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

A report written by members of the public

March 2023
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Chair’s Note

This report is a testament to the dedication and hard work of 35 Ontarians who volunteered their time and expertise to this critical conversation about the future of primary care in Ontario. Cumulatively, they invested some 1,300 hours in this process. The result? 23 significant recommendations that hold the potential to bring about transformative change.

The collaborative process undertaken by the panel also represents a constructive approach to finding common ground and making sense of complex issues like health reform. By bringing together diverse perspectives and experiences, the panel aims to foster an environment where meaningful dialogue can take place. This inclusive method not only enriches the quality of the recommendations but also sets a powerful example for future policy-making endeavors — concerning our health system and beyond.

The panel’s work provides a blueprint that governments to make the province’s primary care system more equitable, accessible and sustainable. By engaging citizens in such a meaningful way, the process empowers individuals to help shape public policy while also fostering a sense of shared responsibility. Far from being apathetic or self-interested, the panel’s work demonstrates the readiness of Ontarians to step up and step into critical debates.

This is why I would like to extend my gratitude to the 35 Ontarian volunteers who devoted their time and energy to this panel. Their contributions are timely call to action for policy-makers who we hope will hear and heed their advice. To our partners, guest speakers, funders and stakeholders, I also want to extend our thanks for your support and contributions to this process.

Sincerely,

Peter MacLeod
Chair, Primary Care Priorities Panel

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What Policy Makers Should Know

Primary care is in crisis. More than 6.5 million people in Canada don’t have a family doctor or nurse practitioner they can see regularly for care. And the situation is poised to get worse with fewer graduating medical students choosing family medicine as a career and many currently practising physicians thinking of leaving practice — retiring or working in other parts of the system.

Primary care is the front door to the health system and without it people are left on their own—struggling to care for new problems, manage existing ones, or access other parts of the system. They also don’t get the benefit of preventive care that would keep them healthy in the long run.

**We need to do something differently. But what?**

I’ve sat at many meetings with policy-makers, fellow clinicians, administrators and researchers to discuss ideas for reform. But all too often, these discussions stall. And usually there is a distinct group missing from the conversation — members of the public.

OurCare is bringing those voices of the public to the forefront so we can design a better system based on the values, needs and priorities of those it’s meant to serve.

This report summarizes the recommendations from 35 members of the public who live in Ontario—people from across the province who are at different life stages, come from different backgrounds and didn’t know each other before OurCare. These 35 panelists spent nearly 40 hours together learning about primary care from some of the top experts in the field and deliberating with each other to come to consensus on recommendations for a better system.

The values they articulate and the specific recommendations set out a bold vision for primary care—one that I hope we can act on together.
To start, the Ontario panelists reaffirmed the importance of primary care for all.

Equity is a foundational value and related to many of the other values they articulate—that primary care should be public and universal, accessible, patient-centred, and holistic, intersectional and culturally responsive. They feel strongly that every person in Ontario should get the care they need regardless of background, socio-economic status, location, or mental or physical capabilities.

They also emphasize the value of continuity and ongoing relationships in primary care and that high-quality primary care should also be data-enabled, evidence-based, accountable and transparent.

Their recommendations keep these values front and centre.

They recommend an expansion of medicare to include mental health, eye care, dental care and medications. They want to see better links between primary care clinics and community agencies to better address the social determinants of health. They propose more upstream investment in public health and primary care to help save money downstream in the long run.

They expressed immense frustration at not being able to access their own health records or those of family members they care for.

They recommend that the government legislate interoperability between all electronic medical record (EMR) systems with the goal of creating a patient portal that could be accessed through a person’s health card (or by other means for those without a health card).

They make several recommendations to address the crisis in the primary care workforce including increasing the number of family medicine residency spots, accelerating integration of international medical graduates, prioritizing recruitment and training of health professionals from equity-seeking communities and including a component of family medicine training for all specialists.

Perhaps the boldest recommendations relate to changing how the primary care system is organized. They want to see us move away from having solo family practitioners paid fee-for-service towards a future where all Ontarians have access to a team-based primary care home, expanding models like Family Health Teams, Community Health Centres, and Aboriginal Health Access Centres. The roll out of teams should prioritize underserved communities and walk-in clinics should be amalgamated into the team models.

In order to ensure every person in Ontario have a primary care home, they recommend automatic rostering similar
The OurCare Ontario panelists have told us what needs to be done. They had the courage, resolve, patience, and mutual respect to listen carefully to each other and key experts, compromise where needed, and agree on a shared vision for a better primary care system. Now it’s time for the rest of us to act.

Dr. Tara Kiran
OurCare Principal Investigator
Ontario Priorities Panel
At-a-Glance

The OurCare Ontario Priorities Panel brought together 35 people living in Ontario, randomly selected to roughly match the province’s demographics. They spent approximately 40 hours learning from experts and deliberating together before making recommendations on what a better primary care system should look like. OurCare will also be conducting Priorities Panels in Quebec, British Columbia, Nova Scotia and Manitoba in 2023. For more information, visit OurCare.ca/PrioritiesPanels.

Recommendation Highlights:

Interoperability
- Legislate and enforce data standards that allow interoperability between different electronic medical record systems
- Ensure patient access to their personal health data

Expansion of Coverage
- Expand OHIP coverage to mental health, vision, dental, and pharmacare
- Expand our understanding of primary care to include Indigenous modes of thinking and knowing
- Strengthen links between primary care practitioners and community agencies

Models of Care
- Expand team-based care to every resident of Ontario
- Connect stand alone walk-in clinics to team-based care organizations
- Implement province-wide automatic rostering system for patients that maintains an element of patient choice
- Develop a centralised digital referral platform for specialist care
- Invest a greater proportion of total healthcare funding in primary care

Members’ Values
Equity • Accountability
  • Continuity
  • Data-Enabled
  • Transparency • Public and Universa
  • Evidence-based
  • Sustainable • Accessible
  • Patient-Centred • Holistic, Intersectional, and Culturally Responsive

35 members
17 speakers
39 program hours
23 recommendations
Recommendation Highlights (cont’d):

**Accountability**
- Develop accountability measures for each of the values identified by the Panel. Monitor and assess compliance
- Hold Ontario accountable to the principles of the Canada Health Act
- Ensure community members are included in the governance of primary care organizations

**Recruitment and Medical Education**
- Increase the number of seats for primary care residencies
- Integrate newcomer practitioners and improve accreditation processes for immigrant primary care providers
- Examine and address the reasons fewer medical students are choosing to practice comprehensive family medicine

**Public Education**
- Educate the public on their rights, including their right to their medical records, by creating a “Health Rights 101” for all Ontarians.
- Educate the public on the value of primary care by developing an education campaign that outlines its contribution towards long-term health
Understanding the panel process

A Priorities Panel is a long-form deliberative process that typically involves 30 to 48 randomly selected residents. These residents are chosen using a process called a civic lottery, a random selection method that prioritizes fairness and wide representation. The individuals selected for a priorities panel come together to learn about, and then advise public authorities on, divisive and complex issues that typically involve trade-offs or compromises. The panel members’ objective is to reach a consensus on a series of recommendations that can be directed to government, professional associations, and society at large.

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.

Over 1,250 invitees volunteered for the Ontario Priorities Panel. These volunteers had completed the OurCare National Survey and indicated their interest in the panel by answering a few demographic questions in a separate questionnaire. Participants were selected through a stratified lottery process — better known as a civic lottery. This process ensured that members of the panel were fairly selected and broadly representative of Ontario’s demographics.

OurCare deliberately sought to overrepresent residents we know are underserved by the primary health care system: racialized, lower income, newcomer, and gender non-conforming residents, and those who live in rural, remote, or northern regions of the province. In short, the panel was composed in such a way as to deliver good demographic diversity and to ensure we heard from residents who are most disadvantaged by the current system.
Panel Snapshot

35 members

Gender:
17 - Women
16 - Men
1 - Non-binary person
1 - Non-disclosed

Age:
5 - 18–29 years old: 5
13 - 45–64 years old: 13
9 - 30–44 years old: 9
8 - 65+ years old: 8

Members who identify as Indigenous: 3

Health:
29 - Good, Very Good, or Excellent
6 - Fair or Poor

Members who have been in Canada less than 10 years: 5

Geography:
7 - East
8 - West
2 - North
18 - Greater Toronto-Hamilton Area

Members who identify as part of a racialized group: 15

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1 - Owing to personal and health-related circumstances, one member stepped away early in the process, and three members were unable to travel to Toronto for the final sessions.
2 - "Women" refers to cisgender and transgender women. "Men" refers to cisgender and transgender men.
The Members’ Report of the OurCare Ontario Priorities Panel on Primary Care
Who We Are and Why We Volunteered

Collectively, we are Ontario, and we care about primary care.

We are a diverse cross-section of residents from various regions of Ontario. The range of needs and experiences we represent reflect those of Ontarians at large.

We have varying levels of interaction with, and access to, the health care system.

We volunteered for this panel because we wanted to work with a group of diverse people to address the primary care needs, desires, and concerns of our whole province. We’re here because we care about our communities, and the generations still to come.

To continue to benefit from our system, we must all learn how best to support it by finding ways to participate in decision-making. It is our duty and responsibility to help steward the health care system. We volunteered to take on that responsibility and to set an example for others of what meaningful participation can look like. We are united in our belief in universal public health care as a unifying force for all Ontarians.

We wanted to examine how to improve health outcomes for the public by returning to the fundamental ideals of a universal, public system, while adapting to the emerging and evolving primary care needs of our communities.

We are here because we care about primary care.

What We See and What We Learned

When it comes to healthcare, there is much more that unites us than divides us. We have to give people the ability and opportunity to participate meaningfully, and to contribute to shaping our health care system. Participating on this panel showed us that people have passion and a wealth of creative ideas — that every individual has the ability to collaborate to help build an effective system. We think everyone would benefit by engaging in this type of process and that many would do so if they had the opportunity.

We understand that the issues related to health care are nuanced, complex, layered and fraught. We heard first-hand about the devastating impact of Covid on medical professionals and the health care system — a group of people and
a system that were already tremendously overburdened.

We heard how much primary care providers care about their work and their patients and how difficult it is for them to do their jobs in our current system. We learned about discontinuities in the system and how this causes actual harm.

We know that health and wellbeing begin with primary care and necessitate addressing the social determinants of health and the inequities that exist across multiple systems. Investing in robust primary healthcare protects and reduces stress on health care resources that should be used for acute or emergency care.

Change will be challenging, but our healthcare system cannot survive without it. The pandemic revealed cracks in the system that have been a long time in the making, and now we’re at a breaking point. Our learning and work together has made us optimistic that change can happen; our support for that change has resulted in this report.

We refuse to wait for another pandemic to make essential change happen.

The Challenges We Want Solved

Our primary care system is in crisis and on the verge of collapse. We have identified five major challenges that need to be addressed.

1. **Our primary care system is fragmented.** This results in a duplication of services in a time of scarcity, inefficiencies and long wait times, and unreasonable administrative burden for providers. Patients experience gaps in their care, and do not know what their rights are or what to expect: where to go when things go wrong, and how different parts of the system are supposed to work together.

2. **Our system is inequitable with significant disparities in access to and quality of care.** Marginalization, systemic bias and stigma result in differential outcomes that disadvantage those who are already vulnerable. Anti-oppressive, culturally responsive care is inconsistently applied or available, and not everyone experiences care that puts their needs and perspective at the centre. The system lacks accountability because we are
not monitoring performance or ensuring a consistent standard of high quality care meets the needs of diverse populations.

3. **We have obsolescent data systems in a digital world.** We are relying on outdated information technology and practices. Most of our information systems don’t communicate with each other, or with patients.

4. **We have a crisis in health human resources.** We are hemorrhaging medical professionals, including primary care providers. Burnout, onerous administrative burden, and the complexity of the work are pushing existing providers out of practice, and we are not planning for the next generation of primary healthcare providers.

5. **Primary care is not prioritized in health system planning.** The system is not prioritizing investment in public access, health promotion and preventative care despite knowing that primary care and preventing illness reduces healthcare costs, leads to improved outcomes for patients, and results in a more equitable system.
Our Values

**Equitable**
Equity in primary health care refers to the distribution of resources, efforts, and access so that every person living in Ontario, regardless of background, socio-economic status, location, or mental or physical capabilities can get the care they need. An equitable system is accessible by default, inclusive by design, and adapts to a range of needs and circumstances. Equity in primary health care ensures everyone can receive the care they need in a timely fashion, promotes dignity and respect for all patients, and empowers each person to be an active partner in their care decisions. Achieving equity in primary health care requires acknowledging privilege at both the systemic and individual levels, in order to create a fair and equitable system for all.

**Continuous**
Continuity in primary health care improves health outcomes for individuals by emphasizing consistent and ongoing care throughout their lives, regardless of age, health status, or location. Continuity of care is characterized by individuals having a relationship with a primary care team who knows and remembers them, and can provide informed care based on their medical history, their family and the context in which they live. Continuity requires that individuals own their medical records and have access to them at all times, and that these are shared across all levels of care a patient receives.

**Accountable**
Accountability in primary care refers to the responsibility of the system and providers to adhere to inclusive standards that reflect the needs of all stakeholders. Measures of accountability are co-designed with all stakeholders, including patients, and allow for adjustment and adaptation when standards are not met. The importance of accountability in primary care cannot be overstated, as it empowers patients to advocate for their care, rebuilds trust between citizens and health service providers, and ensures that patients receive quality care.

**Data-Enabled**
The benefit of a data-enabled health care system is to provide patients and providers with timely access to medical records, measure improvements in public health care over time, enable communities to
identify needs and gaps, and to proactively plan for better health outcomes for individuals and groups. A data-enabled system would allow patients to access and share their records with providers, and help providers to deliver appropriate care.

Accountability, transparency and trust are strengthened when data is collected and analyzed in an ethical and equitable manner, accurately representing diverse communities and perspectives.

**Transparent**
Transparency emphasizes open, honest communication and education among all stakeholders about all aspects of the healthcare system. This includes information about an individual’s health care file, how funding decisions are made, and the different types of care models available to patients. Transparent policies and regulations are publicly driven and developed, help individuals understand their rights, build confidence in the system, and promote equality and respect for all individuals. Transparency also addresses the inherent bias in data collection and methodology and helps to ensure that data is collected and used in a fair and equitable manner.

**Public and Universal**
Public and universal primary care means that comprehensive health care is provided to all people living in Ontario in a timely manner. Public and universal care prioritizes patient-centred care and emphasizes accountability, accessibility, and equity in the delivery of healthcare services. These services are free at the point of service. Public and universal also relates to the comprehensiveness of care covered by public insurance so that it includes all aspects of physical and mental health and well-being.

**Evidence-based**
Evidence-based primary care means that healthcare providers and systems are informed by data and up-to-date scientific evidence when making decisions and creating treatment plans. Evidence-based care empowers practitioners to make informed decisions and provide the best possible care. At a community level, incorporating data and evidence helps the system proactively plan for better care and respond more effectively to regional health crises.
Sustainable
Sustainability in primary care involves ensuring that the health care system is equipped to handle the changing needs and demands of the population. This involves not only financial structures but also a flexible approach that can adapt to new challenges and uncertainties. A sustainable healthcare system should be built to last and not be susceptible to changing government ideologies, so that its benefits may be enjoyed by future generations. Sustainability also means ensuring primary care practitioners experience job satisfaction and security, and that working in primary care is attractive to future graduates, new Canadians, and others seeking employment in the healthcare field.

Accessible
Accessibility in primary care recognizes and prioritizes the right of individuals to receive quality healthcare services without barriers or discrimination. This means creating a system that is equitable, inclusive by design, and responsive to the diverse needs of patients, regardless of their ability, background, location, or socio-economic status.

Patient-Centred
Patient-centred primary care recognizes the crucial role of patients as active and informed participants. This approach centres patients in the decision-making process, taking into account their unique needs, preferences, and goals, leading to a more personalized and effective plan of care. Empowering patients to be part of their own health journey can lead to improved outcomes, increased patient satisfaction, and reduced burden on the health care system. This approach views the physical, mental, and emotional well-being of the patient as interlinked components of overall health and wellness, and is crucial in promoting preventive care and reducing the need for reactive interventions.
Holistic, Intersectional, and Culturally Responsive

Holistic, intersectional, and culturally responsive primary care considers the whole person and aims to create a safe and supportive environment for patients and providers. This approach addresses the physical, mental, and social needs of patients and acknowledges the interconnections between cultural backgrounds and personal experiences that may impact their health. It is supported through mandatory, ongoing training for health care practitioners to develop competencies in deconstructing biases, improving active listening skills, and understanding their patients’ unique needs. This value emphasizes a team-based approach, including providers from diverse specialties, to address patients’ interconnected needs and equalize health outcomes for all. This approach focuses on promoting reciprocal social accountability and building relationships that lead to improved health outcomes for the entire community.
Our Recommendations

A. Public Education

In order to address public distrust and confusion, increase patient agency in primary health care, and encourage Ontarians to push for a better, more accountable system, we recommend:

1. Educating the public on their rights, including their right to their medical records by creating a “Health Rights 101” for all Ontarians.

2. Educating Ontarians on the value of primary care by developing an education campaign that outlines its contribution towards long-term health and a better quality of life.

3. Helping the public navigate the current system efficiently by creating a “Train the Trainer” campaign focused on grassroots level community engagement to ensure every Ontarian is reached — to be reviewed periodically for relevance.

B. Interoperability

In order to address patients’ lack of access to their own medical records, confusion over data privacy legislation, and the inability of health records to be communicated in a timely manner across the medical system, we urgently need to reduce harm to patients by legislating the interoperability of Electronic Medical Records (EMR) systems. This may include reviewing and amending existing legislation.

4. We recommend legislating that all EMR systems meet certain requirements including:
   a. Common data standard that allows interoperability;
   b. Patient portal for accessing and reviewing one’s own information;
   c. Push-style updates across all health records, so that providers have immediate access to any changes in a patient’s record;
   d. Ability to assign family members or next of kin access;
e. Ability to access files throughout the medical system, with different tiers of access for different providers (e.g. pharmacist or specialists get access to only medically pertinent information); and
f. Adherence to best practices in digital accessibility standards, as well as data privacy requirements that necessitate clear, plain language patient consent for any sharing of patient information beyond what is required by healthcare providers.

Your health card would be the primary — but not only — point of access to your health record.

5. We recommend establishing a body (e.g. Health Records Ontario) that oversees and ensures patients’ access to their own records. This body would have responsibility for:
   a. Improving data literacy among the public;
   b. Functioning as a patient ombudsperson, ensuring patients can access and navigate their own records;
   c. Facilitating practitioners and organizations to transition to new EMR systems; and
   d. Enacting proportionate penalties for breach of established EMR legislation, where necessary to protect the public good.

6. We recommend establishing a data governance body that focuses on data and technology, made up of independent subject matter experts and experts from other jurisdictions and organizations with well-established data frameworks.

This body will offer guidance on ethical use of data, including what data should be collected, who gets access, and conditions for data used in research. This body could also encourage publicly accountable research and research that is used to develop public health metrics at different scales.

This body will review data privacy standards periodically and suggest which providers get access to which tier of an individual’s medical records. They will also establish an approved list of EMR providers, updated as needed.
C. **Expansion of coverage**

7. In order to reduce long-term system costs and improve health outcomes, we recommend primary care coverage be comprehensive so as to include all aspects of a person’s health. This includes OHIP coverage of services such as mental health, vision, dental, and medications. This would ensure that an unmet health need, such as mental health, doesn’t jeopardize existing treatment or care plans.

8. In order to support the seamlessness of care, we recommend creating links between primary care and community agencies to improve access to non-medical resources for residents of Ontario. This may include housing, welfare, transportation and poverty supports, all of which directly impact a person’s ability to pursue long-term health goals.

9. In order to accommodate the needs of diverse populations, we recommend expanding our understanding of care and medicine to include Indigenous modes of thinking and knowing.

D. **Models of Care**

10. In order to alleviate pressure downstream (in emergency departments and other acute care settings), improve outcomes for patients, and increase equity, we recommend that the provincial government increase the proportion of funding it directs to the primary care system; it should invest more money upstream in primary care.

11. In order to reduce provider burnout and provide more access to comprehensive care, the Ontario public wants the primary care system to move away from solo providers towards models of team-based care, like Family Health Teams (FHTs), Community Health Centres (CHCs), and Aboriginal Health Access Centres (AHACs). The team-based model should be expanded to ensure all residents of Ontario have a Primary Care Home.
   a. The government should invest more in FHTs/CHCs/AHACs administrative and technological infrastructures, and in team-based practice where doctors work with other healthcare
providers like nurse practitioners, social workers, and pharmacists.

b. The rollout of CHCs should prioritize underserved geographies and communities.
c. The funding model for these FHTs/CHCs/AHACs should account for the population needs in the catchment area.
d. The government should invest in more mobile care options.
e. Independent walk-in clinics should be amalgamated into FHTs, CHCs or AHACs.

12. To ensure that every Ontarian has a primary care home, the government should move towards automatic rostering similar to the public school system. While health teams should be mandated to accept any patient from their catchment area, it is important to maintain an element of patient choice. Patients should be:
   a. Encouraged but not forced to change providers when they move to a new neighbourhood;
   b. Able to choose among multiple health team practices in their neighbourhood, when available;
   c. Able to opt out of or find another team, without penalty, to accommodate gender, language, and other social or cultural preferences; and
   d. Able to request a specific provider within a team.

13. In order to standardize the referral process, reduce administrative burden and reduce wait times for specialist care, we recommend developing a centralized digital referral platform that allows providers and primary care teams to see which specialists are accepting referrals. The platform would outline a specialist’s scope of practice and allow appointment bookings.

14. In order to increase access to primary care for Ontarians who don’t currently have access, we recommend prioritizing the expansion of comprehensive virtual care models to those with mobility challenges and to those in rural, remote, and Northern areas. The long-term goal, however, is to offer publicly-owned and accountable virtual care to all Ontarians.
a. These virtual care models could provide 24/7 access to an in-person visit with a nurse or community paramedic who are then able to virtually connect patients to a physician. These models should be connected to primary care teams and free at the point of service.

b. The government should continue to address the virtual divide with ongoing investments to ensure every Ontarian has access to affordable, reliable internet service.

c. In the short term, public institutions like libraries, community centres, or municipal buildings should offer internet access and private space for virtual care appointments.

E. Accountability

Public trust in medical care has never been lower. Current legislation meant to ensure accountability is ineffective and rarely enforced. Therefore, the following are our recommendations on accountability:

15. In order to ensure that accountability criteria are relevant and impactful, we recommend that the government establish a publicly-funded independent body, with representation from health care providers, those with lived experience, and subject matter experts, to measure outcomes for each of the values outlined in the OurCare report — assessed and enforced at a local level.

16. In order to ensure accountability is enforced, we recommend this independent body be authorized to assess compliance with the identified outcomes, through a fully-resourced primary care advocate office that will:
   a. Investigate individual reports of non-compliance;
   b. Determine effective disciplinary measures;
   c. Support individuals involved; and
   d. Compile data for research.

17. In order to ensure every Canadian receives an appropriate level of health care, we recommend that the federal government:
Hold the provinces accountable for the criteria and conditions laid out in the Canada Health Act; and

Close the loopholes that allow providers to charge fees for medically necessary services, in ways that are inconsistent with the Canada Health Act.

18. In order to clarify rights, expectations, and responsibilities of patients and healthcare providers, we recommend that a comprehensive and revitalized health care bill of rights be consolidated through:
   a. A review of existing legislation and provisions, and
   b. Feedback from public and patient experience.

19. In order to be accountable to communities they serve, we recommend that FHTs, CHCs, and other primary care organizations involve community members in determining the metrics to be used and the service to be provided in their communities.

F. Recruitment and medical education

20. In order to train practitioners with diverse lived experience who are prepared and supported to serve all communities, we recommend Ontario’s medical schools and the provincial government create awareness of and facilitate barrier-free pathways to primary care medical education, especially in equity-deserving communities. As part of reducing barriers, review admission requirements with an eye to equitable access.

21. In order to fill gaps of care and ensure primary care practitioners reflect the diversity of our society, we recommend medical schools and regulating bodies integrate newcomer practitioners and accelerate and improve processes to accredit immigrant primary care providers.

22. In order to increase the supply of primary care providers and renew enthusiasm among practising providers, medical schools and regulatory bodies need to examine and address the reasons that medical students
choose not to specialize in family medicine and/or do not opt to practise comprehensive family medicine, such as:

a. Offering centralized administrative support and technology infrastructure to family health teams and primary care providers to increase time available for focused delivery of primary care;

b. Showcasing and demonstrating the value of primary care to society’s well-being and better health outcomes; and

c. Examining other issues impacting these choices, such as the shortage of practitioners, and the burnout primary care providers are experiencing.

23. Primary care is at the core of quality patient-centred health care. It is essential that all medical practitioners appreciate the foundational nature of primary care and the added value it provides to the health care system. To support this, we encourage medical schools and regulatory bodies to consider how family medicine residency opportunities might be included as a part of all specialist training.

24. In order to increase system capacity long term and ensure primary care providers are linked to our current and future demographics, geographic needs, and populations, the government in partnership with medical schools must significantly increase the number of seats for primary care residents. They should review these requirements regularly and adjust to meet projected future needs. The methodology behind this process must be transparent. Specific attention should be paid to increasing residency placements in underserved communities and rural and remote locations.

25. In order to produce practitioners who have the flexibility and adaptive expertise to meet evolving needs and methods, medical schools and training hospitals should shift their approach to medical education to one that supports and promotes comprehensive and substantive lifelong learning, cultural safety training and a collaborative mindset.
OurCare Priorities Panel Program

The Ontario Priorities Panel, consisting of 35* members from across the province, met online three times beginning November 2022, and then over four days in Toronto in February. During their time together, panel members learned about primary care in Ontario and other jurisdictions; they heard from 17 subject matter experts in presentations or moderated discussions. The members also spent a significant amount of time in conversation with each other as they engaged in a series of facilitated conversations that culminated in the consensus recommendations put forward in this report.

Session 1: Saturday, November 26, 2022 Virtual

The first session oriented the panel members to the process, and to Ontario’s primary care system. It began with a welcome from the Panel Chair, Peter MacLeod and the Principal Investigator, Dr. Tara Kiran.

Peter talked about the panel’s mandate and task, and explained that deliberative processes like a priorities panel are different from a focus group or town hall in that everyone is asked to think about the broader public and to consider the interest of those they represent. Members then had the opportunity to meet one another in small breakout groups.

Peter then delivered a short presentation about Canada’s healthcare system, its history, and how it has evolved and continues to evolve. The Canada Health Act and Medicare were also discussed.

Dr. Elizabeth Muggah, Senior Clinical Advisor at Ontario Health, was the panel’s first guest speaker. She presented an overview of primary care in Ontario and shared some population health statistics. She described the four Cs of primary care.
first contact, comprehensiveness, coordination, and continuity — and made the case for how strong primary care systems benefit individuals and communities. Dr. Muggah also shared some population health statistics and described how health outcomes differ across groups, reflecting the circumstances or context in which people live. The presentation covered the evolution of primary care delivery in Ontario, touching on the different ways primary care is organized and funded in Ontario. Dr. Muggah also spoke about the current crisis in healthcare and how a stronger primary care system was part of the solution.

Members had the opportunity to ask questions of Dr. Muggah before heading into small group discussion about the values that should guide a renewed primary care system.

**Session 2: Saturday, December 10, 2022 Virtual**

The session began with a welcome and recap from Peter MacLeod who reminded members of their mandate and how a high-functioning primary care system leads to better patient outcomes, lower system costs and more equity.

Dr. Tara Kiran presented features from primary care systems in some OECD comparator countries (Finland, the United Kingdom, and the Netherlands) highlighting how these differ from the current delivery and structure of primary care in Ontario. She discussed various features of primary care systems such as practice and rostering models, funding and payment models, use of information systems and data sharing, after hours and urgent care, and accountability measures. After Q&A, members went into small groups to discuss the pros and cons of the different features, and to identify which features should be available to all Ontarians.

**Session 3: Saturday, January 21, 2023 Virtual**

Session 3 focused on access to care for equity-deserving groups. After the welcome and recap of the previous sessions, Peter introduced a video recorded by Dr. Andrew Pinto, Director of the Upstream Lab. Dr. Pinto defined equitable care as giving individuals what they need to be healthy, rather than providing the same level of care to everyone regardless of their needs.
He highlighted the importance of social determinants of health — contextual factors such as income, housing, and education — that significantly impact health outcomes. He also shared some ideas on how to increase equity in primary care, such as implementing a needs-based funding model and creating a network of primary care providers committed to tackling the social determinants of health.

Following Dr. Pinto’s video, Peter moderated a discussion with Dr. Jonathan Fitzsimon, Medical Lead of Renfrew County, Francis Garwe Chief Executive Officer at Carea Community Health Centre, and Dr. Sarah Newbery, Assistant Dean Physician Workforce Strategy at Northern Ontario School of Medicine University.

Each guest described some of the challenges they encountered in their work in rural, remote and northern areas of the province, and with racialized, urban populations. Each speaker also gave examples of interventions that could help improve access and lead to better health outcomes for these equity-deserving populations. These interventions included health care outreach programs, mobile clinics, and the use of technology to improve access to care. Overall, the discussion underscored how critical it is to address health inequities and ensure that people who experience social and economic disadvantages have access to the health care services they need.

After the Q&A, the OurCare Panel members spent time discussing how to ensure a focus on equity in a renewed primary care system.

This was the last of the virtual sessions, and the members adjourned looking forward to the Toronto meetings in February.

Session 4: Thursday, February 9, 2023 Toronto

The Toronto sessions kicked off on Thursday evening with a presentation followed by dinner. The Panel Chair, Peter MacLeod, welcomed everyone to Toronto and kicked off the in-person sessions.

Dr. Tara Kiran presented findings from OurCare’s National Survey. She provided an overview of the survey, including its purpose and structure. The survey gathered insights from
Canadians about their experiences with primary care, and their preferences and priorities for the future of primary care. The survey was available online from September 20 to October 25 2022, and disseminated through multiple channels: by Vox Pop Labs and their proprietary panel, and through an open link circulated to OurCare collaborators and partners, amplified through a social media campaign, and earned media.

Dr. Kiran’s presentation described who responded to the survey (over 9,200 completed responses) its methodology and some of its limitations. Key findings include the startling figure that more than 6.5 million adults in Canada do not have regular access to primary care. People in Ontario were more likely to have a regular family doctor or nurse practitioner (86%) than people in some other regions. Among those who did not have a doctor 17% were not looking for one. Other key findings included a preference (88%) for care to be offered close to home, and overwhelming endorsement (97%) that every person in Canada have a relationship with a primary care provider. When asked what mattered most, a greater proportion of respondents (65%) felt it was very important that their provider know them as a person, and consider all the factors that affect their health. The full results of the survey are available to the public at data.ourcare.ca.

Dr. Kiran then took questions from the members about the survey and the first evening session ended with a preview of what members could expect over the next three days.

**Session 5: Friday, February 10, 2023 Toronto**

On February 10, the Toronto Sessions included a presentation about Indigenous models of care from Dr. Janet Smylie, a short presentation from Dr. Jane Philpott, and a discussion about the role of virtual care and corporations in primary care.

Dr. Janet Smylie, Research Chair in Advancing Generative Health Services for Indigenous Populations in Canada at St. Michael’s Hospital joined the members before lunch, and introduced them to Indigenous models of care and worldviews. She emphasized that Indigenous peoples have distinct cultures, languages, and experiences of health and
wellness that must be recognized and respected in primary care reform. She discussed the importance of recognizing the colonial history of healthcare delivery in Canada and the ongoing health disparities faced by Indigenous peoples, including higher rates of chronic diseases, mental health challenges, and substance use disorders. Dr. Smylie also described principles that guide Indigenous models of care — cultural safety, self-determination, and community-based care — and called for greater integration of Indigenous ways of knowing and healing into mainstream primary care.

In the afternoon, members heard from Dr. Jane Philpott, former Member of Parliament and Minister of Health. Dr. Philpott is now Dean of the Faculty of Health Sciences, Director of the School of Medicine at Queen’s University. She joined the members over Zoom. She spoke about partnerships that Queen’s University is pursuing to both increase access to primary care for people in Kingston, and to increase access to medical school training for Indigenous students in Northern Ontario. Following a short Q&A with Dr. Philpott, members resumed their conversations before breaking for the evening.

Members re-convened at 6pm for dinner followed by a moderated discussion about the role of virtual care and corporations. Peter introduced each guest speaker and gave them each a few minutes to share their perspectives on the promise, the challenges and the path forward for virtual care in Ontario, as well as the role of private, for-profit platforms in the delivery of virtual care.

The speakers — Dr. Sheryl Spithoff, research scientist at Women’s College Research Institute, Dr. Brett Belchetz, Co-Founder and CEO, Maple, and Dr. Ewan Affleck from College of Physicians & Surgeons of Alberta — each brought distinct perspectives on the issues. Dr. Belchetz argued that for-profit companies like Maple could provide efficient and innovative care delivery models that fill gaps in the current system, while Dr. Spithoff raised concerns about the potential for harms of for-profit driven care. Dr. Affleck spoke of structural and systemic issues that impede data sharing between healthcare providers and with patients themselves, and the real-world harms this poses for patients. A lively Q&A with the OurCare members wrapped up the evening and the day.

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Session 6: Saturday, February 11, 2023 Toronto

The members began their third day in discussion with each other about potential solutions that would address issues with the current primary care system. Before breaking for lunch, Peter moderated a discussion with four guests who each spoke about their visions for a better primary care system. Dr. Dominik Nowak, Assistant Professor at University of Toronto, highlighted the importance of teamwork in providing quality healthcare, patient-centred care. Dr. Kamila Premji, Assistant Professor at University of Ottawa discussed the trade-offs involved in leveraging virtual care to improve access to patients in remote areas. She emphasized that while virtual care can be helpful, it’s essential to be mindful of the need for continuity and in-person care where necessary. Dr. Mekalai Kumanan, President of the Ontario College of Family Physicians suggested that the primary care sector’s value is not fully leveraged because providers are working in isolation from each other, and she also highlighted the importance of expanding team-based care to address the human resources crisis and ensure care for all residents in Canada. Dr. Robert Bell, former Deputy Minister of Health and Long-Term Care, felt the public needed to push politicians to hold the health system accountable using measures that meaningfully describe and monitor high-quality care. He also advocated for expanding the definition of primary care to include mental health and other features.

The evening session featured an Ask Me Anything segment, moderated by Chair Peter MacLeod, with guest Dr. Danielle Martin, Professor and Chair of the Department of Family and Community Medicine at the University of Toronto. Peter encouraged members to test some of their recommendations with Dr. Martin, and he opened up the conversation by asking her for her top recommendations for primary care reform. She described investments in team-based models with human and data infrastructure, below market rent for primary care practices in high-rent urban areas, and better access to data for patients and providers as key system reforms that would deliver better care for more people.
Session 7  
Sunday, February 12, 202,  
Toronto

On February 12, the final day of the Toronto sessions, members spent the morning finalizing their recommendations and drafting sections of their report. At 11:30am, 20 health sector leaders joined the group to listen to the members read out their work.

Dr. Tim Rutledge, CEO of Unity Health Toronto welcomed the guests and the panel to the hospital, and thanked the members for their time. Fifteen members then approached the podium to read sections of the report. The Honourable Elizabeth Dowdeswell, Ontario’s Lieutenant Governor, delivered recorded remarks to the members thanking them for their time and commitment to furthering democratic practice through their work on the panel. Dr. Matt Anderson, CEO of Ontario Health, then delivered closing remarks, thanking the members for their time and effort. Dr. Anderson commented on the salience and richness of the members’ recommendations, particularly those related to patient rostering, data and technology, and the consideration of equity that ran throughout. He assured them that there was alignment between what he’d heard and conversations underway between the province and sector.

Following remarks from panel members to the invited guests, and from the guests to the panel members, Dr. Anderson and Dr. Kiran distributed Certificates of Public Service to each panel member, acknowledging and documenting their contribution to the conversation about the future of primary care in Ontario.
Meet the members

MOHAMMAD ABU-RSHAID

Hi! My name is Mohammad and I am a fourth-year forensic psychology student at Laurier, and I work in an HR unit. I really enjoy working with people and solving people’s problems. I am an immigrant from the Middle East who moved to Canada in 2011 and have lived in the Waterloo region for the majority of that time.

I live with one sophisticated cat and an awesome partner. I like to volunteer in relevant community organizations: I sit on the Students’ Union Board of Directors and was elected to a regional Board Advisory Committee for a credit union. I hope to work as a policy analyst in the government sector. I wanted to join this Panel because primary care physicians have turned my life around, and I wouldn’t be here without them.

GEORGE BABU

I am a father of two young kids, a tech entrepreneur, and an avid runner, cyclist, and snowboarder. I recently became a pilot, and am building experience so I can volunteer with Hope Air, a charity that provides medical flights for folks in remote regions of Ontario.

I started my career working for Mayor McCallion at Mississauga City Hall, joined BlackBerry in the late ’90s as an engineer, and worked for the venture group at the Ontario Municipal Employees Retirement System (OMERS) Pension Fund. I co-founded two tech companies (one in the software space and one in robotics) and a venture fund that invested in a number of digital health startups. I am currently starting a new company working at the intersection of tech and climate change.
DAVID BIAGIONI

I was born in Melbourne, Australia, and my family migrated to Canada in 1968 as I approached my 18th birthday and my probable draft into the Australian military for service in Vietnam. Tertiary education followed in Toronto and I completed my academic studies with a carpentry apprenticeship. My various lives have been bicycle mechanic, woodworker, filmmaker, and holographer. In 1992, I moved back to Australia and worked as a carpenter until my return to Canada in 2015. My reason for volunteering for the OurCare panel is that I believe strongly that universal healthcare is important to the foundation of a civilized society. I am now a retired, recovering carpenter, happy to once again be in Canada, where I will remain having realized that weather isn't everything.

PAUL CUMMINGS

Hello! My name is Paul Cummings and I am from the beautiful village of Victoria Harbour, Ontario. We are part of a larger township called Tay and we have four such villages or towns within the township. We are surrounded by beautiful Georgian Bay, and on foot, I can be at the waterfront within seven minutes. In the winter, our village population drops to about 500, while in the summer months, it can grow to over 1,000. I have lived here for 12 years and love it!!!

I volunteered because I feel our primary health care system is in serious trouble and I would like to be part of the solution. This panel, I believe, will play a fundamental role in recommending ways to improve the system, from the bottom (those of us that receive care) to the top (Provincial and Local Health Networks, Provincial and Federal governments, and all of the associations vested in seeing our final recommendations who are capable of making useful and necessary changes for improvement).

Fun facts... Although I am Indigenous and do have status, unfortunately, my sense of direction is horrible. I recently went for what should have been a short walk in the woods following a trail, then several trails broke off from the one — bottom line, I got lost in the forest for five hours. I finally found a road, had no idea where I was, and finally had to ask someone passing by. I was 10 minutes from home and would have known that had I just walked up a small hill and finally realized the street I was on. Filthy, covered in cobwebs and tired, I finally made it home!

CAROLYN CURRAN

I grew up in Sault Ste. Marie and have lived most of my life in New York City. For 50 years, I led organizations and educational programs as a non-profit manager in community arts both locally and nationally. One of my favourite jobs was running the performing arts centre in St. Croix in the US Virgin Islands and being involved in Caribbean culture. In the ’90s, I developed the chronic illness Myalgic Encephalomyelitis (ME) that kept me bedridden for three years — I jokingly call this my Rip Van Winkle period. I proactively sought traditional and alternative medical treatments which enabled me to regain about 80% of my normal function. This experience ignited my passion for health care delivery and policy. I decided to return to Toronto in 2017 to live closer to my extended family, finding the health care system a challenge that I’d like to learn more about and contribute ideas for improvement.
ROBERTA DELLA PICCA

I gratefully contribute to various organizations that make our communities more vibrant. A number of these focus on community health and wellness awareness, using expressive/community-engaged arts and various forms of Indigenous storytelling, Ancestral knowledge, and ceremonies — extremely powerful methods of outreach. These are outstanding ways of “broaching” subjects sensitive in nature, such as systemic and intergenerational trauma, suicide, depression, sexual abuse, addictions, domestic violence, HIV/AIDS, hepatitis C, etc.

I am volunteering for the Panel because, for the past 50 years, I have been passionate about health care and healing in my community, county, and province.

An interesting fact about myself is that I have had the honour and pleasure of having participated in the community-focused creation of the first (in Canada) Outdoor Monument — a Pebble Mosaic — to commemorate survivors of gender-based violence.

RENATA DEREJE-BRAGA

My name is Renata, my pronouns are she/her. I live in Toronto. I am a recently retired Environmental Instrument Field Technician, a job that took me to many very remote and very beautiful places all over Canada. I miss some aspects of my job but I am enjoying retirement completely. I have three grown daughters who live nearby and a deranged cat that lives with me. I don’t remember initially signing up for this but when I was approached by the OurCare team, I was intrigued and keen to participate because I have many opinions about primary care in Ontario and considerable experience within the system.

KEVIN DONALDSON

I am a PhD candidate in Political Science at York University. I have fibromyalgia, MDD, and autism. I love discussing the nuance of policy and debating how society organizes and manages its resources. My research focuses on central banking and the Covid pandemic in Canada, and I currently teach Gender Studies. I believe firmly in the need for socially/government/democratically owned agencies which are held accountable for managing healthcare, and would like to see a shift away from the processes of marketization/privatization which were so popular in the ‘90s.

I am also a huge fan of board games and tabletop role-playing games and have spent many hours facilitating collective storytelling.

JANNE DONER

I emigrated to Toronto from Scotland when I was three years old. I have lived in a number of communities in Ontario but Collingwood has been my home for over 40 years. I’m retired now from the banking and financial sector and my latter few years running a rural post office.

I have one son who has been living in California since last February. Since I no longer have pets of my own, I enjoy dog walking and pet-sitting for friends and neighbours. I am the cat nanny too when several of my friends go away.

I enjoy gardening and watching birds at my feeders, and I belong to a thriving Collingwood Cinema Club. In milder weather, I ride my bike or walk many of the beautiful trails along Georgian Bay and I do a bit of snowshoeing and cross-country
My name is Kelsy (she/her) and I am a mom and neuroscience PhD candidate living on a farm near Cambridge, Ontario. I volunteered for this panel because healthcare is an issue that is very important to me. I believe that access to affordable healthcare is a human right, and I am troubled by the trajectory of healthcare policy in Ontario. As a scientist, I want to see evidence-based policies set in place that can do the most good for the most people, and I am frustrated by the ways in which politics hinders public health policy. When I’m not on my soapbox, I enjoy horseback riding, hiking with my dog, and living-room dance parties with my three-year-old.

KELSY ERVIN

On a brighter note, I value lifelong learning and enjoy music, dance classes, and identifying edible and medicinal plants in my area. Food motivated, I love finding a local bakery, ice cream shop, and café / tea shop wherever I am. Currently unable to work, I volunteer a little bit at a local women’s shelter. I hope to find work in the near future where I can use and further develop data analysis skills. Longer term, my goal is to train to work with data in a meaningful area, perhaps in the field of healthcare information.

TARA DWIVEDI

I am Tara (she/her) from central Ottawa. Born in India, Ottawa is where I was raised & have lived ever since. I volunteered because I’m concerned about the current and future state of healthcare in Canada. Access to appropriate health care is fundamental to individual, community, and societal well-being. I hope to learn more about what led to the current crises and to contribute to solutions for positive systemic change without compromising the values of universal public healthcare.

I come into this as a neurodivergent, 40-something-year-old woman and mother of an adult daughter. My lived experience includes lifelong challenges with mental illnesses and invisible disabilities, usually existing at some level of poverty. At the same time, I’m aware of the privileges I have relative to many others. All this naturally informs my perspective, but I only bring my individual voice to the table and can’t claim to represent anything bigger. I’ve experienced good and bad, benefits and harms in the healthcare system over my life. Finding good primary care close to home over 10 years ago has been so helpful. But having this shouldn’t be a matter of luck for anyone! For me, the concept of healthcare can’t ignore the bigger context, aka the social determinants of health.

Rob Fleury

Having worked in various design firms, in construction management, and as a managing partner of a small architecture firm, I decided to become an entrepreneur and open my own company. I now operate HP Home Design which is a residential design firm in Sudbury, Ontario.

Growing up in Innisfil, Ontario, and later living in several cities across the province, I currently live in the small town of Hanmer, north of Sudbury. I am happily married with two kids, an 11-year-old girl and 9-year-old boy. I enjoy camping with my family, fishing, playing video games, and training in jiu-jitsu.

MADELYN GOLD

I'm a multiracial (Russian Jewish, Caribbean, and French) 56-year-old female with dreadlocks, adopted by an all-white Jewish family. Working in a community organization for over seven years, I've seen the stigmatization, marginalization, and anti-oppressive attitudes towards folks who use drugs. Some healthcare providers are not harm reduction friendly and treat patients unfairly or, worse, not at all. I'm hoping my input will provide advocacy for a harm reduction framework. I'm not smart, I'm emotionally intelligent.

MATTHEW GORMAN

I was born and grew up in Richmond Hill, just north of Toronto in York Region. I now call Whitby in Durham Region home, where I live with my wife and three Labrador Retrievers. I work as a product manager for a large human capital management company, where I design and build applications relating to data and analytics. I volunteered for this panel because I believe the delivery of primary care is vital to the overall success of our health system. In my free time, I like to game, read, paddle, and camp.
LEE HERALD

My name is Lee, and I use they/them pronouns. I live in Toronto. I’m a child and youth care practitioner and currently run an after-school program in the East York neighbourhood of Toronto. I like cake, collecting books, and geography quizzes. I chose to participate in this project because 2SLBTQ+ folx are rarely represented in research that is not specifically about our community. While I cannot and should not speak for the entire community, I believe that my insights and comments are valuable.

MWENYEMKUU HUSSUN

My name is Mwenyemkuu Hussun. I am 58 years old. Born and raised in Kenya, I studied tourism in Kenya. I arrived in Canada in 2000 as a refugee. I could not work in the area of my training as Kenya and Canada have different tourism products. I became sick in 2009 and started developing seizures, so essentially I am living with a disability. It’s for this reason I am volunteering — any decisions made regarding delivery of health care will have a direct impact on me.

HUGUETTE JEAN-FRANÇOIS

I’m an accessibility evangelist and a project manager with many years of experience in IT. As well as solid field experience in project management in the federal government, non-profit, international, and private sectors, I have extensive experience designing accessible teaching materials and training in both project management and computer-related skills. I have a very good knowledge of accessibility.

I applied to participate in this healthcare consultation as the front end of the baby boomers. I am 76 and as a result have experienced healthcare as a child in Hamilton when our doctor always visited us at home when we were sick. Fast forward to the present time experiencing a whirlwind of personal doctors for my family’s care as retirements and career changes had us go through five doctors in five years for my family’s care!

We had to deal with the loss of my mom and mother-in-law in the past 10 years, exposing us to incredible difficulties in health care to assist them in the last stage of their lives!

I have been retired 16 years and am experiencing the usual health complications of age. I tend to talk too much and repeat stories endlessly. I love the beaches of the world with my wife, three adult children, and seven grandchildren.

I worked as a factory labourer, steel worker, social worker, engineering sales manager, employment counsellor, psychology professor, counselling specialist, international consultant, and I am also an active member of the American Psychologists Association. Never held one job longer than 7 years!
EDITH LAW

A Canadian-born retiree of Chinese and Irish patronage, I represented my school as an international exchange student in Ecuador. The following year, I married and returned to Ecuador where I resided for 20 years. I learned the Spanish language and participated in cultural activities. I taught English as a Second Language at an all-girl Catholic school and tutored international executives to polish their English/Spanish language skills. In 1987, I returned to Canada and worked as a legal assistant. In 1990, I moved to Toronto to work in international trade law. These days, I enjoy plotting the genealogy of my family and listening to the laughter of my great-grandchildren.

When my daughter began university this year, I realized that I am able to devote my time to other things that I feel are important to me and that affect all of us. OurCare is a great opportunity for me to be involved in an issue which I am passionate about. I believe that universal and accessible healthcare is extremely important. I am also becoming more involved in my community. I have contacted my councillor and will be attending council meetings and getting involved on issues that matter to my corner of the world. After OurCare, I will be exploring getting involved with other issues that impact our society, such as the environment and education. (My daughter is doing her undergraduate degree in education and child studies which will lead to a B.Ed degree.)

Thank you to the OurCare team for allowing me to be involved with this panel.

PETER MAZZUCCO

I was born in Etobicoke in the west end of Toronto to immigrant parents, and I spent the first 20 years of my life there before moving to various Toronto neighbourhoods. Currently, I live outside of Toronto in the town of Ajax.

My education consisted of the “school of hard knocks,” which eventually led me to study at the University of Toronto Scarborough Campus. I was accepted into the Arts Administration Degree Program where I chose a double major in economics and theatre.

After university, I worked in the corporate world in the fields of logistics and supply chain management in the live music and event industry, before moving into business-to-business sales. During that time, I ventured into live theatre, TV, and film performance, which I still do on occasion.

JOSHUA MCCOY

I’m Joshua McCoy, I grew up on a dairy farm near the city of Ottawa, and have been a longtime resident of Renfrew County. It is, I think, apparent that we have some challenges facing our healthcare system: a number of which I have experienced firsthand on my own account. I have been for most of my life an impassioned advocate for Canadian history, through community theatre as a teenager, historical reenactment as an adult, and music throughout.

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FIONA MCMURRAN

I’m a retired university lecturer living in Welland, where we moved 38 years ago. I live with my husband, who has a mental illness, and our adult autistic daughter, who also suffers from epilepsy. Our healthcare needs have generally been well served, although the loss of specialist doctors over the years has necessitated trips to Hamilton for my daughter’s epilepsy care. In 2006, I became involved with local citizens’ groups fighting to keep Niagara’s small local hospitals open in the face of government consolidation of services into large regional hospitals. This determined effort provoked an investigation by then-Ontario Ombudsman, André Morin, published in 2010 as a report entitled “The LHIN Spin.” Nothing has been resolved since then and I continue to be an advocate for the kind of healthcare envisioned by Tommy Douglas, still only partially achieved through the Canada Health Act.

ELISCIA MCPHEE

My career has mainly been in adult learning and has varied in terms of industry. So far I have been really fortunate to be working at a place where inclusion, belonging, and diversity are embraced, which makes it a great place to work. I grew up out west but have made Toronto my home and enjoy this city and province — it has a lot to offer for my love of dance, food, and connection to people. The opportunity to participate in the OurCare Panel has been another great experience where I had the opportunity to hear, learn, and share perspectives and models of healthcare being executed all over Ontario. My hope is that we continue to look at new ways to ensure all Ontarians have access to all needed healthcare.

SHIREEN NOBLE

I’m privileged to work, play, and live on the unceded ancestral territory of the Algonquin Anishinabeg (colonially: Ottawa).

I’m Shireen (she/her), and I’ve been interested in social justice and equity for a long time. My studies in public health and my work in youth sexual health and relationship education have provided me the opportunity to learn more about these issues, and I’m excited to continue learning with you folks!

I am an avid baker (I make thousands of cookies at the holidays!), quilter, swimmer, and dog lover (ask me about my dog, Macy!)

TANYA ORMEROD

I grew up in Hamilton and briefly lived in Toronto while going to school. I left university and returned home to help care for my mother when she got sick. I eventually decided to finish my education, graduating from the biotechnology program at Mohawk College in 2020. I spent the last two years exploring Ontario, experiencing the diverse communities and ecosystems this province has to offer, while always on the lookout for the best fish and chips. I volunteered for this panel because I have a lot of care and concern for the state of our healthcare system, and hope for a future primary care system that is more accessible, equitable, properly funded, and encourages proactive health care instead of reactive sick care.
Peter Reid

I grew up in a rural fishing community called Hopeall on the island of Newfoundland. I first moved to Ontario in 2008, stayed for a year, and relocated to Labrador in 2009. I returned to Ontario in 2011 where I have lived since — first in Toronto and now in Markham.

I am a social worker by education and have practised in a variety of settings including long-term care, the HIV/AIDS sector, child protection, healthcare and now education.

I enjoy listening to music of various genres, singing, and playing the piano. I’m amazed by nature — in particular, forests and waterfalls. I enjoy trying new cuisines and embracing the food diversity available in the GTA.

I felt compelled to volunteer for the panel as I am concerned about the future of healthcare for myself and fellow Ontarians in terms of quality, access, and sustainability.

G. Stegelmann

I am an artist living in rural Southwestern Ontario. I grew up in the country and, after more than two decades in cities, decided to return. I volunteered for the OurCare panel because I wanted to know more about how our health care system works. I value expert guidance, but also feel public policy is often frustratingly opaque and arm’s length. With real understanding, citizens can better contribute to the creation of smart social infrastructure; I’m excited for opportunities to learn and participate. My educational background is in liberal arts/English Literature. My partner is an elementary school teacher.

Miroslav “Mike” Suta

Hi, my name is Miroslav (Mike) Suta, and I was named after my father. Both of my parents are from the Czech Republic. I was born in Trenton, Ontario. I’m bilingual in English and Spanish. I learned Spanish when I lived in the Dominican Republic (seven years) and Cali, Colombia (one year).

I am retired, having previously worked as a heavy truck mechanic and in sales. I live in London and enjoy my time with my partner Debbie and our two pups, a Golden Retriever and a Goldador.

In 2010, I worked in Whistler, B.C., on the hydrogen hybrid bus project that was part of the Winter Olympics event.

I am looking forward to being on this panel and to hopefully improve our health care system, which I see as being under attack.

Duane Stanley

I live in Brantford, Ontario. I am employed full-time as a quality manager with Slacan Industries Inc. I volunteered for this panel as my wife is a health care worker, and we have been living through the pandemic with the same fears as everyone else for our family. I am a father of two girls and enjoy playing golf, video games, and board/card games with my family. I have had the need of our medical system for a few health issues in the past. I look forward to having some input and say with the direction our government is going with the future of our health care system.
REBECCA SZETO

My name is Rebecca. I am from Windsor, Ontario. I enjoy cycling in my spare time. I volunteered for this panel because I care for relatives who use our healthcare system regularly, and I want to see the ways primary care will grow for the future in a sustainable and economical way.

RAJESH TALPADE

My wife and I immigrated to Canada from India 22 years ago. Fortunately, it was not the first time we had been to North America, so not much of a shock. We decided to continue our journey a little further north, moving up to Thunder Bay, Ontario, for university after a few years. My wife and I love the Northwest for its geographic openness and the ability to engage in a lot more outdoor activities than both of us had growing up. We have one teenage daughter who is presently in her second year of university at Lakehead.

My university degree in nursing and subsequent work as a front-line nurse has allowed me the opportunity to see the gaps and challenges faced by Canadians in accessing equitable healthcare. As a practising nurse practitioner, I chose to be associated with this focus group as I feel a broader provincial representation would allow for a more detailed report to bring about positive and tangible change in our healthcare system.

JOSEPHINE VINCENT

I have an atypical path. I started with med school, then switched to arts, and finally graduated in business and marketing. I’m a very curious person — if you don’t see me geeking out on random subjects, you will most likely find me exploring the city, trying new restaurants, or baking. My love for food even led me to a degree in French pastry. After extremely varying work experiences, I finally settled for consulting, where I help different clients improve their processes and strategies. I strongly believe that access to health care is a right, not a privilege. Joining the panel is an opportunity to make a small contribution in improving our system.
**AMELIA ZINDROS**

Hello, my name is Amelia. I am a mom to seven children, ranging in age from 25 to 2. I started off doing this very young!

I am a very social person who loves interacting with people. As a young mom, I wanted to be a nurse and had even started to pursue it, but an education counsellor told me I was too old and didn’t have the grades, so I gave up. My passion is still there, though, so every time someone in my circle takes a trip to the hospital, they call me. That’s as good as it gets. I do, however, now appreciate that I’ve raised children and that in itself is a very important job. I love to create change, however small, and because of my story I have seen all sorts of situations. I love adventures, vintage anything, and laughing.

I am looking to take a PSW (personal support worker) course to try and build back up what I see as a broken system.

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**ALAN WOLSKE**

Hi! I’m Al Wolske from the GTA area where I have lived all my life raising five children here. So far, I also have five grandchildren and we are all in the GTA.

I spent many years working in the building supply and contracting industry, from working in the retail side at my own hardware store in Whitby to building schools for the York Region District School Board.

In 2003, I was diagnosed with Guillain–Barré syndrome, which has left me with limited use of my legs and a forced early retirement.

Most of the last 20 odd years, I have been teaching myself how to use my legs to walk and volunteering with local groups that I can help with DIY home projects. I can’t do the physical parts anymore but I can still teach and help with the details that make a project come together.

I appreciate the chance to join this panel. I hope to get a better understanding of Ontario’s medical system and to share my experiences and frustrations with it.
Guest Speakers

Seventeen experts generously gave their time and shared their knowledge with the Ontario Priorities Panel on Primary Care. The Panel extends its sincerest thanks to each of them.

Dr. Ewan Affleck is a graduate of the McGill School of Medicine, and Dalhousie University where he studied history, Ewan Affleck worked and lived in northern Canada for 30 years. He is currently serving as the Senior Medical Advisor – Health informatics, College of Physicians & Surgeons of Alberta, and is the past Chief Medical Information Officer of the Northwest Territories. He is currently a member of the Expert Advisory Group of the pan-Canadian Health Data Strategy, and is the chair of the Alberta Virtual Care Working Group. In 2013, he was appointed to the Order of Canada for his contribution to northern health care, and currently sits on the Order of Canada Advisory Committee.

Matthew Anderson is an experienced healthcare leader, team-builder and advocate for positive change. Before joining Ontario Health, Matthew was President and CEO of Lakeridge Health. At Ontario Health, Matthew is leading one of the largest mergers in healthcare history bringing together 22 agencies. Matthew began his career in data analytics and IT. He became Vice President and Chief Information Officer at University Health Network in 2000. In 2008, he was named CEO of the Toronto Central Local Health Integration Network and in 2010, became CEO of William Osler Health System.

Dr. Brett Belchetz is the CEO and Co-founder of Maple (getmaple.ca), Canada's leading virtual care platform connecting patients and healthcare providers like doctors and therapists for online medical visits in minutes. He's also an emergency room physician in Toronto, and a Senior Fellow at the Fraser Institute. In addition, Brett's passion for healthcare communication and policy have led him to work as an on-air medical expert for large television stations in Canada, including CTV and Global News, as well as a contributor to outlets such as the National Post. Previously, Brett worked as a management consultant with McKinsey & Company.

Dr. Robert Bell is an experienced orthopedic surgeon, clinician–scientist, and educator. He completed his medical education and internship at McGill University in 1976, and started his career as a general practitioner and emergency physician. Throughout his career, Bell has held several leadership positions, including Chief Operating Officer at Princess Margaret Hospital and CEO of the University Health Network. Bell was also appointed Deputy Minister of Health and Long-Term Care, where he supported the passage of several important acts and initiatives, such as the Patient’s First Act and OHIP+ Children and Youth Pharmacare.

Dr. Jonathan Fitzsimon graduated from Sheffield University Medical School (U.K.) in 2007. From 2009–2010 he worked as a volunteer physician in Oruro, Bolivia, before returning to the U.K. to complete the General Practice Specialty Training Program. He moved to Ontario in 2014 and started a family practice in Renfrew County. In 2020, Dr. Fitzsimon was appointed as Medical Lead of the Renfrew County Virtual Triage and Assessment Centre, Medical Lead of the Petawawa Integrated Virtual Care program and Assistant Professor at the University of Ottawa, Department of Family Medicine. He was previously Chief of Medicine at Arnprior Regional Health. Dr. Fitzsimon was the recipient of the OMA’s 2021 Glenn Sawyer Service Award.

Francis Garwe is the Chief Executive Officer at Carea Community Health Centre and one of the provincial Health Systems Strategic Advisors for the Ontario Health Advisory Council. He is on the Ontario Tech University Board of Governors (OnTechU). Francis is the current provincial chair for the Black Health Committee (BHC), overseeing the development and design of the Black Health Strategy to address policy gaps and health services disparities across Ontario. He is also an Adjunct Faculty at Schulich Executive Education Centre in the Healthcare Management program, York University. He serves as one of the University of Toronto’s MD Admissions File Reviewers and Interviewer for their MD program.

Dr. Tara Kiran is the Fidani Chair in Improvement and Innovation at the University of Toronto and Vice-Chair of Quality and Innovation at the Department of Family and Community Medicine. She practises family medicine at the St. Michael’s Hospital where she is also a Scientist in the MAP Centre for Urban Health Solutions. Dr. Kiran completed her family medicine residency at McMaster University in 2004 and spent her first couple of years in practice as a locum in indigenous communities in northern Ontario and in Community Health Centres in urban Toronto. She practised at the Regent Park Community Health Centre from 2006 to 2010 before joining St. Michael’s in 2011.

Dr. Mekalai Kumanan, President of the Ontario College of Family Physicians, attended Dalhousie University for her undergraduate studies, Master of Health Administration degree and medical school before completing her residency at the University of Western Ontario. Since 2008, Dr. Kumanan has served the community of Cambridge, Ontario as a family physician with Two Rivers Family Health Team.
Dr. Kumanan is the current Chief of Family and Community Medicine at the Cambridge Memorial Hospital. She has been an active leader with the Cambridge North Dumfries OHT, first as a Governance Co-Design Group Member and as a member of both the Primary Care Collaborative and the Steering Committee.

Dr. Danielle Martin is Professor and Chair of the Department of Family and Community Medicine (DFCM), University of Toronto. Dr. Martin is an active family physician and a respected leader in Canadian medicine. In 2006, her first year in practice, she helped launch Canadian Doctors for Medicare, the voice for Canadian physicians who believe in “a high quality, equitable, sustainable health system built on the best available evidence as the highest expression of Canadians caring for one another”.

Dr. Liz Muggah is the Senior Clinical Advisor for Primary Care at Ontario Health. She is an Associate Professor in the Department of Family Medicine and her research and educational contributions have focused on enhancing primary care quality and equity and advancing physician wellness. She completed her medical degree at McMaster University, her Family Medicine residency at the University of Ottawa and received her Master of Public Health at Harvard University.

Dr. Sarah Newbery is a rural generalist family physician in practice in the community of Marathon for 24 years. She is currently Associate Dean Physician Workforce Strategy for the Northern Ontario School of Medicine and is Chief of the Staff at North of Superior Health Care Group. She is a past president of the Ontario College of Family Physicians.

Dr. Dominik Nowak is a family doctor and health leader. In addition to his clinical practice, Dr. Nowak’s mission is to build teamwork across the health system. Dr. Nowak trained at McMaster University and went on to finish a Master of Health Administration at the Institute of Health Policy, Management and Evaluation at the University of Toronto. Dr. Nowak is currently a faculty member at the Dalhousie School of Public Health and the Department of Family and Community Medicine at the University of Toronto, and he is President elect 2023 – 2024 of the Ontario Medical Association. He is a recipient of the Toronto, and he is President elect 2023 - 2024 of the Family and Community Medicine at the University of Toronto. Dr. Martin is an active family physician and a respected leader in Canadian medicine. In 2006, her first year in practice, she helped launch Canadian Doctors for Medicare, the voice for Canadian physicians who believe in “a high quality, equitable, sustainable health system built on the best available evidence as the highest expression of Canadians caring for one another”.

Dr. Andrew Pinto is the founder and director of the Upstream Lab, a research team focused on tackling social determinants, population health management and using data to enable proactive care. He is a Public Health and Preventive Medicine specialist and family physician at St. Michael's Hospital in downtown Toronto, and an Associate Professor at the University of Toronto. He is also the Associate Director for Clinical Research at the University of Toronto Practice–Based Research Network (UTOPIAN) and the lead for artificial intelligence in a new initiative at the Department of Family and Community Medicine on how new technologies will change healthcare.

Dr. Kamila Premji is a family physician practising comprehensive family medicine in a community-based clinic in Ottawa. She is an Assistant Professor with the University of Ottawa, where she holds the Junior Clinical Research Chair in Family Medicine. She is also completing a PhD in Family Medicine through Western University. Inspired by her practice, she is passionate about research examining primary care access, care continuity, and health system integration.

Dr. Janet Smylie is a respected international leader in the field of Indigenous health. One of Canada's first Métis physicians, her 25 year career has been focused on addressing inequities in the health of Indigenous peoples in Canada by bridging gaps in health knowledge and practice. She has completed a Master of Public Health at John Hopkins University. She currently holds a Tier 1 Canada Research Chair in Advancing Generative Health Services for Indigenous Populations in Canada at St. Michael's Hospital where she directs the Well Living House Action Research Centre for Indigenous Infant, Child and Family Health and Wellbeing and is an active staff physician. She continues part time clinical work as a consulting family physician at Seventh Generation Midwives Toronto.

Dr. Sheryl Spithoff is a family doctor, an Assistant professor at the University of Toronto, and a Scientist at Women's College Research Institute. Her research aims to improve the health and wellbeing of people who use substances. She also conducts research at the intersection of health systems, new technologies and commercial interests.
Appendix

Minority Reports

Members were encouraged to consider all points of view during the panel process. Discussions were lively and respectful throughout the proceedings, 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.

Fiona McMurrnan

Since the task was to address primary care in the province of Ontario, we did not discuss jurisdictional issues that involve the federal government, although it administers the Canada Health Act and funds a large percentage of provincial and territorial healthcare. Theoretically, the federal government has both the authority and the means to ensure that recommendations such as ours on primary care are actually implemented and then adhered to by the provincial governments and territories.

Yet the federal government has shown considerable reluctance to enforce the Canada Health Act. In our recommendations, we have called for an expansion of public health insurance coverage to areas such as mental health. The Trudeau government is moving forward with dental care, but its stated intention to introduce pharmacare seems to have stalled.

Changing the healthcare system to prioritize primary care will require considerable cooperation between both levels of government. Health insurance is provincial, and provinces and territories have the authority to list and delist services. Canadians should be able to count on receiving good healthcare no matter what province or territory they live in, but the fact is that different governments, both federal and provincial/territorial, have different priorities and opinions on public healthcare. How can we create a health system that Canadians can count on to withstand the vicissitudes of changing political landscapes?

G. Stegelmann

While crafting our report, all discussion around health included references to mental health. We felt compelled to mention it every time, specifically, explicitly. We knew failure to do so in our recommendations could mean neglecting its inclusion. But why do we have to distinguish between physical and mental health? CBT and talk therapy builds neural networks, much as physiotherapy builds muscle. Psychiatric drugs address chemical deficits/surfeits in the same way insulin or anticoagulants do. Yet, we still perceive "physical" ailments as substantial, while "mental" health is framed as something abstract—problems that may or may not be related to temperament, willpower, or character. No one says "We don't do physio in this family." or "I don't believe in insulin." No one decides to "work through" a broken bone on their own. So why, in treating our (very corporeal) brains, do we still waver in seeking or delivering care?

Language is culture. The words we choose encode shared beliefs, signal priorities and, eventually, inform policy. When language draws a line between body and mind, they become separate entities. When the umbrella term of “health” refers to everything but mental health, it perpetuates a hierarchy of perceived need and fuels stigma. Governing bodies ultimately feel justified classifying many (and especially early) mental health interventions as elective, omitting crucial services and providers from primary care coverage.

But nothing exists in a vacuum. Our recommendations in this report address providers and patients, accessibility, education, technology, etc., because the only way to repair any structure is to consider the whole. So it is with our bodies, each system contingent and acting on the rest. Breaking healthcare into discrete pockets of need creates policy blindspots and undermines our ability to address issues — individually and societally—in meaningful, sustainable ways. In defining a comprehensive, universal healthcare system, we must accept our bodies as undivided. Right down to the language we use (or don't) we need to embed the conviction that our minds are as quantifiably valuable as muscle and bone. As a result we will know, when policy-makers say “health,” it means all health.
Capitation model: In a capitated payment system, doctors receive a set fee for each person on their roster, rather than per service provided. The fee may be adjusted based on age, sex, or other factors. Ontario’s capitation model adjusts fees for age and sex but is considering accounting for complexity.

Chronic disease: Chronic diseases are long-lasting illnesses with generally slow progression. They can have multiple causes, share common risk factors, and often impact quality of life and daily activities, requiring long-term management from individuals, healthcare providers, and communities.

Community Health Centres (CHCs): CHCs are non-profit organizations offering primary health and health promotion programs for individuals, families, and communities. Governed by a community-elected board, CHCs serve specific geographic or community groups. They provide various services directly to populations, with clinical care being only a small part of their operations. Physicians at CHCs receive a fixed salary.

Family Health Teams (FHTs): FHTs are primary healthcare organizations comprising nurse practitioners, registered nurses, social workers, dietitians, and other professionals working with family physicians to provide care for their community. FHTs ensure local health and community needs are met. Physicians are self-employed in this model.

Fee-for-service Model (FFS): In traditional FFS, self-employed physicians are compensated for each service rendered, as outlined in provincial schedules of benefits. Physicians don’t need to work in groups or formally roster patients under this model.

Local Health Integration Networks (LHINs): LHINs were health authorities responsible for regional administration of public healthcare services in Ontario from 2007 to 2019. In 2019, the Government of Ontario amalgamated various agencies into Ontario Health, and the 14 LHINs were brought under its six regions.

Ontario Health Teams (OHTs): OHTs are groups of providers and organizations responsible for delivering coordinated care to a defined population. They bring together different sectors within a community to better coordinate services.

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

Primary Health Care: Primary health care is a whole-of-society approach to organize and strengthen national health systems, bringing services closer to communities. It includes integrated health services, addressing broader social issues affecting health, and empowering individuals, families, and communities.

Salary model: Physicians receive a regular wage based on units of time, often accompanied by a contract outlining practice responsibilities and privileges.

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

Social Stigma: Social stigma is the disapproval or discrimination against individuals or groups based on perceived characteristics that distinguish them from others in society.

Systemic Bias: Systemic bias, or institutional bias, is the inherent tendency of a process to support particular outcomes, referring to human systems like institutions that lead to inequitable outcomes, whether intentionally or unintentionally.
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

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.

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Patient Advisory Groups
Canadian Medical Association’s Patient Voice Advisory Group
MAP Centre for Urban Health Solutions’ Improving Primary Care Public Advisors Council
Panel development and facilitation

The Ontario 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

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