborate issues they see in primary health care in Quebec, and to enable them to start thinking about the recommendations they would like to propose to decision-makers. To help them in their reflection, an initial presentation on team-based care models was given by Dr. Nancy Côté, associate professor in the Department of Sociology at Laval University, and Christine Laliberté, president of the Association des infirmières praticiennes spécialisées du Québec (AIPSQ) and project manager for the Archimède initiative. Members also attended a discussion on the theme of institutional choices and priorities with Dr. France Légaré, family physician at the Saint Francis of Assisi University Family Medicine Group (GMF-U); Dr. Damien Contandriopoulos, full professor at the University of Victoria School of Nursing; and Marco Laverdière, Esq., research associate at the Canada

Research Chair on Collaborative Culture in Health Law and Policy and at the Hub santé - politique, organisations et droit (H-POD) at the University of Montréal.

**Session 5:
Sunday, May 28
Montreal**

During the final session, members worked on completing the various sections of the report, including an introduction of the panel members, learnings and key findings about primary care throughout the process, values that should guide decisions regarding the primary care system, and, finally, their recommendations for the future of primary care in Quebec. In the afternoon, they presented their work to an audience of 37 people (14 online and 23 in-person) from research and academic institutions and from various organizations involved in primary care, such as the Collège québécois des médecins de famille, Health Canada, the Ministère de la Santé et des Services sociaux, the Ordre des infirmières et infirmiers du Québec and the Health and Welfare Commissioner. The session concluded with distributing recognition certificates to each of the panel members.

associé à la Chaire de recherche du Canada sur la culture collaborative en droit et politiques de la santé et au Hub santé - politique, organisations et droit (H-POD) de l'Université de Montréal.

**Séance 5 :
dimanche 28 mai
Montréal**

Lors de la dernière séance, les membres ont travaillé à finaliser la rédaction des différentes parties constituant le rapport, soit la présentation des membres du panel, les apprentissages et les principaux constats faits sur les soins de première ligne tout au long du processus, les valeurs devant guider les décisions concernant le système de soins de première ligne, ainsi que leurs recommandations. En après-midi, une présentation du fruit de leur travail a été réalisée à l'intention d'un auditoire de 37 personnes, dont 14 étaient en ligne et 23 en présentiel, provenant du milieu de la recherche et universitaire, et de diverses organisations touchant les soins de première ligne, telles que le Collège québécois des médecins de famille, Santé Canada, le ministère de la Santé et des Services sociaux, l'Ordre des infirmières et infirmiers du Québec et le Commissaire à la santé et au bien-être. La séance s'est

terminée par une distribution de certificats de reconnaissance à chacun des membres du panel.



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Meet the members

CHANTAL BÉGIN

I live in the Eastern Townships region. I did my elementary and high school education in Lac-Mégantic; my CEGEP in Sherbrooke; and then lived in Longueuil, Varenne, Aylmer, and am now back in Lac-Mégantic. I have two children studying in university, a spouse who is 11 years older than me, and three grandchildren by marriage under the age of 6. Both my parents are over 72 years old, and my 86 year old mother-in-law is still alive, but all are in poor health. I tell you all this to illustrate that I am concerned about the well-being of several generations. I have mostly worked in daycare administration, but I also have six years of experience in the health care field and held a position for two and a half years in a residential long-term care center (CHSLD) as an administrative officer.

JOËLLE BÉRUBÉ

I am a 38-year-old woman with a passion for gin, baseball, and fishing, and am also fascinated by human psychology. Having survived a major stroke at the age of 30 and working as a part-time public servant since returning to work in 2018, I am involved in educating Canadians about heart disease and stroke in women, as well as the preventable death of women and women's heart research. I was an ambassador for the Gatineau Red Dress Gala in 2019 and remain a spokesperson for the Ottawa region of Heart & Stroke to this day. I consider myself a person who is always ready to debate societal or political issues, is thirsty for new knowledge, and will always have questions for you.

KRISTIAN CLINTON

Hi there! I live in Montreal with my canine kid, Leroy, but I've been fortunate enough to call many places around the world home. Originally from Ontario, I volunteered for the Priorities Panel due to my insatiable curiosity. As an avid traveler, I have been exposed to various health care systems and perspectives, shaping my opinions about health and what it means to be "healthy". As such, I prioritize my health and opt for organic and GMO-free produce while excluding medications and vaccinations from my forms of treatment. I left my position as an eCommerce Specialist, taking time to focus on my overall wellness. This opportunity allowed me to rediscover my love of improvisation, cycling, swimming, and language learning — specifically, French!



MARIE MICHELLE DIMANCHE

Currently, I am a member of the Centre des femmes les unes et les autres (Women's Centre Les Unes et Les Autres) as a participant representative. I have been serving as vice president of the RUTAC in the Rivière-du-Nord Regional Municipal County, a group for adapted and collective transportation users. I also participate in certain activities at Signée Femmes, a women's center in Rivière-Rouge in the Laurentians, to help people discover my culture. I tell stories, sing, and dance while leading tam-tam workshops. Every year, I join an organization in Montreal, the KEPKAA, to help others discover Creole in cultural centres and in schools.

DONALD GILBERT

I grew up in the Saguenay region and left in 1979 to study finance at Laval University. I am passionate about management, business strategies, and organizational development. After eight years in financial management, I reoriented my career towards general management. From 1990 to today, I have held general management positions within organizations in various sectors: telecommunications, agri-food, information technology, research centres, and provincial service associations (Quebec ambulance sector). Having accompanied my parents in the health care system, I found many weaknesses (predominantly procedural) but also dedicated people hoping for change, despite the failures of past reforms. In Quebec, we say that entering the system is difficult, but everything goes relatively well once inside, but still!

JORGE GONZALEZ

Hello. I am married and have two daughters. I was born in 1946 in Chile and worked as a teacher there until the military coup in 1973, which forced me to flee my home country. In 1977, I was welcomed in Canada as a political refugee. In Quebec, I worked for a few years in the mechanical manufacturing sector, then as a translator from French to Spanish. I have been retired since 2012.



SANDRA GUALTIERI

Hi. I'm the president of AbleFly, which is developing an adaptive orthopaedic positioning device that will enable more people with disabilities to fly safely and with dignity. I advocate and strive for universal access and inclusion for all abilities. I am a woman with cerebral palsy, a physical disability that makes me unable to walk and affects my speech. I graduated from McGill University with a Bachelor of Arts in Women Studies and Sociology and today advocate for people with disabilities in various ways, namely by raising awareness among police and the general population of the barriers facing disabled women who need shelter from domestic violence, as well as by improving federal regulations regarding transportation with the Transportation Committee of the Canadian Council for People with Disabilities. I am pleased to be on this panel in hopes of improving Quebec's health care system. Due to my disability, I have been denied pap smears and colonoscopies. In 2016, I participated in a protest concerning the lack of accessibility to physical medical buildings and the inaccessible way in which mammogram testing is done. These issues persist.

ROBIN GUMÉRY

Hello. My pronoun is "he". I am 30 years old and have several years of experience in the health care field as well as in the community. I graduated in Specialized Education in 2014, and I love getting involved in my community and caring for others. I believe in a stronger health care system that will serve a population whose needs are great, and since the system needs to be improved, I am also a fervent defender of people's rights. My day begins with a smile and the hope of changing the world. I'm known as a jokester, a caring and creative person. It's an honour for me to be part of this panel and help move Quebec forward.

TARA HALL

I was born in Ontario and lived on a sheep farm until my French Canadian father and British immigrant mother moved with my little sister and I to Montreal when I was 3 years old. My parents divorced when I was 6 and both re-married, giving me an older step-sister and a younger half brother, both of whom have children and grandchildren. I have been disabled since the age of 27, though I remain undiagnosed 25 years later. I identify as an LGBTQ person. I recently purchased my own home with the help of my family. I love to learn new things.

GILBERT HOOM

Hello! I am an immigrant from Malaysia living in Canada since 2009. I am fortunate to live in this country where I receive privileges as a taxpayer that are not present in my birth country. I have been working in the service industry since I finished high school and now see the repercussions of constantly being on my feet. Living in two different provinces gave me a general contrast of services offered, and I yearn for the day it will be hassle-free to receive health care services. I am aware of how my peers and family are having a hard time receiving services. I am idealistic and curious, and I would definitely like to apply these traits to help make the system better!

LEE KALPIN

I was born in Montreal in 1940 to an immigrant family from Eastern Europe. During WWII, my parents and extended family were concerned that their children would starve as they had starved in Europe during the first World War, so they purchased a farm in Ontario. After the war was over, we moved to Toronto, where I grew up and went to school. I attended business college and became a legal assistant, working for various law firms in Toronto for many years. Then I married, had three children, and moved to the country where I could have horses. The marriage did not work out, and when my kids grew up I went back to college and first became a fitness instructor and then a registered massage therapist. I worked in this profession and taught for 36 years, retiring at the start of the pandemic when I was 80 years old. As part of my career I have developed a keen interest in health care, particularly as it affects seniors. In my retirement, I sold my house and moved to Gatineau, Quebec, where I have family and I am settling in and enjoying my new town and my new friends here.

SARA KEMP

Biography not available.

VENISE LANDRY

Born in the great city of Montreal, I have held a number of management positions, one of which left a lasting impression on me: home care coordinator. Hearing the call of the limelight, I trained as a theatrical actress. An avid improviser, I took the plunge in the 1970s. By taking part in numerous Murder Mystery evenings, I accumulated my UDA credits. In 2004, we moved to Eastman, where I worked for Eastman Correspondances. Over time, I found my calling as a commentator for Sherbrooke radio and a web magazine columnist. These activities go hand-in-hand with my husband, an artist, author, and illustrator, to whom I devote my best energy. I'm about to launch my own podcast, "La volumineuse", fanned by a gentle flame that will ignite our inspiring literature.



MARTIN LANGEVIN

I was born in Ottawa, Ontario. I volunteered for the OurCare project to share my experiences, especially regarding the potential influences of sexual and domestic violence, language, immigration, and homelessness policies on the mental health of Quebec residents and on the frequency of their medical service use. I have previous experience with mental health services in Quebec related to immigration and domestic violence; in the People's Republic of China related to depression when I worked in China; in Ontario and Quebec related to post-traumatic stress disorder and homelessness; and in Quebec, Ontario, and the People's Republic of China related to language trauma.

PHILIPPE LATOUCHE

Hello. I am originally from the Quebec City area. A business analyst, I have been living with a post-infectious disease, long COVID, for more than three years, and it has left me disabled. Having an invisible and chronic disease, I am often stigmatized by health care staff. I am fortunate to have a great medical team surrounding me, but I want to make sure everyone gets the same care. Especially for people with post-infectious diseases such as myalgic encephalomyelitis, long-standing COVID, or fibromyalgia. In the meantime, the pressure on primary care will continue to increase with an aging population. It is therefore important to act now by contributing to this panel so everyone can enjoy a life where care does not become a privilege based on selection criteria.

JOSÉ MATHIEU

I'm 50 years old and was born in Haiti. In Canada for 36 years, I live in Laval, QC, and I have been working for the Canadian Border Services Agency for 18 years. I volunteered for the panel because I am concerned about the future of health care in Canada. As a patient, I often have a hard time getting emergency medical appointments, even though I have a family doctor. I hope that health care will be more accessible in the future.

DARROW MAXIS

Biography not available.

LUCIE MAYER

A lyricist, voice pedagogue, and language passionaria, I am a graduate of Concordia University, UQAM, McGill University, and soon, UQTR (Masters degree in Translation from English - French). I enjoyed a career in Quebec beginning in 1988 and later in Germany from 2003 to 2010. In 2016, a silly accident stopped me in my tracks and I was dropped into a Kafkaesque world, namely that of the Quebec health care system. I am a vehement judge of the establishment as well as a defender of the people who must work within the horrid frameworks it offers. A leftist, I am a fierce advocate of social and political rights for all (including BIPOC), especially that of proper health, good food, education, and universal accessibility. I live in Prévost with my beloved partner and soon a cat.

LAURENT MILLOT

I grew up in the greater Montreal area. For more than 32 years, I have been a resident of Pabos (Gaspé). Before retiring about 3 years ago, I worked in the field of fisheries and aquaculture as a researcher and then as a research centre manager. I am involved in organizations that support seniors. I am a "super neighbour" and I am able to understand certain issues related to the health of isolated people. I also contribute to an organization that aims to offer training to seniors (ADAUQAR). The mission of this organization is to offer learning activities for people aged 50 and over. These activities contribute to their quality of life and mental health; break their isolation; and stimulate curiosity, memory, and thinking skills. I am interested in health because it is an essential determinant for, on the one hand, my own inevitable aging, and, on the other hand, for a healthy society. In my opinion, health must have a well-developed prevention component and be seen in all its aspects: biological, nutritional, social, etc.

PETER MUIR

Born in Victoria, I lived in Calgary, Edmonton, and Port Credit (near Toronto) during my early years. I currently live about 35 minutes northwest of the city of Gatineau on the shore of Lac Bernard, a small lake in the Gatineau Hills. My wife Kathy (born in Montreal) and I have been married for 53 years, and we have two daughters and four grandchildren. We both grew up spending summers at Lac Bernard, where we first met. We became permanent residents 24 years ago and, for us, the lake is the perfect place to enjoy country life, entertain friends, and participate in a close-knit community. I earned my CA designation and went on to work in Ontario (Ottawa and Owen Sound) in a number of senior administrative and financial positions with a variety of large and small health and social service organizations in both the public (provincial, municipal) and private sectors (for-profit, non-profit, charitable).



ROSENA OLIVIER

A young mother of two adorable little girls full of energy and passion, I am a renaissance woman driven by a passion for helping others. I worked as an orderly in residential long-term care centers (CHSLD) and hospitals and also taught transcendental meditation in North and South America, as well as in the Caribbean. I also worked for several years in the tourism and events industry but now work in finance. Among the many hats I wear, I am a close friend of cancer survivors, a committed activist, and citizen, and I want everyone to have equal rights in all spheres of their lives, and more specifically, primary rights.

JULIA PAGÉ-DAIGNEAULT

I am a 20-something woman in good physical health living on the south shore of Montreal. Since my teen years, I have been taught to develop healthy habits for holistic wellbeing. I have longed for a primary care physician for some time, yet have lived 18 years without access to one. My involvement in the OurCare project comes from my limited knowledge about primary care in Quebec. Despite having grown up in the province, I do not feel like I understand the structure surrounding primary care here nor the correct resources to contact if needed. I just completed a master's degree in management which allowed me to become familiar with work/life balance challenges facing individuals, and being involved in this project was the perfect opportunity to join people from various backgrounds to discuss the current post-COVID challenge: the future of primary care in Quebec.

PIERROT PÉLADEAU

I am a 68-year old male in good health (but allergic to cats) but without a family doctor for 4 years, having also accompanied two daughters, my mother, father, and spouse, as well as some relatives, through primary care services. I live alone as a grown man in a suburban area in the Laurentians (a region notorious for its lack of health care personnel and facilities). I'm a researcher and consultant in social evaluation of information systems (lay version: preventing IT from ruining people's lives). I have also worked for several years in and with different organizations for people with disabilities, human rights organizations, and organizations working for digital inclusion and citizen appropriation of digital technologies.

ANNIA PIERRE

I am 29 years old, and I am an administrative technician in the health network on the island of Montreal. I decided to participate in the OurCare project because I am aware of the many issues in the health care system in Quebec. It will be an opportunity for me to take part in these reflections and to discuss possible solutions aiming to improve services available and/or any other sphere that affects the health field. I am ready to learn, exchange, and share my experiences as a user of these services during these meetings.

DANIEL PINAULT

Hello. I'm from Bas-Saint-Laurent, the city of Rimouski to be precise. I was born in a picturesque little village not far from here, Le Bic. I've been on this earth for 70 years now, and I'm not complaining. My education consisted of three years at Cégep in administration. I then took additional courses at the University of Rimouski, UQUAR, and I worked for a telecommunications company for 35 years. I retired in 2007, but not quite, because I've been working all over the place ever since. My community involvement includes: member of Club Richelieu from 1980 to 1990, member of the Rimouski Knights of Columbus for six years, volunteer for the Eastern Quebec Cancer Association for eight years, and volunteer at the Maison de soins palliatifs Marie Élisabeth for 12 years. My hobbies include: nature (forest, seaside), camping, walking, horseback riding, and reading. I am grandfather to two grandsons, Patrice, 17, and Simon, 15, and I have a step-daughter who just turned 44.

EVELYN PITRE

I am a retired teacher who initially specialized in organizational behaviour but eventually turned to teaching business communications. I taught in Canada at the University of Québec at Trois-Rivières, the HEC Montréal, and Wilfrid Laurier University in Ontario, and ended my career at the University of North Texas in Denton, Texas, where I taught many young Americans how to express themselves at work in English. A mother of three young adults, since retirement I have also become caregiver to three people over the age of 90, and access to health care has become a major concern for me.

VALERIE PYKE

Bonjour/Hi, my name is Val! I was born, raised, and still live in Chateauguay, on the south shore of Montreal. I enjoy an exciting career as a security administrator, and also operate my own small business offering wedding photography. In November 2004, following a perfect pregnancy, my first and only son was born unexpectedly with a terminal illness. He, his father, and I spent the majority of his 18 months of life as an inpatient at the Montreal Children's Hospital, and this is when I learned how broken our health care system in Quebec truly is. Almost 20 years and a global pandemic later, it has only gotten progressively worse. I am honoured to be a part of this Priorities Panel and hope to contribute to making changes for all Quebec citizens.



CAROLINE SANTOS

Hi. I grew up in Laval and currently live in Montreal. As the eldest daughter of Brazilian immigrant parents, I've often played the role of cultural mediator and academic role model within my family. With an undergraduate degree in Actuarial Science and Finance, followed by a graduate degree in Business Intelligence, I've immersed myself in the world of data in search of model understanding and optimization. Understanding the factors that influence a model and its results often relies on shortcuts and biases that I constantly strive to challenge. As the world evolves, so too must the underlying assumptions of any new model. Furthermore, efficiency is at the heart of my values, which drives me to seek opportunities for automation and optimization in everything I do, whether at home or at work. This brings me to my participation in the panel! Despite fairly good health, I have encountered many frustrations and inefficiencies within our health care system. Learning about and discussing our health care system, and contributing recommendations to improve its management, accountability, and adaptability, motivated me to join the OurCare mission.

SÉBASTIEN SIROIS

Biography not available.

ALEXIS-PAUL ST-GERMAIN

I'm in my forties, was born on the south shore of Montreal, and was educated in public and private schools, including university, though unfortunately I didn't finish. It is urgent to reform the health care system to guarantee its sustainability in the midst of an aging population, a shortage of workers, and also the pending crisis of climate change. It is therefore imperative to make structural changes to the system after more than 30 years of governmental change. The changes have swung between the decentralization of the health care system with the negative effect of hyperinflation, back to centralization of health care with the inconvenience of a more rigid system. It's time to change the monopolistic public health care sector and bring liberal values back to health care with free market enterprises that better manage resources and respond better to partnership with the public sector. This goes alongside supervision favouring for profit and not for private sector, financed with government assistance.



JULIE YIP

I have worked in the health care field for over 10 years. An occupational therapist by trade, I work as a research professional and contribute to occupational therapy courses at the University of Montréal. My skills in mental health, universal design and working with geriatric patients make me stand out. I like to emphasize the importance of teamwork, and am always highly committed to whatever I undertake. Often described as a quiet force, I am known for giving sound advice and being an attentive listener. I take a keen interest in social innovation and respect for human rights. A great lover of animals, I currently volunteer for Les Pattes Jaunes, a French-language digital catalog for animal adoption from ethical shelters.

Guest speakers

Dr. Geneviève Auclair has been a family physician at the Inuulitsivik Health Centre in Nunavik since 2007. Her professional career has also taken her into management, public health, and teaching. Passionate about her unique work environment, she is a regular speaker on topics such as northern medicine and cultural safety for aboriginal populations. As head of Nunavik's Regional Department of General Medicine (DRMG), she lobbies for greater recognition of the territory's medical particularities.

Prof. Marie-Dominique Beaulieu is a graduate of Laval University and a Fellow of the College of Family Physicians of Canada (CFPC). She is Professor Emeritus in the Department of Family Medicine and Emergency Medicine at the University of Montréal and Associate Researcher at the Centre de recherche de Montréal sur les inégalités sociales et discriminations (CRÉMIS). Her research focuses on the organization and quality of primary care and collaborative practices. She has practiced family medicine for 37 years and has held various leadership positions. President of the College of Family Physicians of Canada (CFPC) in 2012–2013, she received an honorary doctorate from Laval University in 2013. From 2014 to 2018, she was Scientific Director of the Quebec Patient-Oriented Research Support Unit as part of the Canadian Institutes of Health Research's Strategy for Patient-Oriented Research (SPOR). She collaborates with the Institut national d'excellence en santé et en services sociaux du Québec (INESSS) as a medical expert in the field of family medicine and primary care. Recognized as one of the 20 pioneers of family medicine research by the CFPC, she has been a member of the Ordre national du Québec since June 2019 and a member of the Order of Canada since December 2022.

Prof. Mylaine Breton is a full professor in the Department of Community Health Sciences at the University of Sherbrooke's Longueuil campus and holds a Canada Research Chair in Clinical Governance of Primary Care Services. She was awarded the 2019–2020 Canadian Harkness/CFHI Fellowship in Health Care Policy and Practice. Her current research aims to better understand promising organizational innovations to improve accessibility and continuity of services.

Prof. Damien Contandriopoulos is a full professor in the School of Nursing at the University of Victoria in British Columbia. His research program focuses on health policy analysis, the use of scientific knowledge in decision-making processes, and the development of effective primary care models.

Prof. Nancy Côté is an Associate Professor in the Department of Sociology at Laval University, a FRQS research fellow, and a researcher at VITAM, where she is co-director of the Environnements: milieux de vie, milieux de travail et milieux de soins research axis. Her

work lies at the crossroads of the sociology of work, professions, and organizations. Her research focuses on transformations in front-line health and social services organizations and their effects on the work of professionals, doctors, and managers in this sector. She has developed expertise in research conducted in partnership with various front-line players.

Patrick Déry is a deputy editor at Options politiques, as well as a columnist and public policy analyst. He is particularly interested in health issues and democratic institutions. You can follow him on X [@patrickdery](https://twitter.com/patrickdery).

Lesley Hill holds a bachelor's degree in social work from McGill University and a master's degree in organizational management and development from Laval University. Her professional experience has led her to work with diverse populations, including children and their families, seniors, and users of mental health and addiction services. She has held various management positions within the health and social services network in the Mauricie-Centre du Québec, Montérégie, and Montreal regions. In May 2012, Ms. Hill was appointed assistant general manager and then general manager of the Batshaw Youth and Family Centres. Following the merger of the health and social services institutions in 2015, Ms. Hill headed the youth program at CIUSSS du Centre-Sud-de-l'Île-de-Montréal. In 2019, she was appointed commissioner by the Conseil des ministres to the Commission spéciale sur les droits des enfants et la protection de la jeunesse. Retired since 2022, Ms. Hill is involved in a number of social causes, including the well-being of children, families, and people in vulnerable situations. She believes in prevention and the importance of acting on social and health inequalities, while focusing on the participation of people requiring care and services.

Dr. Neb Kovacina is a family physician in Montreal. Since 2017, he has been director of the Continuous Quality Improvement (CQI) program at McGill University's Department of Family Medicine. He has played an advisory role in various provincial and national projects and initiatives related to continuous quality improvement in primary care. In recent years, he has been responsible for CQI for the Quebec College of Family Physicians, and he has remained involved in various initiatives to promote CQI and the improvement of primary care at all levels. He is also the medical advisor and CQI expert for Groupe Innovation Santé, the organization responsible for implementing the Personal Health Centre model within the Correctional Service of Canada. He is one of the founders of the Académie Qualité Santé.

Christine Laliberté is President of the Association des infirmières praticiennes spécialisées (IPS) du Québec (AIPSQ). In addition to her primary care practice, she is

project manager for Archimède, a new model of care that emphasizes interprofessional collaboration by optimizing the use of nurses' roles and professional resources. She is also a lecturer at Laval University in Quebec City.

Marco Laverdière has been a member of the Quebec Bar since 1994, and holds a post-graduate diploma in fundamental rights from the University of Nantes and a master's degree in health law from the University of Sherbrooke. He has been general manager and secretary of the Ordre des optométristes du Québec since 1999. Prior to this, he began his legal career with the Conseil pour la protection des malades in 1993. Since 2002, he has taught graduate programs in health law and policy at the University of Sherbrooke. Since 2014, he has also been a research associate at the Canada Research Chair on Collaborative Culture in Health Law and Policy at the University of Montréal and, since 2021, at the Hub Santé : Politique, Organisation et Droit (H-POD) attached to the same university. Finally, he is involved in various working groups concerning health law and policy and professional regulation in Canada, in addition to acting as a speaker, trainer, and author on various subjects related to his field of expertise.

Isabelle Leblanc is a family physician working in primary care who turned to medicine after training in anthropology and literature. She completed her medical studies at the University of Ottawa and her residency at McGill University. An assistant professor in McGill's Department of Family Medicine, she has taught bioethics, interprofessional communication, and social health issues to both students and residents in family medicine. She practices and teaches in Montreal's Côte-des-Neiges district, and has been an active member of Médecins québécois pour le régime public since 2011.

France Légaré has been a family physician at the Groupe de médecine familiale universitaire (GMF-U) at Saint Francis of Assisi University since 1990. She is a full professor in the Department of Family Medicine and Emergency Medicine at Laval University, and has held the Canada Research Chair in Shared Decision Making and Knowledge Translation since 2006. In 2020, she received the Dr. Léo-Paul Landry Medal of Service from the Canadian Medical Association and the President's Award from the Association of Faculties of Medicine of Canada. In June 2022, she was named Chevalière of the Ordre national du Québec in recognition of her research into user involvement in health care decisions.

Ariane Murray has been a family physician and Head of the Montreal Regional Department of General Medicine (DRMG) since spring 2022. In addition to being a family physician, she is also a clinical assistant professor in the Department of Family Medicine and Emergency Medicine at the University of Montréal. She has worked in a variety of clinical settings (emergency, hospitalization, CHSLD) in addition to caring for her patients at the Groupe de médecine familiale universitaire de Verdun. Local director of the residency program at the Groupe de médecine familiale universitaire de Verdun from 2010 to 2018, she is now the University of Montréal's

representative on the Comité des médecins enseignants of the Fédération des médecins omnipraticiens du Québec, where she also sat on the Comité de l'avenir de la médecine familiale from 2018 to 2020. She joined the Montreal DRMG executive committee in 2018, when she was appointed to the position of local table leader for the Verdun local service network. In 2019, this role expanded to include that of the local medical coordinator in the same sector.

Marie-Claire Rufagari has over 27 years of experience in immigration and intercultural relations. She has worked as coordinator of the training component of the Table de concertation des organismes au service des personnes réfugiées et immigrantes (TCRI) since 1995. As a lecturer in social work at UQAM, she taught the course Modèles d'intervention et relations interethniques for three years, in addition to being a member of the CIUSSS du Centre-Sud-de-l'île-de-Montréal's ethnocultural diversity committee.

Nadia Sourial is a professor in the Department of Management, Evaluation, and Health Policy at the University of Montréal School of Public Health, and a researcher at the Centre de recherche du Centre Hospitalier de l'Université de Montréal. Her research focuses on the evaluation and organization of primary care for the aging population. Dr. Sourial is currently leading a program funded by the Canadian Institutes of Health Research (CIHR) on the evaluation of Family Medicine Groups and their impact on the quality of care and use of health services among the elderly. Prior to her career as a researcher, Nadia acquired several years of experience as a biostatistician in chronic disease and aging research at the federal level and in the pharmaceutical industry. These broad experiences have given her a unique perspective on the challenges and opportunities of improving front-line health care.



Appendix

Minority reports

Members were encouraged to consider all points of view during the panel process. Discussions were lively and respectful and while some minor differences in opinion remained, every member of the panel endorsed the recommendations in this final report. However, members were also given the opportunity to write a minority report in which they could highlight any points of agreement or disagreement, or include their own commentary.

Sandra Gualtieri

Panel members discussed the importance of independent living for the disabled population to avoid unnecessary placement in residential long-term care centers (CHSLD). I'd like to take this opportunity to highlight the importance of providing disabled people with the necessary means to exercise the right to choose their living situation.

I am a disabled person and my ability to live independently is essential. It's important to be considered like everyone else and to be included in the design and development of services. Equal care contributes to improving the mental health and well-being of this population.

For example, the Chèque Emploi-Service (CES) scheme could be an excellent option for disabled people wishing to benefit from home help. Despite its good intentions, the CES program unfortunately has a number of shortcomings.

Problems were compounded during the pandemic as the government recruited and incentivized people to work in CHSLDs, which was desperately needed. However, a large majority of CES home help personnel left to work in CHSLDs, creating a shortage of home helpers for CES users who are currently living independently or who could benefit from the service.

The CES program must be regarded at the same level as the CHSLD program, providing home help with the same higher wages, the same health benefits, the same paid sick leave, the same leave of absence options, etc. The CES payroll methods are obsolete and in desperate need of modernization. Frequent errors occur in the system, resulting in employees not being paid on time or not being paid at all. This is a major deterrent to working in this specific field. In addition, the CES payroll system needs to be innovative and adapt to technology and the digital age by being available online. I've been told that online systems are not secure, but many companies and administrations use this method. There are many services specifically designed to integrate online payroll.

I write in the hope that the important CES service, used by some 12,000 people in Quebec, will be better integrated into the continuum of services promoted and supported by primary care providers. Independent living services are a crucial component of the care offered at home and in the community. A well-functioning, technologically up-to-date assisted-living service would also alleviate the space requirements of the elderly population.



Kristian Clinton

Quebec has disease care, not health care, a reactionary rather than preventive approach that does not promote a life lived in optimal health. Quebec's primary care facilities do not define health, any more than quality life years are defined and tracked, so a sub-optimal outcome is to be expected. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition is a good starting point and moves away from priorities and treatment protocols heavily influenced by the biomedical industry, such as invasive surgeries and expensive pharmaceuticals. A symptom-focused approach without comprehensive individual assessment is ineffective and unsustainable. Use of the above definition does not constitute my endorsement of the World Health Organization. Canadians would be better served by breaking away from their official membership in the organization, opting for a health policy that reflects our unique cultural, demographic, and geographic variations, rather than centralized, globally standardized guidelines. It is essential that the will of the electorate reflects this evolution, and that the accountability of elected and appointed bureaucrats is rigorously maintained, including with regard to the implementation of concrete measures, because health policy has an impact on all Canadians.

Faced with an aging population, an epidemic of chronic diseases and a scarcity of health care professionals, Canadians can't afford to maintain the status quo. A paradigm shift towards preventive care and incorporating historically marginalized and stigmatized treatment solutions used in

integrative medicine is the only way forward. These include acupuncture, chiropractic, massage therapy, naturopathy, and osteopathy. Placing non-invasive therapies at the forefront of care reduces the need for costly surgery and the prevalence of chronic illness. This approach also allows the individual to be their own best advocate, unlike the current model of the gatekeeper GP.

This evolution offers the possibility of a two-tier system. Such a system guarantees every Canadian access to quality care, while allowing individuals to choose modalities that complement their lifestyle. A two-tier system has the added advantage of retaining and attracting human capital to the province, allowing health professionals to practice as they see fit, with the free market regulating costs and improving quality of care through competition. A collaborative public-private system has the flexibility to provide comprehensive care to underserved communities, adapting to unmet needs. This collaboration is fair to both Canadians and practitioners. Canadians benefit from better access and choice, and practitioners enjoy professional autonomy, which encourages development and investment.

Martin Langevin

The Priorities Panel Members' Report on Primary Care, 5.3.1, states:

"That the National Assembly provide mandatory training for elected officials, as well as candidates in provincial and municipal elections, on cross-sectional feminism..."

Recognizing the inappropriateness of giving mandatory training on a particular ideology (especially when that ideology lacks a clear and universally recognized definition) that enjoys no official status to the exclusion of others without allowing alternative mandatory training for those who do not adhere to it, I believe it would be more appropriate to allow all elected persons, as well as candidates in provincial and municipal elections, to take mandatory training on the International Covenant on Civil and Political Rights (a Covenant which Canada has already signed, which already enjoys official status in international law, and which establishes an international standard for civil and political rights) as an alternative according to their preference without discrimination.

Glossary

Centre intégré de santé et de services sociaux (CISSS) and Centre intégré universitaire de santé et de services sociaux (CIUSSS): CISSS and CIUSSS are provincial public organizations that include hospitals, local community service centers (CLSC), long-term care centers (CHSLD), child and youth protection centers (CPEJ), and rehabilitation centers (CR), including centres de réadaptation en déficience intellectuelle et en troubles envahissants du développement (CRDITED), which offer services for people with intellectual disabilities and developmental disorders.

Chronic disease: Chronic diseases are long-term illnesses that generally progress slowly. They can have multiple causes, and often impact quality of life and daily activities. They require long-term management by individuals, health care providers and communities.

Family Medicine Group: A family medicine group is a group of family physicians who work together and in close collaboration with other health and social service professionals.

Nurse Practitioners (NP-SP): NPs are nurses who have clinical experience with a clientele covered by one of the specialty classes, and who have received advanced graduate training in nursing and medical sciences. Specialized nurse practitioners are specialized nurses who practice on the front line of health care provision.

Primary care: Primary care is first-contact, accessible, continuous, comprehensive and coordinated, person-centred care, usually provided by a family physician or nurse practitioner. It involves first-contact accessibility, continuity, comprehensiveness, and coordination.

Primary health care: Primary health care is a comprehensive approach to organizing and strengthening national health care systems, bringing services closer to communities. It includes integrated health services, tackles broader social problems that affect health, and empowers individuals, families, and communities.

Social Determinants of Health: Social determinants of health are non-medical factors that influence health outcomes, including economic policies, social norms, social policies, and political systems. They significantly influence health inequalities within and between countries.

About OurCare

OurCare is a pan-Canadian conversation with everyday people about the future of primary care. It seeks to understand what residents want in a high quality, equitable primary care system and to capture their recommendations for change.

The project is led by Dr. Tara Kiran, a family doctor and renowned primary care researcher based in Toronto. She and the project team are working with Advisory Groups across the country to align with different provincial contexts. OurCare has three stages:

National Research Survey

The survey was online from September 20 to October 25, 2022. More than 9,200 Canadians completed the survey, sharing their perspectives and experiences. Vox Pop Labs co-designed and executed the survey.

Priorities Panels

Priorities Panels will be held in five regions: Nova Scotia, Quebec, Ontario, British Columbia and Manitoba. MASS LBP is co-designing and executing the panels with OurCare advisors and local delivery partners.

Community Roundtables

Two community roundtables will be hosted in each of the five regions, focusing on equity-deserving groups that we did not hear enough from during stages 1 and 2. MASS LBP is co-designing and executing the community roundtables with OurCare advisors and local community organizations.



OurCare Project Partners

OurCare is funded by:

Health Canada

Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances. Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Staples Canada – 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

Max Bell Foundation

Max Bell Foundation began making grants to Canadian charities in 1972. Today, the Foundation supports innovative projects that are designed to inform public policy change in four program areas: Education, Environment, Health & Wellness, and Civic Engagement & Democratic Institutions. The Foundation also delivers the Public Policy Training Institute, a professional development program designed to help participants more effectively engage in the public policy process, and PolicyForward, a future-oriented speaker series that brings thought leaders together to discuss the intersections of policy, technology, and innovation.

OurCare is based at:

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.

St. Michael's Hospital, Unity Health Toronto

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.

OurCare Supporters

Our Care is also supported by:

Department of Family & Community Medicine, University of Toronto

The University of Toronto's Department of Family & Community Medicine is the largest academic department in the world and home to the World Health Organization Collaborating Centre on Family Medicine and Primary Care.

St. Michael's Foundation

Established in 1992, St. Michael's Foundation mobilizes people, businesses and foundations to support St. Michael's Hospital's world-leading health teams in designing the best care – when, where and how patients need it. Funds support state-of-the-art facilities, equipment needs, and research and education initiatives. Because St. Michael's Foundation stops at nothing to deliver the care experience patients deserve.

OurCare is working with:

Each province is working with an advisory group of primary care leaders to provide support in guiding the project. The Quebec Advisory Group met on three occasions for short one-hour meetings between February 24 and August 28, 2023, to advise the project team on the choice of questions and speakers. Here are the members who contributed in Quebec:

Quebec Advisory Group

Chakib Setti, **Association québécoise des médecins du sport et de l'exercice (AQMSE)**

Alain Papineau, **Collège Québécois de Médecins de Famille**

Denis Roy, **Health and Welfare Commissioner (HWC)**

Eric Lavoie, **Regional Department of General Medicine (DRMG)**

Ariane Murray, **Regional Department of General Medicine (DRMG) Montreal**

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Philippe Lachance, Aurore Deligne, & Ginette Martel, **Ministry of Health and Social Services**

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Isabelle LeBlanc, **Department of Family Medicine, McGill University**

Kimberly Munro, **Department of Family Medicine, McGill University**

Maxine Dumas-Pilon, **Department of Family Medicine, McGill University**

Frantz-Daniel LaFortune, **Collège Québécois de Médecins de Famille**

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Marie-Dominique Beaulieu, **Department of Family and Emergency Medicine, University of Montréal**

Mylaine Breton, **Department of Social Science and Medicine, University of Sherbrooke**

Yves Couturier, **School of Social Work, University of Sherbrooke**

Catherine Hudon, **Department of Family Medicine and Emergency Medicine, University of Sherbrooke**

Stephanie Plante-Blanchette, **Ordre des infirmières et infirmiers du Québec (OIIQ)**

National Collaborating Organizations

Ako Anyaduba, **Black Physicians of Canada**

Rick Glazier, **Canadian Institute for Health Research**

John Feeley & Moira Teed, **Canadian Medical Association**

Christie Newton, **College of Family Physicians of Canada**

Benjamin Diepeveen, Kajan Ratneswaran, Susannah Taylor, Elizabeth Toller & Jocelyne Voisin, **Health Canada**

Bill Callery & Jennifer Major, **Healthcare Excellence Canada**

Melanie Osmack, **Indigenous Physicians Association of Canada**

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Amanda Condon, **University of Manitoba**

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Dana Cooper, **Nurse Practitioners' Association of Ontario**

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Isabelle Leblanc, **McGill University**

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Sarah Newbery, **Northern Ontario School of Medicine**
Scott Garrison, **University of Alberta**
Sophia Ikura, **Health Commons Solutions Lab, Sinai Health System**
Vanessa Wright, **Women's College Hospital**
Vivian R Ramsden, **University of Saskatchewan**

Patient Advisory Groups

Canadian Medical Association's Patient Voice Advisory Group
MAP Centre for Urban Health Solutions' Improving Primary Care Public Advisors Council

*OurCare is engaging with distinct Advisory Groups in each province where it is working.
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Panel Development and Facilitation

The Quebec Priorities Panel on Primary Care was designed and facilitated by MASS LBP.

Founded by Peter MacLeod in 2008, MASS 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.

To learn more about MASS LBP's work, please visit masslbp.com

Institut du Nouveau Monde

The Institut du Nouveau Monde (INM) supported MASS LBP as an expert in public consultation in Quebec. INM played a major role through consulting services throughout the process; in the design, organization, and facilitation of the Quebec Priorities Panel; and in recruiting and engaging members of the advisory committee. The INM, in collaboration with MASS LBP, was also responsible for recruiting and managing the needs of participants.

INM is an independent, non-partisan organization dedicated to increasing citizen participation in democratic life. INM's work encourages citizen participation and contributes to the development of civic skills, the strengthening of social ties, and the enhancement of democratic institutions. The INM team is driven by the conviction that citizen participation strengthens democracy.

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