Health Canada Santé Canada

Canadians' Priorities for Primary Health Care

Final Report

Prepared for Health Canada

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February 2022

This public opinion research report presents the results of focus groups conducted by Earnscliffe Strategy Group on behalf of Health Canada. The research was conducted in January 2022.

Cette publication est aussi disponible en français sous le titre : Les priorités des Canadiens concernant les soins de santé primaires

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Executive Summary

Earnscliffe Strategy Group (Earnscliffe) is pleased to present this report to Health Canada summarizing the results of qualitative research aimed at understanding what Canadians want from their health care system.

Integrated, people-centred primary care is the foundation of high-performing health care, providing a first point of contact with the system for most patients and an initial site of treatment for many health complaints or conditions. However, access to primary care in Canada has been flagged as a persistent challenge. Even those with a dedicated primary care provider often have to wait days or weeks for an appointment and can struggle with a lack of coordination between their primary care provider and other care settings.

In the 2021 Speech from the Throne, the Government of Canada committed to strengthening our healthcare system and the public health supports for all Canadians, with a focus on accessibility.

This research was required to support the Government of Canada's understanding of public priorities and perceptions with respect to innovative models of primary care, team-based care, and virtual care. The total contract value for this research was $107,416.29 including taxes.

To meet the research objectives, Earnscliffe conducted a series of fifteen online focus groups. The groups took place from January 24 to 27, 2022. Ten of the groups comprised of people residing in one of five specific regions: Atlantic Canada, Quebec, Ontario, the Prairies, and British Columbia/Territories. In each region, two groups were conducted – one among those who were identified as heavy users of the health care system (defined as people with a chronic health condition); and the other among people with more typical usage of the system ("regular" users were defined as those with no chronic health condition). In addition, separate groups were conducted with each of five specific audiences: LGBTQ2S+; official language minorities (Anglophones in Quebec and Francophones outside of Quebec); Indigenous participants; and recent immigrants. These groups included a mix of regular and heavy system users. The groups with regular and heavy system users in Quebec, as well as the group with Francophones outside Quebec, were conducted in French. The sessions were approximately 90 minutes in length.

It is important to note that qualitative research is a form of scientific, social, policy, and public opinion research. Focus group research is not designed to help a group reach a consensus or to make decisions, but rather to elicit the full range of ideas, attitudes, experiences, and opinions of a selected sample of participants on a defined topic. Because of the small numbers involved, the participants cannot be expected to be thoroughly representative in a statistical sense of the larger population from which they are drawn, and findings cannot reliably be generalized beyond their number. As such, results are directional only.

Key Findings

Participants value the universality of the Canadian health care system but are frustrated by delays in access to health care services, including primary care. **In their minds, high quality care is directly linked to timely access, not just the quality of the actual health care services an individual receives. Consequently, participants were reluctant to describe the Canadian system in purely positive terms.**

Most were keen to be involved, as partners, in decisions impacting their health care. However, some noted that some find it difficult to influence their doctor’s decisions about their health care in ways they want and/or feel the need to prepare arguments or questions in advance of appointments. **Often, they find that because the system is overloaded, their doctor does not have the time to explain their decisions or listen to patient concerns, another factor that drives negative impressions of the system.**

Participants were open to some services or types of care aimed at filling current accessibility gaps. Upon learning about the team-based approach to care, most could see how the option to meet with health practitioners other than their family doctor, as long as they were qualified to deal with the issue at hand, could improve access, reduce wait times and meet their health care needs. Those who understood the concept of coordinated care agreed that it was fundamental to providing high quality care. In contrast, walk-in clinics were viewed as necessary, but a reliance on them was an unsatisfactory way to fill current gaps in access. **Taken together, the results suggest that faster access to a dedicated primary care team is fundamental to improving the quality of primary care in the eyes of participants.**

While virtual care was welcomed, particularly in the context of COVID, with time-savings for patients noted as a principle advantage for participants, it was clear that **not all care should be virtual.** Appropriateness was about patients having choice in their care modality (in-person vs. virtual), as well as being about the nature of the health concern.

Access to personal health information was valued and participants were generally keen to take advantage of new health care digital tools. The **benefits of digital health and digital tools were largely about efficiency** (flow of information, tracking appointments, etc.), but also about transparency between patient and doctor and access to information. **The biggest drawback to digital health tools is the risk of a security breach.** Some felt such a breach was unavoidable, while others had more confidence that systems would be put in place to adequately protect their information, including deidentified health data. **Weighing the benefits against the drawbacks, none of the participants felt the risks to the privacy of their information outweighed the efficiency and access benefits to using digital health and related tools**, largely as people assumed policies and measures would be implemented that would lessen the impact of the drawbacks. In short, they are open to more broad adoption of digital health tools.

Research Firm:

Earnscliffe Strategy Group (Earnscliffe)
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I hereby certify as a representative of Earnscliffe Strategy Group that the final deliverables fully comply with the Government of Canada political neutrality requirements outlined in the Communications Policy of the Government of Canada and Procedures for Planning and Contracting Public Opinion Research. Specifically, the deliverables do not include information on electoral voting intentions, political party preferences, standings with the electorate or ratings of the performance of a political party or its leaders.

Signed: Date: February 9, 2022

Stephanie Constable
Principal, Earnscliffe

Introduction

Earnscliffe Strategy Group (Earnscliffe) is pleased to present this report to Health Canada summarizing the results of qualitative research aimed at understanding what Canadians want from their health care system.

Integrated, people-centred primary care is the foundation of high-performing health care, providing a first point of contact with the system for most patients and an initial site of treatment for many health complaints or conditions. However, access to primary care in Canada has been flagged as a persistent challenge. Even those with a dedicated primary care provider often have to wait days or weeks for an appointment and can struggle with a lack of coordination between their primary care provider and other care settings.

In the 2021 Speech from the Throne, the Government of Canada committed to strengthening our healthcare system and the public health supports for all Canadians, with a focus on accessibility.

Subsequently, the Prime Minister's Mandate Letter to the Minister of Health laid out several priorities for strengthening health care in Canada, including:

- supporting provinces and territories to hire new family doctors, nurses and nurse practitioners;
- expanding the number of family doctors and primary health teams in rural communities and work to give rural communities greater access to a full suite of health and social services professionals;
- expanding virtual care, help to cover digital infrastructure and other system improvements so that Canadians can access virtual medical consultations or remote monitoring; and,
- in consultation with provinces and territories and a broad range of partners, expediting work to create a world-class health data system that is timely, usable, open-by-default, connected and comprehensive

This research was required to support the Government of Canada's understanding of the considerations above. The research aims to provide insights on public priorities and perceptions with respect to primary care in general, as well as innovative models of primary care, team-based care and virtual care. The specific objectives of the research were to understand what Canadians want from their health care system, including:

- Are they satisfied with their ability to access primary care in a timely manner? What are the major barriers that they currently face with respect to accessing primary care?
- Are they satisfied with the quality of the primary care they receive? What does "high-quality" care mean to them?

- Have they accessed elements of their care virtually/online? If so, are they satisfied with their experience? In what situations would they prefer to use virtual care going forward?
- What are their thoughts and preferences regarding a team-based approach to primary care? What are their priorities with respect to team-based care (e.g., timely access, maintaining a relationship with a ‘main’ provider, access to a wide variety of health professionals)?
- What are their needs with respect to coordinating care between their primary care provider and other sites of care? Are their ways in which digital health tools could make this experience better for them?
- Do they feel they are currently treated as a partner in decisions impacting their health care?
- What are their expectations with respect to accessing their own health information, and are these currently being met? Is accessing their own health information important to them? Why/why not?
- Would they be willing to grant others access to their deidentified health data if it meant decision-makers could use that information to improve the performance of the health system? Why/why not?

These objectives informed the development of the focus group discussion guide, which can be found in Appendix C.

To meet the research objectives, Earnscliffe conducted a series of fifteen online focus groups. The groups took place from January 24 to 27, 2022. Ten of the groups were comprised of people residing in one of five specific regions: Atlantic Canada, Quebec, Ontario, the Prairies, and British Columbia/Territories. In each region, two groups were conducted – one among those who were identified as heavy users of the health care system (defined as people with a chronic health condition); and the other among people with more typical usage of the system (“regular” users were defined as those with no chronic health condition). In addition, separate groups were conducted with each of five specific audiences: LGBTQ2S+; official language minorities (Anglophones in Quebec and Francophones outside of Quebec); Indigenous participants; and recent immigrants. These groups included a mix of regular and heavy system users. The groups with regular and heavy system users in Quebec, as well as the group with Francophones outside Quebec, were conducted in French. The sessions were approximately 90 minutes in length. A total of 127 people participated in the groups (see table 1).

The table below shows the composition, date, and time of each group, as well as the number of participants per group.

Table 1 – Focus Group Composition, Schedule and Number of Participants

Group	**Audience**	**Region/Language**	**Time**	**Number of Participants**
Monday January 24, 2022				
1	Regular system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST	10
2	Heavy system users	Ontario (EN)	6:00 pm EST	10
3	Regular system users	BC/Territories (EN)	8:00 pm EST / 5:00 pm PST	10
Tuesday January 25, 2022				
4	Regular system users	Ontario (EN)	5:00 pm EST	8
5	Heavy system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST	8
6	Heavy system users	Quebec (FR)	5:00 pm EST	7
7	Heavy system users	BC/Territories (BC)	8:00 pm EST / 5:00 pm PST	7
Wednesday January 26, 2022				
8	Heavy system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST	8
9	Regular system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST	9
10	Regular system users	Quebec (FR)	5:30 pm EST	8
11	LGBTQ2S+	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST / 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST	8
Thursday January 27, 2022				
12	Francophones outside Quebec	ATL, ON, Prairies, BC, Territories (FR)	5:30 pm EST / 6:30 pm AST / 7:00 pm NST / 4:30 pm CST / 3:30 pm MST / 2:30 pm PST	10
13	Indigenous peoples	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST	8
14	Anglophones in Quebec	QC	5:00 pm EST	9
15	Recent immigrants	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST	7

Appended to this report are the screener and discussion guide.

It is important to note that qualitative research is a form of scientific, social, policy, and public opinion research. Focus group research is not designed to help a group reach a consensus or to make decisions, but rather to elicit the full range of ideas, attitudes, experiences, and opinions of a selected sample of participants on a defined topic. Because of the small numbers involved, the participants cannot be expected to be thoroughly representative in a statistical sense of the larger population from which they are drawn, and findings cannot reliably be generalized beyond their number.

Detailed Findings

This qualitative report is divided into four sections. The first outlines participants' contextual impressions of health care in Canada. The second explores participants' experiences with, perceptions of and preferences when it comes to primary care. The third deals with personal involvement in health care. The final section explores digital health experiences, perceptions, and preferences.

It is worth noting that although the groups were segregated based on expected usage of the health care system, the opinions expressed by regular users of the health care system and heavy users tended to be very similar in theme and direction, with perhaps some modest differences in terms of the number of experiences. As a result, on most questions, we found the same tendencies regardless of group. On questions where there tended to be consensus, a similar consensus tended to be found across all groups. Where there tended to be a mix of opinions, there was also a similar mix of the same kinds of opinion.

In terms of geography, while there were a few mentions of specific (seemingly unique) provincial approaches or tools, there were also some differences in experiences and access, and therefore in the resulting opinions, based upon the size or remoteness of the community in which a participant lived. Since these groups included a mix of participants living in urban, suburban, and rural locations, the geographic differences in opinions regarding primary care and digital health may be more related to community size/remoteness more than the region within the country.

Contextual impressions of health care in Canada

At the outset of each focus group, participants were asked what they think should be the highest priority for the federal government. Health and health care tended to be among the issues most frequently mentioned. In some cases, participants mentioned public health and dealing with the pandemic. In others, they referenced a system that is under intense pressure and/or need of attention. For some who did not indicate health or health care, discussions revealed that in several cases they felt the issue they named was related to health. For the few who did not name health care as the top priority, there was certainly a tendency to consider it to be a high priority, if not necessarily "as high" as health care.

When asked for their thoughts on Canada's health care system today, much of the discussion among participants revolved around the pandemic and the impact it has had on capacity, on health care professionals, on access to services and on increased delays in treatments.

Few had any tendency to start with a "big picture" assessment of the health care system, but if prompted, most said there are both things they appreciate about it and things that are disappointing or frustrating. Participants were often reluctant to say that the system is good, but some did express that sentiment and others offered the qualified compliment of it at least being better than some comparator (e.g., the U.S. system).

Strengths and Challenges of the Health Care System

Participants were asked to name the best and worst things about the Canadian health care system. The best things mentioned always included the concept of universality. In virtually all groups, several participants appreciated that **key parts of the health care system are free to access for all Canadians, meaning that patients are not subject to the stress of having to pay an unaffordable bill or being denied treatment due to affordability**. As one Indigenous participant explained, "*I'm just thankful for our health care system because I have friends that live down in the States and just hearing their horror stories of like, the amounts of money that they're paying and everything for health care down there*." This idea of universality was important to participants. One regular system user in BC specifically referred to it as a "point of pride" for Canadians.

Even when asked to highlight the best things about it, there was some reluctance to describe the health care system in positive terms overall. The reluctance seemed to be driven by the factors that were unsatisfactory and nominated as the "worst things" about the system. Most consistently, these included **the amount of time it takes to see a professional, access a testing facility or get a treatment**. A few of the participants living in rural communities and in the Territories seemed to feel this problem more acutely, with one heavy system user in Ontario explaining, "*I find that city folk get preferential treatment, we in rural or small communities, we have nothing. And we have to wait months and months and months to get even in to see a doctor."* Some also had the sense that overworked staff compound the issue, with one regular system user in Ontario stating, *"The staff are just way too overworked. And as a result, the patients are the ones who typically pay for it, like, wait times right now are just absolutely insane."* Another participant echoed the same sentiment based on an experience they had visiting an emergency room:

> *I found going to the ER, if you are able to walk and talk, they pretty much shuffle you off into the waiting room for sometimes up to 18 hours with cracked vertebrae and say it's okay to walk around. So there's just no staff and it's not that it's that person's fault. It's just they're so tired and frazzled, they can't deal because there's too many people in the waiting rooms. -Recent immigrant*

Other criticisms of the health care system included issues with information sharing between health care professionals and the need to repeatedly provide the same information to different providers**. Some felt captive to a particular family doctor due to their inability to find another one**. **Others simply did not have a family doctor, despite their efforts to find one**. As one regular user in the Territories explained, *"I do not have access to a family doctor. It is* *absurd. There is a lack of doctors. They fly up doctors every month and it’s a new doctor every time. There is a two, three month wait.”* A few were also critical of the perceived “gate-keeper” role that family doctors play in determining the course of action for their patients. They complained that their doctor had not been open to questions about their (the patient’s) health issues and/or alternate forms of treatment and had not always respected their preferences.

In terms of other critiques, a few participants felt that the health care system is centered around immediate need. They wished the system focused more on preventative care. One or two pointed out that not all surgeries or procedures are free, including dental care and gender-affirming surgery for those under the age of 18.

In most of the focus groups, discussion about the advantages and disadvantages of the Canadian health care system touched on the idea of paying for health care services. Often, the discussion stemmed from frustration with their ability to access primary care. Some wished that the Canadian system offered more flexibility in this respect. One heavy system user in Ontario explained, “*In Canada, there is no flexibility of, well, if you have this, then I [the system] will allow you do this. Or if you wanted to, like pay for a certain whatever it is that you need, like an MRI or something, there's no opportunity to do that.”* Among those who supported the idea, the option to be able to pay for some services could even help alleviate pressure on other parts of the system. Notably, the health care services participants most often mentioned wishing they could pay to access tended to be more specialized, including surgery, rather than primary care.

In contrast, many participants were quick to oppose the idea of paying for health care services. Even those who could see possible advantages had concerns, as one regular system user in Atlantic Canada said, “I think that it could be a good idea, a good system for people that can afford it. The only thing is our health care system in Canada is so drained that we don't have enough staff that if they were to privatize health care, it would take the staff that we do have.” In addition to the impacts on staffing, participants feared that allowing people to pay for health care would create a two-tiered system and/or exacerbate differences in access to health care based on income. This was a particularly sensitive point for Indigenous participants and those who live in more rural or northern communities, who worried it would impact the quality of care available to them:

> *“I want to say that I disagree with the pay for health service, because then that creates an imbalance or, you know, the people who have the money who can pay for it get priority. And it's not a, it's an inequitable system. Because many Indigenous people don't have money. So, they can't get the medical, get their needs met. If they can't pay for it, then that creates a further divide. So not only Indigenous people, but low-income people as well.” -Indigenous participant*

Primary care experiences, perceptions, and preferences

Views of the health care system were generally derived from participants' experiences with primary care. Many common themes emerged during the discussion of both the health care system broadly and primary care specifically.

Access to primary care

Most participants indicated that they have a family doctor. Those who did not were unable to get one and/or were on a waiting list for one. As was discussed in the previous section, the participants without a family doctor were frustrated by the difficulties they had encountered trying to find one and navigating the system to get the care they needed was often difficult. The combination of these experience suggests that primary care is a foundational element of a strong health care system.

Most participants said that they access primary care at least a couple of times per year. Some heavy system users access it far more, visiting their primary health care provider anywhere between 5 to 10 times per year. Discussions over **the ability to access primary care in a timely manner exposed what is perhaps the rawest nerve when it comes to the health care system**. While there were some in every group who did not feel they had much of a problem accessing care, there were always several who were vocal about the inability to schedule an appointment, as well as the length of time it takes between the request and the date of the appointment offered:

> *"You call on Tuesday, and then they say the first available appointment is next Thursday. And depending on what the issue is that may be either too long, or heck, the thing might even resolve itself by then or have worsened by then or who knows what. So, to seek medical attention, even though we have a family physician, our family physician at times is not the first option." -Regular System User, BC/Territories*

As the participant above alluded to, many participants claimed to be unable to visit their regular family doctor in a timely manner, and consequently looked for other options. Walk-in clinics were one such option. Most, though not all and especially those without a family doctor, had used a walk-in clinic at some point. Experiences with wait times at walk-in clinics were also mixed. There were some who described walk-in clinics as having convenient systems for booking appointments. Others described long waits at the site or arriving at the site early in the morning to avoid waiting. One LGBTQ2S+ participant explained, *"Usually the walk-in clinics are open, like taking patients for the first like 15 minutes or half hour of the day, there'll be like 80 people waiting outside the walk in first thing in the morning."*

Views on the use of and care received at such clinics were mixed. Some appreciated the option (particularly, it seemed, if what the participant was thinking of was an after-hours clinic to which their doctor is connected). Those who appreciated walk-in clinics tended to like the convenience and ability to get seen more quickly. Some who had used a walk-in clinic felt the option was less satisfactory than seeing their own doctor because there was little interest in developing a deep knowledge of the patient's case, circumstances or long-term needs and information was not maintained or communicated within the clinic or between the clinic and their main provider. One regular system user in BC noted, "I think that consistency is important, especially if, you know, it really depends on your health. If you have complex medical conditions, or are on certain long-term medications, you know, doctor shopping is not helpful. It's actually harmful." They were concerned that this approach could lead to negative health outcomes.

Participants tended to feel that walk-in clinics are necessary as a fall-back measure when they cannot access their regular primary care provider. None articulated that this was a model they preferred, just that they make use of it to fill gaps in their frequent inability to access primary care. One heavy system user in Atlantic Canada said, "Well, it [the walk-in clinic] gives you options if you can't get a hold of your family doctor, you can't get an appointment at least there's something there." Since the way the system functions means they cannot get service in the way they prefer, participants tended to see this as something that fills – sometimes satisfactorily – an undesirable gap in their ability to see their own family doctor when they want to.

Quality of primary care

Although most participants expressed dissatisfaction with long wait times to see a primary care provider, most felt the care they receive when they do see a primary care provider is good. The sense was that barriers and delays aside, **when primary care is ultimately delivered, it tends to be satisfactory**. As one heavy system user in Quebec stated, "The quality of care, once you are in, it's fine, you are well followed, we have a quality system." However, participants felt strongly that overall quality of primary care depends, at least in part, on the timeliness of access:

> *"High quality care is something I had when my children were young, 45 years ago. They're all in their 40s. If I phoned and said, my child had an earache, or a tummy ache or something like that, my doctor every time would say, come in. I don't know what's changed now. But that is not happening. I'm so glad that I'm not raising kids now. Or seniors, the same things that come up, you know, that the care is not the same. It's so fragmented now." -Regular System User, BC/Territories*

In short, participants were clear that **high quality care means the ability to receive care rapidly**.

In addition, having health care professionals who listen, take the time to get to know a patient's full health picture and are responsive to patients' wishes – even if it means accessing a test or type of care the doctor thinks is not ideal – were all factors that shaped participants' definition of high quality care. A few also felt that high quality care hinges in part on clear communication about the patient's health and any treatment, consultations or tests they receive between the health care professionals they interact with (e.g., between family doctors and specialists).

The things that participants noted stand in the way of high-quality care, aside from wait times, included feeling rushed by their health care provider. One LGBTQ2S+ participant elaborated, *"When I think of high-quality care, I would say like, when they're not doing the doorknob approach, like they're not standing in the room with their hand on the doorknob waiting to go see the next patient."* It was important to participants that their primary care provider be present, focused and listen actively.

Impact of COVID-19 on experiences with primary care

The COVID-19 pandemic has impacted participants' primary care experience. Virtual care has played an increasingly important role in how they access primary care; the experiences of which are explored further in the Digital health experiences, perceptions and preferences section of this report. For example, most participants said that over the course of the last two years, they have taken advantage of virtual care to meet with their doctor either over the phone or via video call when they would have met in person prior to the pandemic. Some liked the flexibility this had allowed them, while others found it impersonal. Several felt that the pandemic had lengthened the amount of time they have to wait for an appointment, but others did not feel there was a noticeable change on this front. A few said that their doctor has reduced their administrative staff complement, which negatively impacted their experience visiting their doctor's office. Either they felt they had to wait longer to speak to someone about making an appointment, or felt their doctor's office seemed less organized than in the past.

A team-based approach and coordinated care

After discussing their experiences accessing primary care, participants were presented with the following definition of a "team-based" approach to health care:

> *In some models of primary care, a family doctor or "GP" will work as part of a team of medical professionals who work collaboratively to provide health services to patients and their caregivers. Under this team-based approach, patients may not see a family doctor every time they need care; rather, they would be under the*

> *care of multiple providers from different professions (e.g., GPs, Licensed Practical Nurses, Nurse Practitioners) who work together to meet their needs.*

Reactions were nearly always positive to this definition and the idea of a team-based approach to primary care. While some indicated having experienced such care first- or second-hand, for others this was a new, but sensible and welcome concept. Most could see the benefits to this approach. Many assumed it would mean more rapid access to the care they need, given the possibility that some of their issues might not require the attention of their family doctor, whose availability tended to be the biggest drawback to their primary care. A few participants had even experienced this model of care, for example visiting a nurse practitioner who worked alongside their doctor for certain matters, or a practitioner more specialized in mental health. They were universally satisfied with their experience. A few spoke about their experience seeing a nurse practitioner who worked alongside their doctor:

> *"She [my doctor] doesn't have a rule like most places where like, you can only see her for like one issue. So normally, when we meet, I'll say everything that's going on, and she'll triage, what she should be handling. And then she'll actually make appointments for me to meet with the nurse practitioner for the other issues. So that somebody else can handle like, if I needed, I don't know, a TWINRIX shot, or something like that, I don't need to see her [the doctor] to get that shot." -Heavy System User, Ontario*

> *"I don't have a problem with it [seeing a nurse practitioner instead of a family doctor]. If it means that I can get care with still sort of my doctor, at least it's someone who has my file, knows my history, can talk to the doctor about anything, any problems that I'm having, I don't have a problem with that." -Regular System User, Prairies*

> *"It's been great for me. They do it based on the availability of the team and the need. For example, I can have an appointment with a nurse practitioner. I like that I have options because I don't always need to see my doctor." -OLMC, French outside Quebec*

One or two had visited other health care practitioners affiliated with their doctor's office. As the participant below noted, sometimes these individuals can be more helpful or qualified to deal with certain health issues than a family doctor:

> *"We can all kind of move around where we need to be and not tie up specific needs so yeah, I think it's great. Also, I find for my son, he had some mental health issues, and it was nice for him to be able to float around within the office because somebody else was more qualified in that area for his age category. And although he wasn't our family physician, he just had a bit more insight and so he was then*

> *able to refer him in different areas and had other patients sort of similar. I like the team approach. For us, it's worked well." -Indigenous participant*

Others who had not experienced the team-based approach to primary care appreciated the possibility that there would be diverse expertise or perhaps more opinions available for providing their care or shaping the treatment they receive. One participant summed up this idea:

> *"I like the team-based concept, because like, all the different skill sets, like nurse practitioner, primary care, physician specialists, those are all meant to be complimentary, right? Like, there's a specialist because they're a specialist. Right. And as the severity or seriousness of a medical condition progresses, you need to access those different skill sets. So, I like the team approach, I think in its own way it addresses, it kind of delivers its own unique form of continuity and consistency, which I also like." -Regular System User, BC/Territories*

A key criterion for a team-based approach to be satisfactory that was often raised was how well information is shared among the professionals on the team. The better the body of consolidated information that a health care team can access or discuss together, the better this approach was seen to be.

A few participants expressed concerns about the team-based model. The drawbacks they noted included **concern that they might not be able to access their family doctor**. They wanted assurances that access to their doctor would still be available when warranted. Similarly, participants wanted to be sure that the skills of the person they saw were no worse than the skills they would access from their main provider. Discussions indicated many felt this would likely be the case, but some were more cautious in their assumption.

Participants were also presented with the idea of "coordinated care", defined as follows:

> *Coordinated care is when different areas of the health care system (e.g., primary care, specialty care, acute care) share information and coordinate patient care activities, such that a patient receives consistent care as they move across the health system.*

Discussions on the notion of coordinated care across different areas of the health care system provided a mix of interpretations. Some did not clearly grasp the concept and found it confusing. Others readily understood the description. For those with more ability to talk about coordinated care, the need to **share information across sites was fundamental.** As noted earlier, it was described as a component of high-quality care**.** The idea that health care professionals could have access to a centralized repository of patient information was welcome one:

> *I'm all for this sharing of information between your medical professionals, like you go into a clinic or you go to see a doctor, you have to go through the whole*

> *rigmarole of saying, you know, I have this, I have that, I have this, I take this medicine for that, and this and that. And if they all actually shared the information and have a centralized database that they can go to, to pull your medical records and actually be prepared for your appointment that you're going to, that would be fantastic. -Heavy System User, BC*

In fact, information sharing was often the main driver of whether someone felt they had received care that was well-coordinated or felt that accessing health care across different sites/providers (e.g., managing a referral from a primary care doctor to a surgeon or specialist) demonstrated to them there was a lack of coordination. Personal experiences highlighted that some felt their care was coordinated, for example that specialists would send any results from tests they had conducted to their primary care provider. Others did not feel this way and had experienced a **lack of communication between primary care providers and other parts of the health care system**:

> *I have a number of health issues; I see a number of different specialists. And each time I go to each one, it's like, no one knows what's going on with any other area. And even when I go to my GP, it's like, well, you know, what did this specialist say last time he saw what did this specialist say? Why? Why are they not getting reports and having the information so that they know what all of these specialists are saying? -Regular System User, Prairies*

Personal involvement in health care

Participants were asked if they would consider themselves proactive or actively involved in managing their health. Most agreed that they were and felt that the role they play in managing their health is appropriate, particularly when it comes to dealing with a chronic health condition (e.g., monitoring blood sugar for those with diabetes, ensuring they understand and can manage medications, taking their blood pressure, etc.) as well as doing what they could to improve their overall health (e.g., diet, exercise, mitigating the risk of conditions they may be already genetically pre-disposed to). However, asking more directly about whether they feel either enabled or forced to be an advocate for their own care elicited a variety of opinions, some positive and others more challenging. **Participants definitely wanted to be a partner in decisions affecting their own care**, but some found it more difficult to influence decisions in ways they wanted. To access services that they may want or feel they need, many participants explained that they had to advocate for themselves for fear of being forgotten or overlooked by a health care provider along the way:

> *"I think it comes down to like, you have to advocate for yourself in the system. If you're not willing to speak up, if you're not willing to say, no, this is something that I need to get addressed. In the system, it's very easy to just kind of, I don't want to*

> *say get ignored. That's not the right word. But just like, follow up, right? You get lost." -Regular System User, BC/Territories*

> *"I believe we do have to advocate for ourselves. If you think it's all going to come to you, you'll be waiting forever. Sometimes you have to force the issue; push ahead." -OLMC, French outside Quebec*

Some found it more difficult than others to influence decisions related to their health care. Sometimes, it seemed the barrier was an unwillingness on the part of a family doctor to agree to their requests or accept alternative perspectives on treatment or possible diagnoses. Relatedly, several felt this reluctance to agree to their requests was due to their doctor being rushed and too busy to really consider what they were asking.

Others who described challenges when it comes to being involved often spoke of situations where they felt the need to prepare in advance or be aware of questions to raise. Most felt it was wise to prepare for appointments and note the questions they wanted to ask, though a few were frustrated that they have to "do their own research". Some were also frustrated by a lack of information sharing or a requirement to constantly repeat or provide vital information to primary care providers that they felt should not be their responsibility to provide.

When asked whether they felt they are treated as a partner in decisions impacting their health care, views were mixed. It was **important to all to be treated as a partner, but not all felt that they were**. Those who did feel that they are treated as a partner in their health care tended to have open and clear communication with their doctor and believed that their doctor listens to them. Those who disagreed, tended to feel their doctor does not do enough to explain options, provide context or respond to their questions/suggestions.

Digital health experiences, perceptions, and preferences

Invariably, the topics of digital health and digital tools came up organically at different points earlier in the focus group discussions. To ensure everyone had the same basis of understanding, participants were provided with the following definitions of digital health and digital tools:

> *For the purposes of our discussion, digital health refers to the use of information technology/electronic communication tools (or digital tools), services and processes to deliver health care services or to facilitate better health. Some examples could include: a patient portal to allow for the access of health information and make appointments. Another might be an online mental health tracking platform, to supplement appointments with a counsellor.*

> *Digital tools are software, programs, applications, platforms, or other online resources that can be accessed using a digital device, such as a computer or tablet.*

Access to personal health information

Participants nearly universally valued being able to access their own health information, although not all have had a need to do so. Satisfaction with experiences accessing one's own health information ranged. Many had complaints, often explaining that providers were reluctant to share information, would sometimes only share it in paper form (and at a cost to the patient). These behaviours made it more challenging to ensure the right information was in the right hands at any given/vital moment. Of those who described better experiences, these were largely attributed to electronic access (particularly to test results) via portals or email.

> *"I think it's very important. If you move or travel, to correct errors, if you need to change doctors or see a specialist." -OLMC, French outside Quebec*

Virtual care and digital tools

As mentioned earlier, the majority had accessed an element of virtual care. Some had scheduled virtual care appointments with their doctor. Additionally, a few had accessed virtual care through an app (a few mentioned the Telus app specifically). Generally, **participants were satisfied with their experience with virtual appointments and felt this kind of appointment is a viable option, as long as whatever issue the patient is communicating can be easily dealt with without a physical examination.** Examples of when a virtual appointment might be more appropriate than one conducted in-person included prescription renewal, reviewing test results, and to discuss mental health issues. One participant also noted that virtual appointments could be very useful for parents, who often have to remove their children from school for a half-day or more to see a doctor. Participants who had accessed virtual care were generally satisfied with the process and happy that this approach saved them time:

> *"For me, it was very positive. Basically, I had some test results. The doctor wanted to go over them with me and we did it through zoom. It was fairly easy, done on pretty much wherever you have access to the internet, so you don't have to go into the office, wait, take half the day off. So, I actually did it from work. I just plugged in on the computer, logged on. And I had my appointment. And that was it, I took a break 15-minute break. So, for me, it was really positive." -Heavy System User, Ontario*

> *"I'm fortunate enough through work to have a benefit, where you have access to online practitioners in like locally in your town, and we use that. My wife had a cut*

> *on her finger, and we showed the nurse practitioner on the screen. And they said, well, you may need antibiotics and it may be infected, something like that. Then we got transferred to a doctor online, on the phone. And they emailed the prescription to our local pharmacy and ended up getting it delivered to our house during COVID. It was an awesome experience.” -Heavy System User, Ontario*

> *“That’s a positive point for me about the pandemic. My doctor has a team of 5 or 6 healthcare professionals. They created an email system. I can send an email, attach photos, and they’ll either call me back or a nurse will send me a prescription.” -OLMC, French outside Quebec*

Many were grateful for the digital tools that they already employ. In addition to the virtual appointments and appointment scheduling noted above, the tools participants already used included health metric tracking devices, such as FitBits or other devices that monitor sleep, heart rate, menstrual cycles, etc. Those who had not tried any such tools were keen to hear more about what they could access and could easily come up with ways they could be beneficial:

> *“You know, this sounds glib, but like, I didn't come with like an owner's manual. Right? So given my age, my genetic background, it would be great to have essentially, like an app, which says, okay, hey, you're 55, here's some of the things you need to consider. Or hey, did you know you're basically due for a service checkup, like your car.” -Regular System User, BC/Territories*

Benefits and drawbacks of digital tools

The perceived **benefits of digital tools were largely related to efficiency**. Participants saw many opportunities for efficiencies through the use of these tools, including facilitating the flow of information from one medical provider to another. They also felt these tools could save them time (e.g., as noted above, virtual appointments could remove the time it takes to travel to appointments, help them avoid having to wait in line for an appointment). As one regular system user in Ontario explained, “I don't have to take three hours off work to go see the doctor. I can just wait in the queue while I'm working. And then, have my 10-minute appointment to get my prescription refilled or get my referral to a specialist, and then go back to work.” Others felt there were efficiencies to be gained from greater transparency of their health information and access to such information online.

Overall, participants agreed digital health care and tools could fit within the health care system but should not completely replace in-person visits. As one participant explained, they should be part of a menu of options available to Canadians:

> *"So, in my work, we have people order pizza, and we have what we call different channels, right? There's people who want to order over the phone. And there's people who want to order from our website on their computer. And there's people who want to order from our mobile app. And there's people who want to order from third parties, and we meet all of those customers where they want to be. And when it comes to this digital approach, we have to make sure that whatever approach we take gives avenues or venues or channels for everybody to interact." -Regular System User, BC/Territories*

Some, including the participant quoted above, did have concerns that a move to offering some services exclusively in a digital format could create a barrier to access or reduce the quality of care. **They felt Canadians should be able to choose the method of access – whether virtual or in-person –** with which they are most comfortable. A few also worried that it could lead to changes driven by a desire to save money in the system, rather than improve patient experience:

> *"So, if the purpose of digital health is to improve patient engagement and experience with the health care system, if that's the first priority, then that's great. But if it's, if it saves money, while it does that, that's great. But I'm concerned that government's first priority is to save money, and that's what will drive the decision." -Heavy System User, Ontario*

When asked about drawbacks, nearly all either offered or agreed that the **risk of a breach of security protecting their personal information was a threat.** While it was not a threat that was unimportant, some felt that systems would be in place to protect the information as best as can be done. Some, while still concerned about the possibility of a leak or hack, said that this sort of thing happening to their health information would be less serious than a breach of their financial information. Others were resigned to the fact that hacking will likely be attempted or occur and that was something we just have to live with these days. As the quotes below demonstrate, the degree of concern varied:

> *"I think it's just like everything else, like banking, online banking, online shopping, anything you do. Once, you put it in a computer or a phone, wherever, once you swipe your card, then it's vulnerable. So, in my mind, I feel that it doesn't really matter. Either way, you're, you're going to be vulnerable. And you'll have to trust that they're going to put in the safe factors that they need to put in and hope that they hold." -Regular System User, Atlantic Canada*

> *"I think they do everything they can to keep it [health information] safe. I just feel like with computers and technology in general, there's always people that are ten steps ahead or better at hacking. And it's a real issue with cybersecurity where I mean, you've heard about multiple people getting hacked, and multiple companies*

> *being hacked, pipelines being shut down. And if, you know if people can't stop that from happening, then it's a problem. And I think it has to be more money has to be allocated towards security." -Heavy System User, Prairies*
>
> *"The Government of Canada can't protect our information. And they've had so many cybersecurity breaches, how in the world, are they going to take care of our health information?" -Indigenous participant*

The context of what specific source of threat participants had in mind was a factor. For example, some were particularly concerned about their information being sold to, leaked to, or otherwise exploited for the benefit of corporate interests such as insurance companies. One or two were concerned that a centralized database of health information, presumably run by the government, would mean government could access their health information. This was particularly relevant for one Indigenous participant who referring to the historically problematic relationship Indigenous peoples have had with researchers, academics and other data collectors said, "I really don't trust government research. They have a bad history with Indigenous peoples." The opportunity to provide informed consent first seemed to assuage some of these concerns.

Despite their concerns about data security and privacy, none of the participants felt the drawbacks outweighed the benefits to using digital health and related tools, particularly since they assumed policies and measures would be implemented that would lessen the impact of the drawbacks. There was also a sense that society is moving towards digitization in almost every other aspect, so making the transition in health care is almost inevitable. Moreover, participants felt it could play an important role in the future of Canada's health care system particularly in terms of modernization, improved efficiency, and care.

When it comes to sharing their personal health information, one of the first questions often raised was "for what purpose?" More participants were comfortable sharing their information for public health purposes than any other, with the caveat that it be **de-identified**, and, for some, that they explicitly consented to its use for this purpose:

> *"Deidentified? Absolutely. I don't think that there's any problem with that at all. The only way we can learn and advance and progress is by gathering this information and analyzing it. So, you know, the more information we can give public health, the better." -Regular System User, Prairies*
>
> *"I think they need to use this information to improve and to understand and to see trends and to actually crunch the data into something that they can use for forecasting and everything else. But they don't need to know it's me personally. Remove the name, use the actual data, but just make sure it's not tied back to my name." -LGBTQ2S+ participant*

> *“I would have some apprehensions about how anonymous that data would be. I mean, there's already conversations going on right now about the government using health tracking data, without the appropriate permissions to try, probably with good intent to deal with the pandemic. But without my knowledge, or other people's knowledge, they're using information that tells a lot about a person and privacy in this digital age is going to be very hard to get and needs to be protected and fought for.” -Regular System User, BC/Territories*

The more serious concerns seemed to be about whether personal health information would be used for profit or for justifying adjustments to the system that result in pared down care.

All in all, the vast majority of participants felt **digital health is an important and natural progression in the evolution of Canada’s health care system**. The perceived benefits such as increased efficiency, improved communication flow, and ease managing their health care, were seen as ways to address some of the health system challenges, including the ones they identified initially. However, there was a sense that digital health was not without risk, mainly around data security and privacy. And, while not all were personally preoccupied with this, reasoning it was not much different than other online behaviours in which they engage, some were more skeptical of who might access their health information and for what purpose. Health care providers accessing the information was less of a concern than researchers or the government (especially the federal government) accessing such information. The majority were more comfortable sharing de-identified health information.

Conclusions

While there are elements of the health care system for which participants are grateful, namely that it is universally accessible and free, there are clear pain points when it comes to access to primary care and the pressure on providers' time. Both wait times and feeling rushed through appointments are concerning, regardless of whether one is a regular or heavy system user.

In fact, although the groups were segregated based on expected usage of the health care system, the opinions expressed by regular users of the health care system and heavy users tended to be very similar in theme and direction, with perhaps some modest differences in terms of the number of experiences. As a result, on most questions, we found the same tendencies regardless of group.

For the most part the care participants receive is rated highly, though the overall quality of primary care hinges on quick access to a dedicated and attentive primary care provider.

Participants were open to some changes to how the health care system is structured, while other changes were deemed more controversial. Controversial changes included allowing Canadians to pay for services out of pocket, fearing it would create a two-tiered system, while other were open to the idea to free up capacity. Many were also opposed to growing reliance on walk-in clinics, and preferred to visit a dedicated health care team. However, the team-based approach was met with much more acceptance and participants could see the benefits of this approach, both in terms of reduced wait times and wider range of expertise. Those who understood the concept of coordinated care agreed that coordinated sharing of information across sites and health care providers was fundamental to providing high quality care. **In short, the changes that participants felt would improve access, efficiency and wait times while preserving the universality of care and providing access to a dedicated primary care team were the least controversial and preferred options.**

Overall, participants agreed that there is a place for more digital health and tools in the system. There was enthusiasm for various aspects of digital health and digital tools, with some reservations. Participants sensed that most other aspects of life are moving towards digitization and these types of changes could be an important part of how the health care system is modernized to improve patient access to health care information and timely primary care. **However, should the health care system continue to move towards these tools, security of health information will only grow in terms of importance.** Participants were somewhat wary of sharing their health information, though more open to the idea if it was for public health purposes and was de-identified.

The findings suggest that improving the quality of primary care in Canada is linked to improving timely access. **There is likely openness to new and innovative ways of providing care,**

such as a team-based approach and taking advantage of digital health and tools, though reassuring the population that the providers they see are qualified to deal with their issue and that their data is secure will be important to securing support and uptake.

Appendix A – Focus Group Methodology Report

Methodology

This research included a series of fifteen online focus groups with 127 participants. The groups took place from January 24 to 27, 2022. Ten of the groups comprised of people residing in one of five specific regions: Atlantic Canada, Quebec, Ontario, the Prairies, and British Columbia/Territories. In each region, two groups were conducted – one among those who were identified as heavy users of the health care system (defined as people with a chronic health condition); and the other among people with more typical usage of the system ("regular" users were defined as those with no chronic health condition). The list of chronic health conditions used for screening purposes can be found in Appendix B.

In addition to the regular and heavy system user groups, one group was conducted with each of five specific audiences: LGBTQ+; official language minorities (Anglophones in Quebec and Francophones outside of Quebec); Indigenous participants; and, recent immigrants. These groups included a mix of regular and heavy system users. The groups with regular and heavy system users in Quebec, as well as the group with Francophones outside Quebec, were conducted in French. The sessions were approximately 90 minutes in length and participants received an honorarium of $100.

The table below shows the composition, date, and time of each group, as well as the number of participants per group.

Group	Audience	Region/Language	Time	Number of Participants
Monday January 24, 2022				
1	Regular system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST	10
2	Heavy system users	Ontario (EN)	6:00 pm EST	10
3	Regular system users	BC/Territories (EN)	8:00 pm EST / 5:00 pm PST	10
Tuesday January 25, 2022				
4	Regular system users	Ontario (EN)	5:00 pm EST	8
5	Heavy system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST	8
6	Heavy system users	Quebec (FR)	5:00 pm EST	7
7	Heavy system users	BC/Territories (BC)	8:00 pm EST / 5:00 pm PST	7
Wednesday January 26, 2022				
8	Heavy system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST	8
9	Regular system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST	9

10	Regular system users	Quebec (FR)	5:30 pm EST	8
11	LGBTQ2S+	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST / 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST	8
Thursday January 27, 2022				
12	Francophones outside Quebec	ATL, ON, Prairies, BC, Territories (FR)	5:30 pm EST / 6:30 pm AST / 7:00 pm NST / 4:30 pm CST / 3:30 pm MST / 2:30 pm PST	10
13	Indigenous peoples	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST	8
14	Anglophones in Quebec	QC	5:00 pm EST	9
15	Recent immigrants	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST	7

Recruitment

Participants were recruited using a screening questionnaire (included in Appendix B). For each group we recruited 10 participants, for 8-10 to show.

The target audiences for this research were heavy users of the health care system (defined as those with a chronic health condition) and regular system users (defined as those without a chronic health condition). The research also included groups with Indigenous individuals, LGBTQ2S+ individuals, Francophones outside Quebec, Anglophones in Quebec, and recent immigrants (defined as having been in Canada for 5 years or less). Additionally, we screened participants to ensure we aimed for a good mix of household income, employment, education, household type, urban vs suburban vs rural, etc.

Quality Response, and their selected suppliers reached out to members of their respective databases first via email and follow-up with telephone calls to pre-qualify participants. This is the approach employed most often. They then conducted telephone recruitment to supplement in each market.

For recruitment in Atlantic Canada and Ontario, Quality Response relied on their own proprietary database of approximately 35,000 Canadians with profiling on a range of attributes including standard personal demographics, household composition, medical background, technology usage, financial services, health and wellness, business profiles, and other relevant criteria. Their database is constantly being updated and replenished and operates out of their own, onsite telephone room in Toronto, Ontario. Potential group participants are recruited to their database via mixed-mode: following a proprietary telephone survey, online, referral, social media and print advertising. Initial contact is often made via email or online pre-screening for speed and economies, followed up by personal telephone recruitment and pre-group attendance confirmation.

For recruitment in Atlantic Canada, Ontario, and British Columbia and the Territories, Quality Response partnered with Metroline Research. Metroline's database includes approximately 4,500 Canadians. New participants are added to their database via referrals and online advertising. Metroline profiles their database for a variety of characteristics including but not limited to: location; marital status; occupation; income; smoking habits; drinking habits, etc.

For recruitment in Quebec, Quality Response partnered with MBA Recherche. MBA Recherche's vast database includes approximately 35,000 Canadians across Quebec. They use Google ads, their website, telephone RDD lists, and referrals to recruit new participants. In addition to a variety of demographics, MBA Recherche's profiling includes automobile types, substance use, and mobile phone attributes.

For recruitment in Ontario, Quality Response also partnered with Brookson Research. Brookson Research's database is comprised of approximately 9,500 Canadians. New people are added to the database via phone, text, email and corporate website. The company does twice-yearly drives to refresh the database in English and French. The database is profiled by name, gender, age, contact information, city of residence, education, mother tongue, occupation and history attending market research sessions.

For recruitment in the Prairies, British Columbia and the Territories, Quality Response partnered with Pele Research. Located in Manitoba and Saskatchewan, Pele Research's database includes approximately 3,000 Canadians per province. Pele Research profiles their database by name, age, gender, income, education, occupation, and phone number.

For recruitment in British Columbia and the Territories, Quality Response also partnered with Walmsley Research. Walmsley's database is comprised of approximately 5,500 residents of Vancouver. They rely on referrals and online advertisements to recruit to their database. In addition to a variety of demographics, their database is profiled for: age of children, occupation, spouse's occupation, health issues, etc.

To recruit the special audiences in this study, Quality Response relied on all the partners above.

Moderation

Two moderators were used to conduct the focus groups. Our team worked together to moderate the groups, debriefing, after each night of groups on the functionality of the discussion guide; any issues relating to recruitment, turnout, technology and, key findings including noting instances that were unique and that were similar to previous sessions. Together, we discussed the findings on an ongoing basis in order to allow for probing of areas that required further investigation in subsequent groups and before the final results are reported.

A note about interpreting qualitative research results

It is important to note that qualitative research is a form of scientific, social, policy, and public opinion research. Focus group research is not designed to help a group reach a consensus or to make decisions, but rather to elicit the full range of ideas, attitudes, experiences and opinions of a selected sample of participants on a defined topic. Because of the small numbers involved the participants cannot be expected to be thoroughly representative in a statistical sense of the larger population from which they are drawn and findings cannot reliably be generalized beyond their number.

Glossary of terms

The following is a glossary of terms which explains the generalizations and interpretations of qualitative terms used throughout the report. These phrases are used when groups of participants share a specific point of view and emerging themes can be reported. Unless otherwise stated, it should not be taken to mean that the rest of participants disagreed with the point; rather others either did not comment or did not have a strong opinion on the question.

Generalization	**Interpretation**
Few	*Few* is used when less than 10% of participants have responded with similar answers.
Several	*Several* is used when fewer than 20% of the participants responded with similar answers.
Some	*Some* is used when more than 20% but significantly fewer than 50% of participants respondents with similar answers.
Many	*Many* is used when nearly 50% of participants responded with similar answers.
Majority/Plurality	*Majority* or *plurality* are used when more than 50% but fewer than 75% of the participants responded with similar answers.
Most	*Most* is used when more than 75% of the participants responded with similar answers.
Vast majority	*Vast majority* is used when nearly all participants responded with similar answers, but several had differing views.

Unanimous/Almost all	*Unanimous* or *almost all* are used when all participants gave similar answers or when the vast majority of participants gave similar answers and the remaining few declined to comment on the issue in question.

Appendix B – Recruitment Screener

Focus Group Summary

- Recruit 10 participants for 8-10 to show.
- Groups are 90 minutes in length.
- 15 groups in total.
  - 5 groups will be conducted with heavy users of the health care system (have a chronic health condition)
  - 5 groups will be conducted with regular users of the health care system (do not have a chronic health condition)
  - 5 groups will be conducted with each of the following: Francophones outside Quebec, Anglophones in Quebec, recent immigrants, LGBTQ2S+ persons, Indigenous peoples. Mix of heavy and regular system users in each group.
- Ensure good mix of other demos (age, gender, ethnicity, income, education, household type, urban/suburban/rural etc.).

Group	Audience	Region/Language	Time
Monday January 24, 2022			
1	Regular system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST
2	Heavy system users	Ontario (EN)	6:00 pm EST
3	Regular system users	BC/Territories (EN)	8:00 pm EST / 5:00 pm PST
Tuesday January 25, 2022			
4	Regular system users	Ontario (EN)	5:00 pm EST
5	Heavy system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST
6	Heavy system users	Quebec (FR)	5:00 pm EST
7	Heavy system users	BC/Territories (BC)	8:00 pm EST / 5:00 pm PST
Wednesday January 26, 2022			
8	Heavy system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST
9	Regular system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST
10	Regular system users	Quebec (FR)	5:30 pm EST
11	LGBTQ2S+	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST / 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST
Thursday January 27, 2022			
12	Francophones outside Quebec	ATL, ON, Prairies, BC, Territories (FR)	5:30 pm EST / 6:30 pm AST / 7:00 pm NST / 4:30 pm CST / 3:30 pm MST / 2:30 pm PST
13	Indigenous peoples	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST
14	Anglophones in Quebec	QC	5:00 pm EST

15	Recent immigrants	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST

Respondent's name: Respondent's phone number: (work) Respondent's phone number: (cell) Respondent's email: Sample source: panel random client referral	Interviewer: Date: Validated: Quality Central: On list: On quotas:	

Hello/Bonjour, this is _______________ calling on behalf of Earnscliffe, a national public opinion research firm. We are organizing a series of discussion groups on issues of importance on behalf of the Government of Canada. We are looking for people who would be willing to participate in a 90-minute online discussion group. Up to 10 participants will be taking part and for their time, participants will receive an honorarium of $100. May I continue?

Yes	CONTINUE
No	THANK AND TERMINATE

Participation is voluntary. We are interested in hearing your opinions; no attempt will be made to sell you anything or change your point of view. The format is a 'round table' discussion led by a research professional. All opinions expressed will remain anonymous and views will be grouped together to ensure no particular individual can be identified. I would like to ask you a few questions to see if you or someone in your household qualify to participate. This will take about three minutes. May I continue?

Yes	CONTINUE
No	THANK AND TERMINATE

Monitoring text:

READ TO ALL: "This call may be monitored or audio taped for quality control and evaluation purposes.
ADDITIONAL CLARIFICATION IF NEEDED:
To ensure that I (the interviewer) am reading the questions correctly and collecting your answers accurately;
To assess my (the interviewer) work for performance evaluation;
To ensure that the questionnaire is accurate/correct (i.e. evaluation of CATI programming and methodology – we're asking the right questions to meet our clients' research requirements – kind of like pre-testing)
If the call is audio taped, it is only for the purposes of playback to the interviewer for a performance evaluation immediately after the interview is conducted or it can be used by the Project Manager/client to evaluate the questionnaire if they are unavailable at the time of the interview – all audio tapes are destroyed after the evaluation.

1. Do you or does anyone in your immediate family or household work in any of the following areas?

Area	Yes	No
A marketing research firm	1	2
A magazine or newspaper, online or print	1	2
A radio or television station	1	2
A public relations company	1	2
An advertising agency or graphic design firm	1	2
An online media company or as a blog writer	1	2
In health care or in a health care setting	1	2
The government, whether federal, provincial or municipal	1	2

IF "YES" TO ANY OF THE ABOVE, THANK AND TERMINATE

2. In which province or territory do you live?

Newfoundland and Labrador	1
Nova Scotia	2
New Brunswick	3
Prince Edward Island	4
Quebec	5
Ontario	6
Manitoba	7
Saskatchewan	8
Alberta	9
British-Columbia	10
Nunavut	11
Northwest Territories	12
Yukon	13

3. Which of the following age categories do you fall in to? Are you…? *ENSURE GOOD MIX*

Under 18 years	1	THANK AND TERMINATE
18-24 years	2	
25-29 years	3	
30-34 years	4	
35-44 years	5	
45-54 years	6	
55-65 years	7	
66+ years	8	

4. Are you…? *ENSURE GOOD MIX*

Male gender	1	
Female gender	2	
Other gender identity	3	ELIGIBLE FOR LGBTQ2S+ GROUP

5. What is your sexual orientation?

Heterosexual	1	CONTINUE
Homosexual	2	ELIGIBLE FOR LGBTQ2S+ GROUP
Bisexual	3	
Other [SPECIFY]	4	
Don’t know/Prefer not to say	9	THANK AND TERMINATE

6. Which of the following categories best describes the situation of the people living in your household? Please note that “a couple” refers to either a married or a “common-law” couple. Are the people living in your household…? *ENSURE GOOD MIX*

A couple with no children living at home	1
A couple with at least one child under 18 living at home	2
A single parent family with at least one child under 18 living at home	3
A non-family household, for example roommates	4
Lives alone	5
Other (specify)	6
Don’t know/Prefer not to say	9

7. Have you been diagnosed with a chronic health condition?

Yes	1	ASK 7A
No	2	CONTINUE FOR SPECIAL AUDIENCES OR REGULAR USERS
Don’t know/Prefer not to say	9	THANK AND TERMINATE

7a. What is it? CODE ALL THAT APPLY, CONFIRM WITH RESPONDENT AS NEEDED.

INTERVIEWER NOTE, EXPLAIN AS NEEDED: A chronic health condition is defined broadly as a condition that lasts 1 year or more and requires ongoing medical attention and/or limits the activities of daily living.

Angina	1	QUALIFY FOR HEAVY USER GROUPS & SPECIAL AUDIENCES
Arthritis	2	
Asthma	3	
Cancer	4	
Cardiovascular disease (e.g., hypertension)	5	
Chronic respiratory disease (e.g., Asthma, Chronic Obstructive Pulmonary Disease)	6	
Diabetes	7	
Epilepsy	8	
Fibromyalgia Syndrome	9	
Heart Attacks	10	
Hypertension	11	
Inflammatory Bowel Disease (Crohn’s disease, colitis)	12	
Mental illness (e.g., depression, bipolar disorder)	13	
Multiple Sclerosis	14	
Osteoporosis	15	

Parkinson's disease	16	
None of the above/Do not have a chronic illness	98	THANK AND TERMINATE
Don't know/Prefer not to say	99	THANK AND TERMINATE

NOTE THAT THE 5 SPECIAL AUDIENCE GROUPS (ANGLOS IN QC, FRANCOS OUTSIDE QC, LGTBQ2S, INDIGENOUS AND RECENT IMMIGRANTS) SHOULD INCLUDE A MIX OF REGULAR AND HEAVY SYSTEM USERS

8. Do you have a primary care provider, like a family doctor or nurse practitioner?

Yes	1	
No	2	AIM FOR 1-2 PER GROUP
Don't know/Prefer not to say	9	THANK AND TERMINATE

9. What language do you speak most often at home?

English	1	IF EN IN QC, RECRUIT FOR ANGLO IN QC GROUP
French	2	IF FR OUTSIDE QC, RECRUIT FOR FRANCO OUTSIDE QC GROUP
Other	3	CONTINUE
Don't know/Prefer not to say	9	THANK AND TERMINATE

10. Were you born in Canada?

Yes	1	SKIP TO S12
No	2	CONTINUE TO S11
Don't know/Prefer not to say	9	THANK AND TERMINATE

11. Have you lived in Canada for…

5 years or less	1	ELIGIBLE FOR RECENT IMMIGRANT GROUP
More than 5 years	2	CONTINUE FOR OTHER GROUPS
Don't know/Prefer not to say	9	THANK AND TERMINATE

12. Do you identify as an Indigenous person, that is, First Nations (Status or non-Status) (North American Indian), Métis, or Inuk (Inuit)?

Yes	1	ELIGIBLE FOR INDIGENOUS GROUP
No	2	PROCEED TO S13

13. [IF NOT INDIGENOUS] To make sure that we speak to a diversity of people, could you please tell me what is your ethnic background? DO NOT READ *ENSURE GOOD MIX*

Caucasian	1
Chinese	2
South Asian (i.e., East Indian, Pakistani, etc.)	3
Black	4
Filipino	5
Latin American	6

Southeast Asian (i.e. Vietnamese, etc.)	7
Arab	8
West Asian (i.e. Iranian, Afghan, etc.)	9
Korean	10
Japanese	11
Other (please specify)	12
DK/NR	13

14. What is your current employment status? *ENSURE GOOD MIX*

Working full-time	1	
Working part-time	2	
Self-employed	3	
Retired	4	
Unemployed	5	
Student	6	
Other	7	
DK/NR	9	THANK AND TERMINATE

15. Which of the following categories best describes your total household income; that is, the total income of all persons in your household combined, before taxes? [READ LIST] *ENSURE GOOD MIX*

Under $20,000	1	
$20,000 to under $40,000	2	
$40,000 to under $60,000	3	
$60,000 to under $80,000	4	
$80,000 to under $100,000	5	
$100,000 to under $150,000	6	
$150,000 or more	7	
DK/NR	9	THANK AND TERMINATE

16. What is the last level of education that you have completed? *ENSURE GOOD MIX*

Some high school only	1	
Completed high school	2	
Some college/university	3	
Completed college/university	4	
Post-graduate studies	5	
DK/NR	9	THANK AND TERMINATE

17. How would you describe the area in which you live? [ENSURE GOOD MIX]

Large urban population centre, that is, it has a population 100,000 or greater	1
Medium urban population centre, that is, it has a population of 30,000 to 99,999	2
Small urban population centre, that is, it has a population of 1,000 to 29,999	3
Rural area, that is, it has a population of less than 1,000	4
Remote area, that is, it has a population of less than 1,000 and you are isolated from other communities	5
Don't know/Prefer not to say	9

18. Have you participated in a discussion or focus group before? A discussion group brings together a few people in order to know their opinion about a given subject.

Yes	1	MAX 2 PER GROUP, ASK S19, S20, S21
No	2	SKIP TO S22
DK / NR	9	THANK AND TERMINATE

19. When was the last time you attended a discussion or focus group?

If within the last 6 months	1	THANK AND TERMINATE
If not within the last 6 months	2	CONTINUE
DK / NR	9	THANK AND TERMINATE

20. How many of these sessions have you attended in the last five years?

If 4 or less	1	CONTINUE
If 5 or more	2	THANK AND TERMINATE
DK / NR	9	THANK AND TERMINATE

21. And what was/were the main topic(s) of discussion in those groups?

IF RELATED TO THE HEALTH CARE SYSTEM/OTHER HEALTH ISSUES, THANK AND TERMINATE

This research will require participating in a video call online.

22. Do you have access to a computer, smartphone or tablet with high-speed internet which will allow you to participate in an online discussion group?

Yes	CONTINUE
No	THANK AND TERMINATE

23. Does your computer/smartphone/tablet have a camera that will allow you to be visible to the moderator and other participants as part of an online discussion group?

Yes	CONTINUE
No	THANK AND TERMINATE

24. Do you have a personal email address that is currently active and available to you?

Yes	CONTINUE, PLEASE RECORD EMAIL
No	THANK AND TERMINATE

INVITATION

25. Participants in discussion groups are asked to voice their opinions and thoughts. How comfortable are you in voicing your opinions in front of others? Are you…? (READ LIST)

Very comfortable	1	MINIMUM 4 PER GROUP
Fairly comfortable	2	CONTINUE
Comfortable	3	CONTINUE
Not very comfortable	4	THANK AND TERMINATE
Not at all comfortable	5	THANK AND TERMINATE
DK/NR	9	THANK AND TERMINATE

26. Sometimes participants are asked to read text, review images, or type out answers during the discussion. Is there any reason why you could not participate?

Yes	1	ASK S26
No	2	SKIP TO S28
DK/NR	9	THANK AND TERMINATE

27. Is there anything we could do to ensure that you can participate?

Yes	1	ASK S27
No	2	THANK AND TERMINATE
DK/NR	9	THANK AND TERMINATE

28. What specifically? [OPEN END]

INTERVIEWER TO NOTE FOR POTENTIAL ONE-ON-ONE INTERVIEW

29. Based on your responses, it looks like you have the profile we are looking for. I would like to invite you to participate in a small group discussion, called an online focus group, we are conducting at [TIME], on [DATE]

As you may know, focus groups are used to gather information on a particular subject matter. The discussion will consist of 8 to 10 people and will be very informal.

It will last up to 90 minutes and you will receive $100.00 as a thank you for your time. Would you be willing to attend?

Yes	1	RECRUIT
No	2	THANK AND TERMINATE
Don't know/Prefer not to say	9	THANK AND TERMINATE

PRIVACY QUESTIONS

Now I have a few questions that relate to privacy, your personal information and the research process. We will need your consent on a few issues that enable us to conduct our research. As I run through these questions, please feel free to ask me any questions you would like clarified.

P1) First, we will be providing a list of respondents' first names and profiles (screener responses) to the moderator so that they can sign you into the group. Do we have your permission to do this? I assure you it will be kept strictly confidential.

Yes	1	GO TO P2
No	2	GO TO P1A

We need to provide the first names and background of the people attending the focus group because only the individuals invited are allowed in the session and this information is necessary for verification purposes. Please be assured that this information will be kept strictly confidential. GO TO P1A

P1a) Now that I've explained this, do I have your permission to provide your first name and profile?

Yes	1	GO TO P2
No	2	THANK & TERMINATE

P2) A recording of the group session will be produced for research purposes. The recordings will be used by the research professional to assist in preparing a report on the research findings and may be used by the Government of Canada for internal reporting purposes.

Do you agree to be recorded for research and reporting purposes only?

Yes	1	THANK & GO TO P3
No	2	READ RESPONDENT INFO BELOW & GO TO P2A

It is necessary for the research process for us to record the session as the researchers need this material to complete the report.

P2a) Now that I've explained this, do I have your permission for recording?

Yes	1	THANK & GO TO P3
No	2	THANK & TERMINATE

P3) Employees from the Government of Canada may also be online to observe the groups.

Do you agree to be observed by Government of Canada employees?

Yes	1	THANK & GO TO INVITATION
No	2	GO TO P3A

P3a) It is standard qualitative procedure to invite clients, in this case, Government of Canada employees, to observe the groups online. They will be there simply to hear your opinions firsthand although they may take their own notes and confer with the moderator on occasion to discuss whether there are any additional questions to ask the group.

Do you agree to be observed by Government of Canada employees?

Yes	1	THANK & GO TO INVITATION
No	2	THANK & TERMINATE

INVITATION:

Wonderful, you qualify to participate in one of our discussion sessions. As I mentioned earlier, the group discussion will take place on [DATE] at [TIME] for up to 90 minutes.

Group	Audience	Region/Language	Time
Monday January 24, 2022			
1	Regular system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST
2	Heavy system users	Ontario (EN)	6:00 pm EST
3	Regular system users	BC/Territories (EN)	8:00 pm EST / 5:00 pm PST
Tuesday January 25, 2022			
4	Regular system users	Ontario (EN)	5:00 pm EST
5	Heavy system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST
6	Heavy system users	Quebec (FR)	5:00 pm EST
7	Heavy system users	BC/Territories (BC)	8:00 pm EST / 5:00 pm PST
Wednesday January 26, 2022			
8	Heavy system users	Atlantic Canada (EN)	4:00 pm EST / 5:00 pm AST / 5:30 pm NST
9	Regular system users	Prairies (EN)	7:00 pm EST / 6:00 pm CST 5:00 pm MST
10	Regular system users	Quebec (FR)	5:30 pm EST
11	LGBTQ2S+	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST / 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST

Thursday January 27, 2022			
12	Francophones outside Quebec	ATL, ON, Prairies, BC, Territories (FR)	5:30 pm EST / 6:30 pm AST / 7:00 pm NST / 4:30 pm CST / 3:30 pm MST / 2:30 pm PST
13	Indigenous peoples	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST
14	Anglophones in Quebec	QC	5:00 pm EST
15	Recent immigrants	Canada-wide (EN)	7:30 pm EST / 8:30 pm AST/ 9:00 pm NST / 6:30 pm CST / 5:30 pm MST / 4:30 pm PST

Can I confirm your email address so that we can send you the link to the online discussion group?

We ask that you login a few minutes early to be sure you are able to connect and to test your sound (speaker and microphone). If you require glasses for reading, please make sure you have them handy as well.

As we are only inviting a small number of people, your participation is very important to us. If for some reason you are unable to attend, please call us so that we may get someone to replace you. You can reach us at [INSERT PHONE NUMBER] at our office. Please ask for [NAME]. Someone will call you in the days leading up to the discussion to remind you.

So that we can call you to remind you about the discussion group or contact you should there be any changes, can you please confirm your name and contact information for me?

First name
Last Name
email
Daytime phone number
Evening phone number

If the respondent refuses to give his/her first or last name, email or phone number please assure them that this information will be kept strictly confidential in accordance with the privacy law and that it is used strictly to contact them to confirm their attendance and to inform them of any changes to the discussion group. If they still refuse THANK & TERMINATE.

Appendix C – Discussion Guide

Introduction 10 min 10 min

Moderator introduces herself/himself and her/his role: role of moderator is to ask questions, make sure everyone has a chance to express themselves, keep track of the time, be objective/no special interest.

- The name of the firm the moderator works for, and the type of firm that employs them (i.e., an independent marketing research firm).
- Role of participants: speak openly and frankly about opinions, remember that there are no right or wrong answers and no need to agree with each other.
- All information including the results from this research are kept confidential and reported all together/individuals are not identified/participation is voluntary.
- The length of the session (1.5 hours).
- The presence of any observers, their role and purpose, and the means of observation (observers viewing and listening in remotely).
- The presence and purpose of any recording being made of the session.
- Confirm participants are comfortable with the platform and some of the specific settings such as: how to mute and unmute themselves; where the hand raise button is; and, the chat box.
- As mentioned, when we invited you to participate in this discussion group, we're conducting research on behalf of Health Canada. The purpose is to explore issues related to health care in Canada.

Moderator will go around the table and ask participants to introduce themselves.

- **Introduction of participants:** To get started, please tell us your first name, what you do during the day, and one of your favourite interests or hobbies.

General discussion about health care 10 min 20 min

1. First, as far as you're concerned, what issue(s) should be the highest priority for the federal government right now? Why?

   Please use the chat box to record your answer. You can send your response to "everyone". *[IF PARTICIPANTS HAVE DIFFICULTIES RECORDING THEIR ANSWER IN THE CHAT, THEY WILL BE CALLED UPON TO PROVIDE THEIR RESPONSE VERBALLY].*

2. [IF HEALTH CARE NOT RAISED:] As a priority for the federal government, how does health care compare to the issue(s) you raised? Is it a higher priority, lower priority, or about the same level of priority? Why do you say that?
3. What do you think of Canada's health care system today? What are the best and worst things about Canada's health care system?
   a. Let's start with the best. What are they and how much do these things matter to you?
   b. And what would you say are the worst things? How much do these things matter to you?

4. How, if at all, has the pandemic impacted your impression of Canada's health care system? Why do you say that?

Primary care 25 min 45 min

For the purposes of our conversation today/tonight, I'd like us to focus on primary care. So that we are all on the same page, primary care refers to the provision of first-contact health care services (i.e., first contact with family doctors, nurse practitioners, pharmacists, walk-in clinics and telephone advice lines) and supports the coordination of care across the health care system to ensure continuity of care. Primary care does not include specialists, surgeons, hospitals (except for ER).

5. *[HANDS UP]* Do you have a regular family physician/doctor?
    a. *[IF NOT]* Do you mind my asking, why not? Is it a question of choice or for some other reason?
6. How many times in a typical, non-COVID, year would you have sought primary care in one way or another?
    a. How, if at all, has the COVID-19 pandemic changed your relationship with your provider?
7. Generally, how satisfied are you in your ability to access primary care in a timely manner? Why do you say that?
    a. What are the major barriers that you face in accessing primary care? [OLMC Groups: Probe for barriers related to language].
8. *[HANDS UP]* Has anyone ever had trouble making an appointment with/getting in to see your family doctor/doctor?
    a. What did you do?
    b. *[HANDS UP]* Has anyone ever opted for a walk in clinic or the ER instead? Why or why not?
    c. How do/did you feel about having to exercise that option? Why?
    d. How does this make you feel about our health care system? Why?

9. How satisfied are you with the quality of the primary care you receive? Using a 10-pt scale where 10 is extremely satisfied and 0 is extremely dissatisfied, how would you rate your satisfaction with the quality of primary care you receive? Please use the chat box to record your rating. *[THOSE UNABLE TO USE THE CHAT BOX WILL PROVIDE THEIR RATING VERBALLY]*. Why do you say that?
10. What does "high-quality" care mean to you? Please describe what that looks like.
11. As far as you're concerned, is it ok for people to pay for health services that would normally be covered by the province? Why or why not?

In some models of primary care, a family physician or "GP" will work as part of a team of medical professionals who work collaboratively to provide health services to patients and their caregivers. Under this team-based approach, patients may not see a family doctor every time they need care; rather, they would be under the care of multiple providers from different professions (e.g., GPs, Licensed Practical Nurses, Nurse Practitioners) who work together to meet their needs.

12. What are your thoughts and/or preferences regarding a team-based approach to primary care? Why do you say that?
13. *[HANDS UP]* Is this kind of teamwork (between a primary care doctor and other health professionals) something that is or would be of benefit to you? Why or why not?
    a. Have you received care from a primary care team (Nurse Practitioner, "GP", dietician, etc.) before? If so, what are your thoughts on this approach to health care delivery?
    b. Can you please describe your experience? Were you generally satisfied? Why or why not?

14. What are your priorities with respect to team-based care? Probe: timely access; maintaining a relationship with a 'main' provider; access to a wide variety of health professionals
15. For those of you who have a team managing your care, how satisfied are you with the quality of service provided by your family physician/doctor? Why do you say that?

Coordinated care is when different areas of the health care system (e.g., primary care, specialty care, acute care) share information and coordinate patient care activities, such that a patient receives consistent care as they move across the health system.

16. What are your needs with respect to coordinating care between your primary care provider and other sites of care?
17. In your opinion, is the health care you receive "coordinated"? Why or why not?

Personal involvement in health care 15 min 60 min

18. Would you consider yourself proactive or actively involved in managing your health?
    a. If so, what do you do?
    b. How do you feel about the level of personal involvement required in managing your health? Why?
    c. Do you feel enabled or even forced to be an advocate for your own care? How do you feel about that? Why?
    d. Do you need the help of someone other than a health care provider to help manage your health/care? This could be a family member or other caregiver who is actively involved in your health care, either formally (paid) or informally (unpaid).
    e. What role does your caregiver play in your care?
19. Do you feel you are treated as a partner in decisions impacting your health care? Why or why not?
    a. How important is it to you to be treated as a partner? Why?
    b. What part(s) of the health care system could be improved to enable you to be a more active partner?

Digital health 25 min 85 min

20. What are your expectations in terms of accessing your own health information? Are they currently being met? Why or why not?
    a. Do you have easy access to your personal health information?
    b. If so, how are you accessing your health information?
    c. Is accessing your own health information important to you? Why or why not?

21. *[HANDS UP]* Has anyone accessed elements of their care virtually/online?
    a. Can you please describe your experience? Were you generally satisfied? Why or why not? [OLMC Groups: Probe for barriers related to language].
    d. In what situations, if any, would you prefer to use virtual care going forward? Why?
    b. What about access to health care providers? How important is it to you to have electronic access to health care providers and services (i.e., email consultation, online appointment booking, etc.)? Why?

22. *[HANDS UP]* Has anyone heard of the term digital health? What does it mean to you?

For the purposes of our discussion, digital health refers to the use of information technology/electronic communication tools (or digital tools), services and processes to deliver health care services or to facilitate better health. Some examples could include: a patient portal to allow for the access of health information and make appointments. Another might be an online mental health tracking platform, to supplement appointments with a counsellor.

23. What role, if any, should digital health play in the future of Canada's health care system? Why do you say that?
    a. What do you think are the benefits of digital health?
    b. What would be the drawbacks?
    c. Do the benefits outweigh the drawbacks or do the drawbacks outweigh the benefits? Why do you feel that way?
24. Do you think digitizing the health care system could help address some of the health system challenges you have encountered? Why or why not? In what ways/How so?

Digital tools are software, programs, applications, platforms, or other online resources that can be accessed using a digital device, such as a computer or tablet.

25. To the best of your knowledge, how, if at all, are digital tools used to manage your health and health care? How do you feel about that? Why?
26. Thinking about the way you use digital tools in your everyday life – in everything from online banking to booking a vacation for yourself – are there ways you could be using digital tools to manage your health and health care? Why or why not?
27. What are the benefits and risks of using digital tools to manage your health and health care electronically?
    a. Let's start with the benefits. What are they and how much do these things matter to you? Probe: convenience; empowerment; minimizing frustration; peace of mind
    b. And what would you say are the risks? How much do these things matter to you? Probe: access to personal information; data security breach; data entry error
    c. Do the benefits outweigh the risks or do the risks outweigh the benefits? Why do you feel that way?

Earlier we discussed the team-based approach to health care and your experiences working with different health care providers.

28. Are there ways in which digital health tools could make this experience better for you? How so?
29. What are your expectations in terms of data sharing?
30. How would you feel about your health information being shared across the system (i.e., with specialists, labs, etc.)?
31. Do you trust the health system and its providers to manage and/or safeguard your health information appropriately? Why or why not?
32. [IF NOT] What are you most worried about? Why?
33. What level of detail or types of information would you be willing to share?
34. Is there any information that you would not be willing to share? Why and with whom?
35. Would you be comfortable sharing your health information with governments or researchers to support public health efforts? Why or why not?
36. What about for research and innovation? Why or why not?
37. Would you be willing to grant others (i.e., other health care providers, specialists, health system administrators, pharmacists, etc.) access to your deidentified health data (meaning

there's no way the data could be linked back to you) if it meant decision-makers could use that information to improve the performance of the health system? Why or why not?

38. What, if anything, do you think the government could/should do to address/alleviate your concerns?

Conclusion 5 min 90 min

[MODERATOR TO REQUEST ADDITIONAL QUESTIONS ARE SENT VIA THE CHAT BOX DIRECTLY TO THE MODERATOR AND PROBE ON ANY ADDITIONAL AREAS OF INTEREST.]

- This concludes what we needed to cover. Given our conversation here today/tonight, is there anything else you would like to share on primary care gaps or challenges or do you have any concluding thoughts? Why?
- Does anybody have any final thoughts or comments to pass along?
- Thank you! We really appreciate you taking the time to share your views. Your input is very important.