Public experiences and perspectives of primary care in Canada: results from a cross-sectional survey

Tara Kiran MD MSc, Maryam Daneshvarfard MScCH, Ri Wang MMath, Alexander Beyer PhD, Jasmin Kay MA, Mylaine Breton PhD, Danielle Brown-Shreves MBBS MSGH, Amanda Condon MD, Michael E. Green MD MPH, Lindsay Hedden PhD, Alan Katz MBChB MSc, Maggie Keresteci MA, Neb Kovacina MDCM MHsc, M. Ruth Lavergne PhD, Aisha Lofters MD PhD, Danielle Martin MD MPP, Goldis Mitra MD, Sarah Newbery MD, Katherine Stringer MBChB MCISc(FM), Peter MacLeod MA, Clifton van der Linden PhD

Abstract

Background: Through medicare, residents in Canada are entitled to medically necessary physician services without paying out of pocket, but still many people struggle to access primary care. We conducted a survey to explore people's experience with and priorities for primary care.

Methods: We conducted an online, bilingual survey of adults in Canada in fall 2022. We distributed an anonymous link through diverse channels and a closed link to 122 053 people via a national public opinion firm. We weighted completed responses to mirror Canada's population and adjusted for sociodemographic characteristics using regression models.

Results: We analyzed 9279 completed surveys (5.9% response rate via closed link). More than one-fifth of respondents (21.8%) reported having no primary care clinician, and among those who did, 34.5% reported getting a same or next-day appointment for urgent issues. Of respondents, 89.4% expressed comfort seeing another team member if their doctor recommended it, but only 35.9%, 9.5%, and 12.4% reported that their practice had a nurse, social worker, or pharmacist, respectively. The primary care attribute that mattered most was having a clinician who "knows me as a person and considers all the factors that affect my health."

After we adjusted for respondent characteristics, people in Quebec, the Atlantic region, and British Columbia had lower odds of reporting a primary care clinician than people in Ontario (adjusted odds ratio 0.30, 0.33, and 0.39, respectively; *p* < 0.001). We also observed large provincial variations in timely access, interprofessional care, and walk-in clinic use.

Interpretation: More than 1 in 5 respondents did not have access to primary care, with large variation by province. Reforms should strive to expand access to relationship-based, longitudinal care in a team setting.

Research over decades has shown that health systems with strong primary care have better health outcomes, better equity in outcomes, and lower costs.[1,2] Yet, worldwide, countries have struggled with reforming their primary care systems to meet the demands of a growing, aging population[3] in the context of widening socioeconomic inequities,[4] increasing medical complexity,[5] a rising prevalence of mental health and addictions,[6] and a proliferation of medical evidence and guidelines for care.[7] Even before the COVID-19 pandemic, people in Canada reported some of the worst access to primary care among high-income countries. Many people do not have access to regular primary care and, among those who do, many struggle to

access timely care for urgent concerns or after hours.[8,9] The situation in Canada is notable, given its systems of health insurance that covers physician and hospital visits for all permanent residents.

Existing research suggests that the COVID-19 pandemic spurred early retirements[10] and that many practising family physicians are contemplating closing their practices in the coming years.[11] Reported rates of burnout are high.[12] The situation is compounded by a backlog of care, high administrative burden, and ineffectual digital systems.[13] The landscape is also complicated by the increasing reliance on urgent care and walk-in services that prioritize timely episodic care over continuity.[14,15]

Reforms should be co-designed with patients and the public, but little information is available on their experiences with primary care after the start of the COVID-19 pandemic and what matters most to them.[16,17] We aimed to capture a snapshot of people's experiences with primary care in Canada, what matters most to them, and how these differ by sociodemographic characteristics.

Methods

Context and setting
More than 39 million people live in Canada,[18] on colonized Indigenous lands. The population is diverse,[19] with almost one-quarter being first-generation immigrants.[20] French is the first language of 23% of the population.[21] About 18% live in rural areas.[22] Through medicare — the collection of federal, provincial, and territorial single-payer insurance plans — all permanent residents have health coverage for physician and hospital services without copayments or deductibles.[23] Our study represents the first phase of OurCare, an 18-month, pan-Canadian initiative to co-create a vision for better primary care with patients and the public. In addition to this work, OurCare is conducting a series of 5 provincial priority panels with demographically representative members of the public (phase 2), as well as 10 community roundtables with members of equity-deserving communities (phase 3).

Study design, population, and participant recruitment
Between Sept. 20 and Oct. 25, 2022, we conducted a national, cross-sectional survey, available online in English and French and open to people in Canada aged 18 years and older. We used the Checklist for Reporting Results of Internet E-Surveys[24] for reporting.

The OurCare survey was hosted on Qualtrics[25] and distributed in 2 ways. We widely distributed an open link and promoted it through our partner networks, earned media (e.g., news reports and op-eds), social media posts, social media ads, and via the project website (Appendix 1, E-Exhibit 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.231372/tab-related-content). In addition, a national public opinion firm, Vox Pop Labs, sent a closed, unique link to 122 053 people from its proprietary panel, following up with 2 personalized reminders. To help attain a representative sample of respondents, we adjusted probabilities to favour people who were underrepresented in the panel receiving an email invitation. The selection of individuals on this list of invitations itself was not intended to be representative of the population in Canada as a whole, but the resulting completed surveys were. Accordingly, we oversampled populations that Vox Pop Labs knew were less likely to participate in its surveys, and undersampled groups with higher likelihood of participation. The Durham Community Health Centre promoted the survey to people in high-priority neighbourhoods and had client-facing staff directly support survey completion, offering a $10 gift card for completion. No other incentives were offered for participation. See Appendix 1, E-Exhibit 2, for details on survey design, content, consent, and privacy.

Statistical correction and inclusion criteria
So that our sample would approximate the population of Canada, we gave each response a weight, produced by iterative proportional fitting based on marginal distributions derived from the Statistics Canada Census 2021. We weighted the responses using age, gender, education, income, language, and region, and iteratively adjusted the weighting until the survey sample distribution aligned with the broader population (Appendix 1, E-Exhibit 3). We analyzed completed surveys only (Appendix 1, E-Exhibit 4 details the exclusion criteria). Completeness meant respondents reached the end of the survey, no aberrations existed (e.g., no variation in responses within question blocks), and we obtained usable answers for all demographic questions required for weighting. We also excluded surveys that terminated in less than 550 seconds (3.3 percentile for total survey duration).

Data analysis
We calculated demographic characteristics of respondents before and after weighting; all further analysis was done using weighted data. We assessed differences in survey responses across demographic variables for the following key outcomes: who has a family doctor or nurse practitioner (primary care clinician); timeliness of care; access to interprofessional care; attending a walk-in clinic in the last 12 months; and the attributes of care that people thought were most important (Appendix 1, E-Exhibit 5). For each outcome, we calculated crude responses for each sociodemographic stratum and the odds ratio (OR) before and after adjustment for all sociodemographic variables. We conducted statistical analysis using R version 4.0.0.

Ethics approval
We obtained ethics approval from the Unity Health Toronto Research Ethics Board (Approval 22-143, 01.09.2022).

Results

A closed, unique link was distributed to 122 053 people from Vox Pop Labs' proprietary panel. Of these, 7213 people responded (5.9% response rate). In total, 14 018 people responded to the survey and we analyzed data for 9279 (66.2%) completed surveys (Appendix 1, E-Exhibit 4); 6747 (72.7%) were completed in English and 2532 (27.3%) in French. Unweighted demographic characteristics of respondents are presented in Appendix 1, E-Exhibit 6. After weighting, the effective sample size was 3199; 50.9% of respondents were women, 49.6% were aged 50 years or older, 39.3% were from Ontario, 24.5% had a university degree, 86.2% reported their race as White, 87.8% were Canadian born, and 41.9% reported their health as very good or excellent (Table 1).

Having a regular primary care clinician
Overall, 77.0% of survey respondents reported having a primary care clinician they could see regularly for care. There were large variations by region, and differences persisted after adjustment for respondent characteristics (Ontario 87.2% [reference] v. Atlantic region 69.1% [adjusted OR 0.33, 95% confidence interval (CI) 0.22–0.50]; Quebec 69.0% [adjusted OR 0.30, 95% CI 0.19–0.45]; and

Table 1 (part 1 of 2): Demographic characteristics of all respondents included in the analysis after weighting, stratified by method of participant recruitment

Characteristic	% of respondents overall	% responded via anonymous link	% responded via proprietary panel
Gender			
Woman	50.9	75.1	42.2
Man	48.9	24.8	57.6
Diverse	0.3	0.1	0.3
Age, yr			
18–29	16.8	8.3	19.9
30–39	17.6	12.9	19.3
40–49	16.0	13.2	16.9
50–64	25.4	29.3	24.1
≥ 65	24.2	36.3	19.8
Region			
Ontario	39.3	66.8	29.5
Atlantic*	6.6	6.1	6.7
Prairies†	7.0	4.5	7.9
Quebec	23.2	4.1	30.1
British Columbia	23.9	18.6	25.8
Education			
University degree	24.5	48.7	15.8
College or trade school	33.5	22.5	37.5
High school or below	42.0	28.8	46.8
Income, $‡			
< 30 000	10.1	9.2	10.4
30 000–49 999	15.4	12.7	16.4
50 000–69 999	15.4	11.8	16.8
70 000–89 999	13.7	16.4	12.7
90 000–149 999	26.2	28.3	25.4
≥ 150 000	19.2	21.5	18.4
Language			
English	75.7	95.8	68.4
French	22.1	1.8	29.5
Other	2.2	2.4	2.1
Residence			
Urban	40.6	43.2	39.7
Suburban	35.9	34.2	36.5
Rural	22.6	21.6	23.0
Do not know	0.9	1.0	0.8

Table 1 (part 2 of 2): Demographic characteristics of all respondents included in the analysis after weighting, stratified by method of participant recruitment

Characteristic	% of respondents overall	% responded via anonymous link	% responded via proprietary panel
Race			
White	86.2	86.5	86.1
Racialized	12.2	12.4	12.1
Do not know or prefer not to answer	1.6	1.1	1.7
Canadian born			
Yes	87.8	84.5	89.0
No	12.2	15.5	11.0
Self-reported health			
Very good or excellent	41.9	43.1	41.5
Good	36.8	34.4	37.7
Poor or fair	21.3	22.5	20.9
Any disabilities			
No	77.0	74.1	78.0
Yes	21.1	23.7	20.2
Do not know or prefer not to answer	2.0	2.3	1.8
Any health benefits			
Yes	82.2	82.2	82.2
No	17.9	17.9	17.8

*Atlantic region: New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island.
†Prairies region: Alberta, Manitoba, Saskatchewan.
‡Individual income.

British Columbia 72.3% [adjusted OR 0.39, 95% CI 0.30–0.51]). Men, young adults, those reporting poor or fair health, and those without a disability also had significantly lower odds of reporting they had a primary care clinician (Figure 1).

Access to care for those with a regular primary care clinician

Among respondents who had a family doctor or nurse practitioner, 94.6% reported that the clinician they saw regularly was a family doctor and 5.4% said it was a nurse practitioner. Of these, 51.2% said they could always or usually get care from another primary care clinician from the same practice when their clinician was away; 35.9% said someone in the practice was available to help with urgent issues before 0900, after 1700, or on the weekend. In addition, 38.6% said they tried to book an appointment in the last 12 months with their primary care clinician or someone in their practice because they urgently needed care;

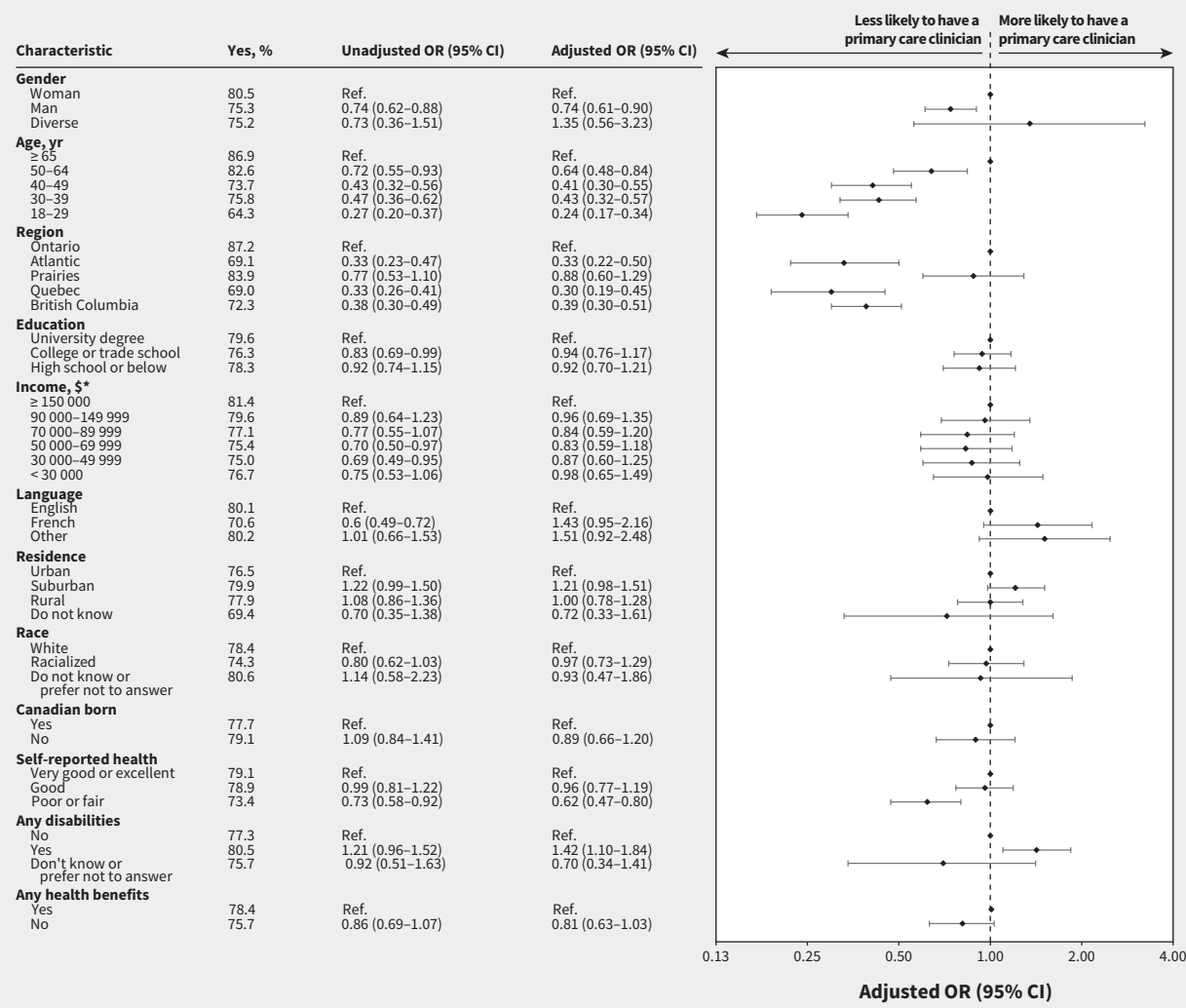| Characteristic	Yes, %	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Gender			
Woman	80.5	Ref.	Ref.
Man	75.3	0.74 (0.62–0.88)	0.74 (0.61–0.90)
Diverse	75.2	0.73 (0.36–1.51)	1.35 (0.56–3.23)
Age, yr			
≥ 65	86.9	Ref.	Ref.
50–64	82.6	0.72 (0.55–0.93)	0.64 (0.48–0.84)
40–49	73.7	0.43 (0.32–0.56)	0.41 (0.30–0.55)
30–39	75.8	0.47 (0.36–0.62)	0.43 (0.32–0.57)
18–29	64.3	0.27 (0.20–0.37)	0.24 (0.17–0.34)
Region			
Ontario	87.2	Ref.	Ref.
Atlantic	69.1	0.33 (0.23–0.47)	0.33 (0.22–0.50)
Prairies	83.9	0.77 (0.53–1.10)	0.88 (0.60–1.29)
Quebec	69.0	0.33 (0.26–0.41)	0.30 (0.19–0.45)
British Columbia	72.3	0.38 (0.30–0.49)	0.39 (0.30–0.51)
Education			
University degree	79.6	Ref.	Ref.
College or trade school	76.3	0.83 (0.69–0.99)	0.94 (0.76–1.17)
High school or below	78.3	0.92 (0.74–1.15)	0.92 (0.70–1.21)
Income, $*			
≥ 150 000	81.4	Ref.	Ref.
90 000–149 999	79.6	0.89 (0.64–1.23)	0.96 (0.69–1.35)
70 000–89 999	77.1	0.77 (0.55–1.07)	0.84 (0.59–1.20)
50 000–69 999	75.4	0.70 (0.50–0.97)	0.83 (0.59–1.18)
30 000–49 999	75.0	0.69 (0.49–0.95)	0.87 (0.60–1.25)
< 30 000	76.7	0.75 (0.53–1.06)	0.98 (0.65–1.49)
Language			
English	80.1	Ref.	Ref.
French	70.6	0.6 (0.49–0.72)	1.43 (0.95–2.16)
Other	80.2	1.01 (0.66–1.53)	1.51 (0.92–2.48)
Residence			
Urban	76.5	Ref.	Ref.
Suburban	79.9	1.22 (0.99–1.50)	1.21 (0.98–1.51)
Rural	77.9	1.08 (0.86–1.36)	1.00 (0.78–1.28)
Do not know	69.4	0.70 (0.35–1.38)	0.72 (0.33–1.61)
Race			
White	78.4	Ref.	Ref.
Racialized	74.3	0.80 (0.62–1.03)	0.97 (0.73–1.29)
Do not know or prefer not to answer	80.6	1.14 (0.58–2.23)	0.93 (0.47–1.86)
Canadian born			
Yes	77.7	Ref.	Ref.
No	79.1	1.09 (0.84–1.41)	0.89 (0.66–1.20)
Self-reported health			
Very good or excellent	79.1	Ref.	Ref.
Good	78.9	0.99 (0.81–1.22)	0.96 (0.77–1.19)
Poor or fair	73.4	0.73 (0.58–0.92)	0.62 (0.47–0.80)
Any disabilities			
No	77.3	Ref.	Ref.
Yes	80.5	1.21 (0.96–1.52)	1.42 (1.10–1.84)
Don't know or prefer not to answer	75.7	0.92 (0.51–1.63)	0.70 (0.34–1.41)
Any health benefits			
Yes	78.4	Ref.	Ref.
No	75.7	0.86 (0.69–1.07)	0.81 (0.63–1.03)

Figure 1: Percentage of respondents who said they had a family doctor or nurse practitioner they could see regularly for care, and corresponding odds ratio (OR) by sociodemographic characteristic. C-statistic (AUC) = 0.693. *Individual income. Note: CI = confidence interval, Ref. = reference category.

when these respondents were asked how long it was between when they first tried to book the appointment until they had the appointment, 34.5% responded the same or next day, 18.5% 2–3 days, 10.8% 4–6 days, 13.9% 1–2 weeks, 13.6% more than 2 weeks, and 7.5% were never able to get an appointment.

In respondents reporting that they were able to see a primary care clinician on the same or next day for an urgent problem, we saw large differences by region, education, and self-reported health (Figure 2).

Interprofessional care

Those with a primary care clinician reported having the following health professionals working in their practice (multiple selections allowed): 68.9% family doctor, 35.9% nurse, 30.9% nurse practitioner, 12.8% dietitian, 12.4% pharmacist, 9.5% social worker, and 9.4% other health professionals. Overall, 60.8% reported having 1 or more of a nurse, social worker, pharmacist,

dietitian, or Indigenous cultural service provider; however, odds were significantly lower for those living outside Ontario or Quebec, even after adjustment. Before but not after adjustment, odds were also lower for men, people without a university degree and those who were racialized (Figure 3). Notably, 89.4% of respondents were comfortable or very comfortable with getting support from another member of the team, if their primary care clinician recommended it.

Walk-in clinics

Among all respondents, 47.3% reported visiting a walk-in clinic 1 or more times in the last 12 months. After adjustment, women, young adults, those living in BC, people not living in rural areas, and those reporting poor or fair health had higher odds of visiting a walk-in clinic (Figure 4). The biggest difference in walk-in clinic use was between those who did and those who did not have a primary care clinician ("yes" 41.2% [reference] v. "no"
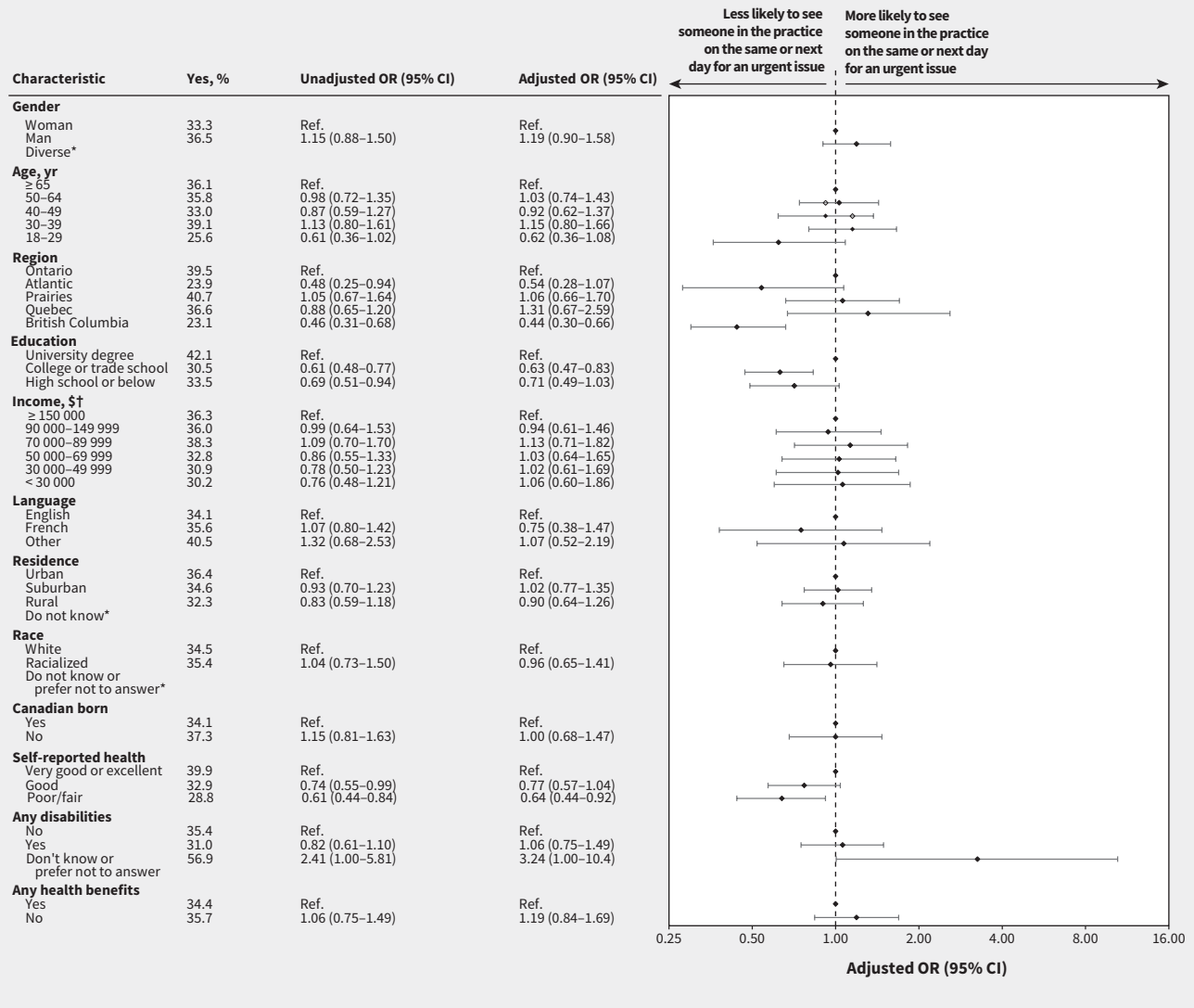
Research

Characteristic	Yes, %	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Gender			
Woman	33.3	Ref.	Ref.
Man	36.5	1.15 (0.88–1.50)	1.19 (0.90–1.58)
Diverse*			
Age, yr			
≥ 65	36.1	Ref.	Ref.
50–64	35.8	0.98 (0.72–1.35)	1.03 (0.74–1.43)
40–49	33.0	0.87 (0.59–1.27)	0.92 (0.62–1.37)
30–39	39.1	1.13 (0.80–1.61)	1.15 (0.80–1.66)
18–29	25.6	0.61 (0.36–1.02)	0.62 (0.36–1.08)
Region			
Ontario	39.5	Ref.	Ref.
Atlantic	23.9	0.48 (0.25–0.94)	0.54 (0.28–1.07)
Prairies	40.7	1.05 (0.67–1.64)	1.06 (0.66–1.70)
Quebec	36.6	0.88 (0.65–1.20)	1.31 (0.67–2.59)
British Columbia	23.1	0.46 (0.31–0.68)	0.44 (0.30–0.66)
Education			
University degree	42.1	Ref.	Ref.
College or trade school	30.5	0.61 (0.48–0.77)	0.63 (0.47–0.83)
High school or below	33.5	0.69 (0.51–0.94)	0.71 (0.49–1.03)
Income, $†			
≥ 150 000	36.3	Ref.	Ref.
90 000–149 999	36.0	0.99 (0.64–1.53)	0.94 (0.61–1.46)
70 000–89 999	38.3	1.09 (0.70–1.70)	1.13 (0.71–1.82)
50 000–69 999	32.8	0.86 (0.55–1.33)	1.03 (0.64–1.65)
30 000–49 999	30.9	0.78 (0.50–1.23)	1.02 (0.61–1.69)
< 30 000	30.2	0.76 (0.48–1.21)	1.06 (0.60–1.86)
Language			
English	34.1	Ref.	Ref.
French	35.6	1.07 (0.80–1.42)	0.75 (0.38–1.47)
Other	40.5	1.32 (0.68–2.53)	1.07 (0.52–2.19)
Residence			
Urban	36.4	Ref.	Ref.
Suburban	34.6	0.93 (0.70–1.23)	1.02 (0.77–1.35)
Rural	32.3	0.83 (0.59–1.18)	0.90 (0.64–1.26)
Do not know*			
Race			
White	34.5	Ref.	Ref.
Racialized	35.4	1.04 (0.73–1.50)	0.96 (0.65–1.41)
Do not know or prefer not to answer*			
Canadian born			
Yes	34.1	Ref.	Ref.
No	37.3	1.15 (0.81–1.63)	1.00 (0.68–1.47)
Self-reported health			
Very good or excellent	39.9	Ref.	Ref.
Good	32.9	0.74 (0.55–0.99)	0.77 (0.57–1.04)
Poor/fair	28.8	0.61 (0.44–0.84)	0.64 (0.44–0.92)
Any disabilities			
No	35.4	Ref.	Ref.
Yes	31.0	0.82 (0.61–1.10)	1.06 (0.75–1.49)
Don't know or prefer not to answer	56.9	2.41 (1.00–5.81)	3.24 (1.00–10.4)
Any health benefits			
Yes	34.4	Ref.	Ref.
No	35.7	1.06 (0.75–1.49)	1.19 (0.84–1.69)

Less likely to see someone in the practice on the same or next day for an urgent issue ← → More likely to see someone in the practice on the same or next day for an urgent issue

Adjusted OR (95% CI) — 0.25 0.50 1.00 2.00 4.00 8.00 16.00

Figure 2: Percentage of respondents who said they could see their family doctor or nurse practitioner on the same or next day for an urgent issue, and corresponding odds ratio (OR) by sociodemographic characteristic. C-statistic (AUC) = 0.572. *Cell sizes < 6 have been suppressed. †Individual income. Note: CI = confidence interval, Ref. = reference category.

71.7% [adjusted OR 3.15, 95% CI 2.56–3.87]). Overall, 76.2%, 32.2%, and 12.0% reported having the walk-in clinic visit in person, by phone, and by video, respectively (multiple selections allowed). Common reasons for attending a walk-in clinic are summarized in Appendix 1, E-Exhibit 7.

Virtual care and access to medical information
Among respondents with a primary care clinician, the most common appointment types were scheduled in-person (73.8%) and phone calls (70.7%). All respondents were asked about how they would like to get care; respondents listed scheduled in-person (92.5%), phone (66.1%), and drop-in in-person (54.4%) as the 3 most important modes.

Most respondents (59.1%) reported using an app or website to see their medical information, with laboratory test results (90.0%) and vaccination history (59.4%) being the most commonly reported information viewed online. Of respondents, 93.5% said it was fairly or very important to have 1 personal health record that all health professionals working in the province could see and use.

Most important attributes of primary care
Of respondents, 97.2% said that it was very or fairly important that every person living in Canada have a relationship with a family doctor, nurse practitioner, or team of health care professionals they could see regularly if they needed to. Figure 5 summarizes how respondents ranked various attributes of primary care. The attribute selected as very important by the largest percentage of respondents (65.0%) was that their primary care clinician "know me as a person and consider all the factors that affect my health." However, after adjustment, we saw significant variation in the percentage who selected it as very important, by
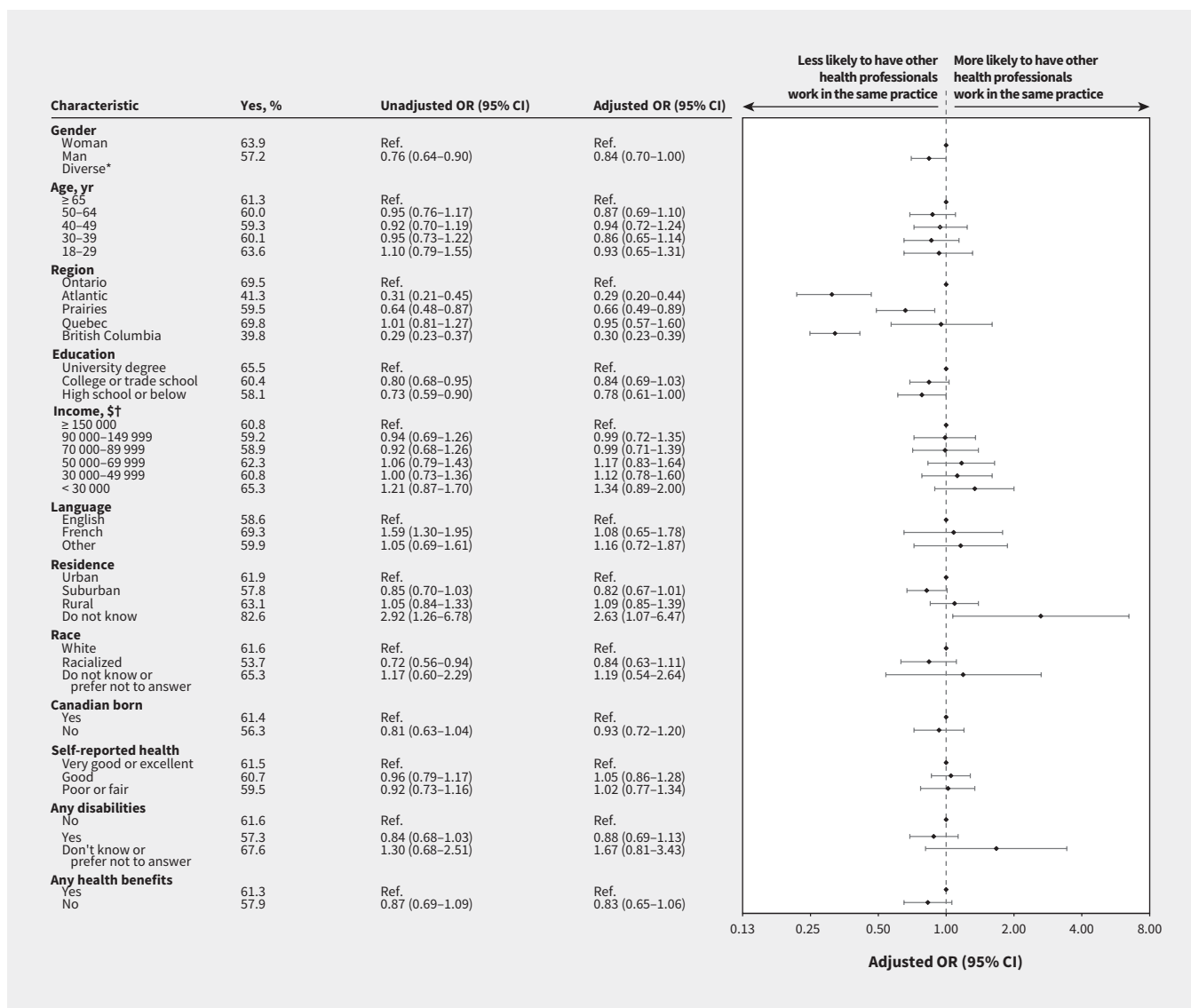
Characteristic	Yes, %	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Gender			
Woman	63.9	Ref.	Ref.
Man	57.2	0.76 (0.64–0.90)	0.84 (0.70–1.00)
Diverse*			
Age, yr			
≥ 65	61.3	Ref.	Ref.
50–64	60.0	0.95 (0.76–1.17)	0.87 (0.69–1.10)
40–49	59.3	0.92 (0.70–1.19)	0.94 (0.72–1.24)
30–39	60.1	0.95 (0.73–1.22)	0.86 (0.65–1.14)
18–29	63.6	1.10 (0.79–1.55)	0.93 (0.65–1.31)
Region			
Ontario	69.5	Ref.	Ref.
Atlantic	41.3	0.31 (0.21–0.45)	0.29 (0.20–0.44)
Prairies	59.5	0.64 (0.48–0.87)	0.66 (0.49–0.89)
Quebec	69.8	1.01 (0.81–1.27)	0.95 (0.57–1.60)
British Columbia	39.8	0.29 (0.23–0.37)	0.30 (0.23–0.39)
Education			
University degree	65.5	Ref.	Ref.
College or trade school	60.4	0.80 (0.68–0.95)	0.84 (0.69–1.03)
High school or below	58.1	0.73 (0.59–0.90)	0.78 (0.61–1.00)
Income, $†			
≥ 150 000	60.8	Ref.	Ref.
90 000–149 999	59.2	0.94 (0.69–1.26)	0.99 (0.72–1.35)
70 000–89 999	58.9	0.92 (0.68–1.26)	0.99 (0.71–1.39)
50 000–69 999	62.3	1.06 (0.79–1.43)	1.17 (0.83–1.64)
30 000–49 999	60.8	1.00 (0.73–1.36)	1.12 (0.78–1.60)
< 30 000	65.3	1.21 (0.87–1.70)	1.34 (0.89–2.00)
Language			
English	58.6	Ref.	Ref.
French	69.3	1.59 (1.30–1.95)	1.08 (0.65–1.78)
Other	59.9	1.05 (0.69–1.61)	1.16 (0.72–1.87)
Residence			
Urban	61.9	Ref.	Ref.
Suburban	57.8	0.85 (0.70–1.03)	0.82 (0.67–1.01)
Rural	63.1	1.05 (0.84–1.33)	1.09 (0.85–1.39)
Do not know	82.6	2.92 (1.26–6.78)	2.63 (1.07–6.47)
Race			
White	61.6	Ref.	Ref.
Racialized	53.7	0.72 (0.56–0.94)	0.84 (0.63–1.11)
Do not know or prefer not to answer	65.3	1.17 (0.60–2.29)	1.19 (0.54–2.64)
Canadian born			
Yes	61.4	Ref.	Ref.
No	56.3	0.81 (0.63–1.04)	0.93 (0.72–1.20)
Self-reported health			
Very good or excellent	61.5	Ref.	Ref.
Good	60.7	0.96 (0.79–1.17)	1.05 (0.86–1.28)
Poor or fair	59.5	0.92 (0.73–1.16)	1.02 (0.77–1.34)
Any disabilities			
No	61.6	Ref.	Ref.
Yes	57.3	0.84 (0.68–1.03)	0.88 (0.69–1.13)
Don't know or prefer not to answer	67.6	1.30 (0.68–2.51)	1.67 (0.81–3.43)
Any health benefits			
Yes	61.3	Ref.	Ref.
No	57.9	0.87 (0.69–1.09)	0.83 (0.65–1.06)

Figure 3: Percentage of respondents who reported having a nurse, social worker, dietitian, pharmacist, or Indigenous cultural service provider work in the same practice as their family doctor or nurse practitioner, and corresponding odds ratio (OR) by sociodemographic characteristics. C-statistic (AUC) = 0.610. *Cell sizes < 6 have been suppressed. †Individual income. Note: CI = confidence interval, Ref. = reference category.

gender, age, region, place of birth, and self-reported disability (Figure 6). The attribute ranked second highest as very important was that their clinician and practice "stand up for me"; attributes related to timely access, care coordination, and comprehensiveness all ranked highly.

Reimagining care

Respondents were open to new ways of organizing care. Nearly three-quarters (72.7%) somewhat or strongly agreed with reorganizing care similarly to the public school model, where teams of family doctors and nurse practitioners would have to accept as a patient any person who lived in the neighbourhood near their office, and 65.9% somewhat or strongly agreed with this type of neighbourhood care guarantee, even if it meant patients would be encouraged to change providers if they moved. Of respondents, 90.8% were somewhat or very willing to

see the same nurse practitioner consistently for most things, except when the nurse practitioner felt a doctor was needed; 75.7% were somewhat or very willing to see any primary care clinician in the practice in a situation where everyone in the practice had access to their health record.

Interpretation

Primary care is the front door to the health care system — the first point of access to address acute concerns, manage chronic disease, prevent illness, and support people to navigate other parts of the system. Yet we found that among more than 9000 respondents to a national survey of adults in Canada conducted in fall 2022, more than 1 in 5 did not have a primary care clinician they could see regularly for care. In our survey, the largest variation in primary care access was regional, with almost 1 in

Characteristic	Yes, %	Unadjusted OR (95% CI)*	Adjusted OR (95% CI)
Gender			
Woman	51.2	Ref.	Ref.
Man	44.6	0.77 (0.67–0.88)	0.67 (0.58–0.79)
Diverse*			
Age, yr			
≥ 65	34.4	Ref.	Ref.
50–64	41.9	1.38 (1.14–1.66)	1.39 (1.14–1.70)
40–49	55.1	2.34 (1.89–2.90)	2.03 (1.59–2.59)
30–39	57.4	2.57 (2.09–3.16)	2.41 (1.91–3.03)
18–29	60.1	2.88 (2.21–3.74)	2.35 (1.76–3.13)
Region			
Ontario	39.7	Ref.	Ref.
Atlantic	50.7	1.56 (1.14–2.13)	1.40 (0.99–1.98)
Prairies	48.2	1.41 (1.10–1.80)	1.24 (0.95–1.63)
Quebec	54.1	1.79 (1.51–2.12)	1.19 (0.84–1.68)
British Columbia	55.0	1.86 (1.52–2.26)	1.70 (1.37–2.12)
Education			
University degree	48.8	Ref.	Ref.
College or trade school	50.2	1.06 (0.92–1.21)	1.06 (0.89–1.25)
High school or below	45.9	0.89 (0.75–1.05)	0.98 (0.79–1.23)
Income, $†			
≥ 150 000	47.1	Ref.	Ref.
90 000–149 999	47.2	1.00 (0.78–1.28)	0.92 (0.70–1.21)
70 000–89 999	49.3	1.09 (0.84–1.41)	1.02 (0.77–1.35)
50 000–69 999	46.5	0.97 (0.76–1.25)	0.77 (0.58–1.03)
30 000–49 999	48.4	1.05 (0.82–1.36)	0.86 (0.63–1.17)
< 30 000	52.2	1.23 (0.93–1.61)	0.93 (0.66–1.31)
Language			
English	46.3	Ref.	Ref.
French	53.8	1.35 (1.16–1.58)	1.25 (0.90–1.75)
Other	50.4	1.18 (0.84–1.67)	1.09 (0.73–1.63)
Residence			
Urban	49.6	Ref.	Ref.
Suburban	49.0	0.98 (0.83–1.15)	1.00 (0.84–1.19)
Rural	42.8	0.76 (0.63–0.92)	0.78 (0.63–0.96)
Do not know	67.9	2.15 (1.13–4.09)	1.84 (0.87–3.91)
Race			
White	46.7	Ref.	Ref.
Racialized	56.4	1.48 (1.20–1.83)	1.20 (0.92–1.55)
Do not know or prefer not to answer	57.9	1.57 (0.89–2.76)	1.42 (0.75–2.70)
Canadian born			
Yes	48.1	Ref.	Ref.
No	46.7	0.95 (0.77–1.16)	1.00 (0.78–1.29)
Self-reported health			
Very good or excellent	43.2	Ref.	Ref.
Good	49.6	1.30 (1.11–1.52)	1.37 (1.15–1.63)
Poor or fair	55.5	1.64 (1.36–1.98)	1.61 (1.29–2.01)
Any disabilities			
No	46.7	Ref.	Ref.
Yes	52.3	1.25 (1.05–1.49)	1.14 (0.92–1.41)
Don't know or prefer not to answer	6.3	1.47 (0.92–2.36)	1.56 (0.92–2.66)
Any health benefits			
Yes	48.8	Ref.	Ref.
No	44.4	0.84 (0.70–1.00)	0.88 (0.72–1.07)
Have a family doctor or nurse practitioner			
Yes	41.2	Ref.	Ref.
No	71.7	3.63 (2.97–4.43)	3.15 (2.56–3.87)

Less likely to attend a walk-in clinic | More likely to attend a walk-in clinic

0.50 1.00 2.00 4.00

Adjusted OR (95% CI)

Figure 4: Percentage of respondents who attended a walk-in clinic 1 or more times in the last 12 months, and corresponding odds ratio (OR) by sociodemographic characteristic. C-statistic (AUC) = 0.680. *Cell sizes < 6 have been suppressed. †Individual income. Note: CI = confidence interval, Ref. = reference category.

3 reporting not having a primary care clinician in Quebec and the Atlantic region, a 70% reduced odds compared with Ontario even after accounting for demographic differences in respondents. Men, people younger than 65 years, and people with poor self-reported health also had lower odds of reporting they had a primary care clinician. When asked about the ideal state, respondents noted the most important attribute of primary care was having a primary care clinician who knew them as a person and considered all the factors that affected their health. This attribute was more important for women, people older than 65 years, people born outside of Canada, and people with a disability.

In 2019, before the COVID-19 pandemic, surveys estimated that 15% of people in Canada aged 12 years and older did not have a regular health care provider.[26] Our results are consistent with other research showing a decrease in primary care attachment since the start of the pandemic.[27] Our findings suggest that provincial policies strongly influence access to primary care in Canada. Ontario respondents had the highest odds of reporting having access to a primary care clinician even after accounting for other factors, a finding consistent with the results from the Canadian Community Health Survey 2015 and 2019.[26] Underlying reasons are unclear but could include increases in physician payment, a shift from fee-for-service to capitation, and investment in interprofessional teams in Ontario over the last 2 decades, which made primary care careers in Ontario more attractive to physicians.[28,29] More research is needed to understand why respondents with poor or fair self-reported health have lower odds of having a primary care clinician.
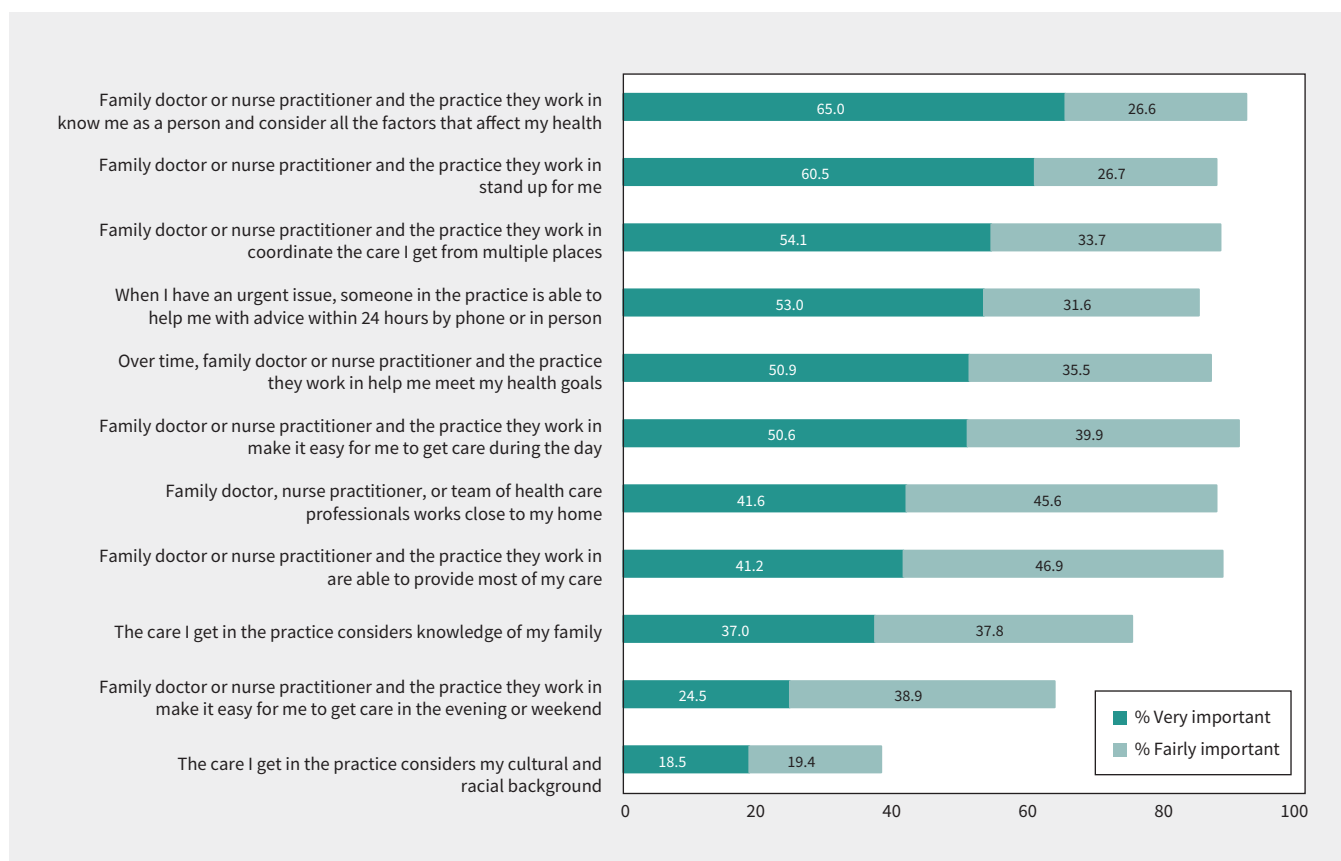
Figure 5: Percentage of survey respondents who indicated an attribute of primary care as very (or fairly) important, in rank order by importance.

Even respondents with a primary care clinician reported challenges in accessing timely care. A minority of respondents reported that their practice offered care outside 0900 to 1700, Monday to Friday, and more than half said they were not able to get an urgent appointment within 3 days of trying to book one. These findings are consistent with results from the 2020 Commonwealth survey.[9] We found timely access for urgent concerns was worse for people with lower educational attainment, those with poorer self-reported health, or people who lived in a province with lower primary care attachment. Given challenges with timely access, it is not surprising that we also found that almost half of all respondents had received care at a walk-in clinic in the last year, an episodic care model that does not provide ongoing care continuity. These types of episodic care models have grown over the course of the pandemic[30] but are not in line with what respondents said they valued most in primary care: an ongoing relationship with a clinician. Numerous studies have shown that relational continuity positively affects patient outcomes, health care use, and costs,[31–36] and our findings clearly show it is also what respondents most desire — particularly people with more complex care needs.

Investment in interprofessional primary care teams is suggested internationally by clinicians, researchers, and professional associations as part of the solution to the current primary care crisis[16,37–42] and our findings indicate the public would be supportive of such a shift. Of respondents, 90% said they would

be comfortable getting care from another team member if their primary care clinician recommended it. However, less than 15% reported that their primary care clinician worked with a social worker or pharmacist or dietitian, and the odds of working with any health professional were lower for people living outside Ontario and Quebec. Evidence suggests teams have the potential to improve patient outcomes and clinician joy in work, and increase clinician capacity to take on more patients.[43–46] That attachment to a primary care clinician was relatively low in Quebec despite investment in teams speaks to the complexity of implementation and the importance of designing teams to enhance capacity and the influence of other health system factors.[47]

Limitations

Our biggest study limitation is response bias. The survey was offered only in English and French, was Internet based, and required 15 minutes to complete. Respondents may have been driven by strong interest or opinions on health care. We excluded almost 5000 incomplete surveys. We had a low response rate to the closed link and in particular observed a low number of responses from people new to Canada, those who are racialized, and those who identify as Indigenous — groups we know are less likely to receive high-quality primary care. We also had no complete responses from people residing in the territories, a geographic area with unique challenges regarding primary care

Characteristic	Yes, %	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Gender			
Woman	71.5	Ref.	Ref.
Man	58.7	0.57 (0.49–0.66)	0.58 (0.50–0.68)
Diverse	75.9	1.26 (0.58–2.72)	1.60 (0.72–3.55)
Age, yr			
≥ 65	75.5	Ref.	Ref.
50–64	71.0	0.79 (0.65–0.97)	0.86 (0.70–1.07)
40–49	61.5	0.52 (0.41–0.65)	0.60 (0.46–0.77)
30–39	57.7	0.44 (0.36–0.55)	0.47 (0.37–0.59)
18–29	53.4	0.37 (0.29–0.48)	0.42 (0.31–0.56)
Region			
Ontario	71.0	Ref.	Ref.
Atlantic	62.9	0.69 (0.50–0.97)	0.73 (0.50–1.05)
Prairies	68.0	0.87 (0.66–1.14)	1.01 (0.76–1.35)
Quebec	49.2	0.39 (0.33–0.47)	0.66 (0.44–0.98)
British Columbia	71.3	1.01 (0.81–1.27)	0.99 (0.78–1.25)
Education			
University degree	67.5	Ref.	Ref.
College or trade school	62.5	0.80 (0.69–0.93)	0.94 (0.79–1.12)
High school or below	66.2	0.94 (0.78–1.13)	0.92 (0.74–1.16)
Income, $*			
≥ 150 000	65.9	Ref.	Ref.
90 000–149 999	64.0	0.92 (0.71–1.19)	0.98 (0.75–1.29)
70 000–89 999	65.4	0.98 (0.75–1.28)	1.02 (0.77–1.36)
50 000–69 999	66.4	1.02 (0.78–1.32)	1.17 (0.88–1.56)
30 000–49 999	65.9	1.00 (0.77–1.30)	1.09 (0.80–1.48)
< 30 000	64.4	0.94 (0.70–1.25)	0.89 (0.63–1.25)
Language			
English	69.9	Ref.	Ref.
French	48.5	0.41 (0.35–0.48)	0.70 (0.47–1.03)
Other	75.6	1.33 (0.92–1.94)	1.31 (0.87–1.97)
Residence			
Urban	66.2	Ref.	Ref.
Suburban	64.6	0.93 (0.79–1.11)	0.93 (0.78–1.12)
Rural	64.3	0.92 (0.76–1.12)	0.90 (0.73–1.11)
Do not know	74.5	1.49 (0.77–2.88)	1.39 (0.72–2.71)
Race			
White	65.1	Ref.	Ref.
Racialized	68.5	1.17 (0.93–1.47)	1.13 (0.87–1.47)
Do not know or prefer not to answer	47.7	0.49 (0.28–0.85)	0.49 (0.26–0.92)
Canadian born			
Yes	63.9	Ref.	Ref.
No	75.0	1.7 (1.35–2.14)	1.39 (1.08–1.80)
Self-reported health			
Very good or excellent	63.8	Ref.	Ref.
Good	63.7	1.00 (0.84–1.18)	0.93 (0.78–1.11)
Poor or fair	70.0	1.32 (1.08–1.62)	1.15 (0.91–1.45)
Any disabilities			
No	63.1	Ref.	Ref.
Yes	73.0	1.58 (1.29–1.94)	1.39 (1.11–1.73)
Don't know or prefer not to answer	67.5	1.21 (0.71–2.07)	1.15 (0.62–2.15)
Any health benefits			
Yes	64.5	Ref.	Ref.
No	68.6	1.20 (0.99–1.46)	1.05 (0.85–1.30)
Have a family doctor or nurse practitioner			
Yes	67.2	Ref.	Ref.
No	58.6	0.69 (0.57–0.83)	0.89 (0.73–1.09)
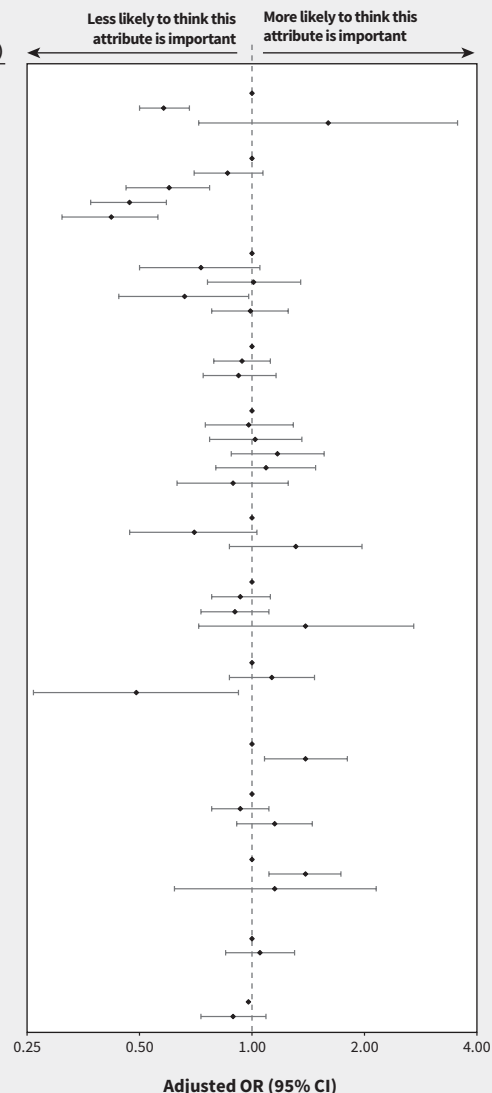
Figure 6: Percentage of respondents who said it is very important that their family doctor or nurse practitioner and the practice they work in "know me as a person and consider all the factors that affect my health," and corresponding odds ratio (OR) by sociodemographic characteristic. C-statistic (AUC) = 0.673. *Individual income. Note: CI = confidence interval, Ref. = reference category.

access. Further, data were collected at one point in time, some questions may have been unclear, and multiple-choice responses inherently limit depth of understanding. The next phases of the OurCare initiative include citizen dialogues in multiple regions to better understand values, key issues, and potential recommendations for improving Canada's health care systems.

Conclusion

We found that more than 1 in 5 people who responded to our survey did not have access to primary care, and the situation was worse in some regions. Among those who did have a family doctor, most struggled to get timely care. Regardless of whether they had a family doctor, many were turning to walk-in clinics;

however, the episodic walk-in clinic model is not aligned with what respondents reported being most important to them: having a primary care clinician who knows them as a person and takes into account all the factors that affect their health. Respondents were supportive of interprofessional care, one of many potential reforms that could alleviate the primary care crisis. Our results should be interpreted in the context of a low response rate and response bias. More research is needed to understand which policies, regulations, and contextual factors have influenced the observed regional variation in attachment, timely access, and availability of interprofessional teams. Future reforms should be co-designed with patients and the public and preferentially support the creation and expansion of relationship-based, longitudinal models of primary care.

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Affiliations: Department of Family and Community Medicine (Kiran, Lofters, Martin), Temerty Faculty of Medicine, University of Toronto; Department of Family and Community Medicine (Kiran), and MAP Centre for Urban Health Solutions (Kiran, Daneshvarfard, Wang), Li Ka Shing Knowledge Institute, St. Michael's Hospital; Institute of Health Policy, Management and Evaluation (Kiran, Martin), University of Toronto, Toronto, Ont.; Department of Political Science (Beyer, van der Linden), McMaster University, Hamilton, Ont.; Vox Pop Labs (Beyer, van der Linden); MASS LBP (Kay, MacLeod), Toronto, Ont.; Department of Community Health (Breton), Université de Sherbrooke, Longueuil, Que.; Department of Family Medicine (Brown-Shreves), University of Ottawa; Restore Medical Clinics (Brown-Shreves), Ottawa, Ont.; Department of Family and Community Medicine (Brown-Shreves), Queen's University, Kingston, Ont.; Department of Family Medicine (Condon), University of Manitoba, Winnipeg, Man.; Department of Family Medicine (Green), and Health Services and Policy Research Institute (Green), Queens University; ICES Queen's (Green), Kingston, Ont.; Faculty of Health Sciences (Hedden), Simon Fraser University, Burnaby, BC; Departments of Community Health Sciences and Family Medicine (Katz), University of Manitoba, Winnipeg, Man.; Canadian Association for Health Services and Policy Research (Keresteci), Ottawa, Ont.; Department of Family Medicine (Kovacina), McGill University, Montréal, Que.; Department of Family Medicine (Lavergne, Stringer), Dalhousie University, Halifax, NS; Peter Gilgan Centre for Women's Cancers (Lofters), and Department of Family and Community Medicine (Martin), Women's College Hospital, Toronto, Ont.; Department of Family Practice (Mitra), University of British Columbia, Vancouver, BC; Clinical Faculty (Newbery), Section of Family Medicine, NOSM University, Thunder Bay, Ont.