Beyond Frameworks: A 5+2 Blueprint for Aligning Primary Care Reform in Canada

Ivy Oandasan, MD, MHSc, EMBA, CCFP, FCFP — Department of Family Medicine, School of Medicine, York University, Toronto, ON; Department of Family and Community Medicine, Temerty Faculty of Medicine, University of Toronto, Toronto, ON

Kaye Phillips, PhD — PhD; Founder & CEO, Konnected-care; Ottawa, ON, Canada.

Corresponding author: Ivy Oandasan, ivyomd@york.ca

Abstract

Despite substantial federal investment and multiple evidence-informed frameworks, an estimated 5.7 million Canadian adults lack a regular primary care provider. This gap reflects not a shortage of ideas but a failure to align implementation across the micro, meso and macro levels of the system. We propose a 5+2 blueprint: an alignment architecture connecting five representative frameworks with two cross-cutting enablers, payment reform and digital integration, toward shared outcomes anchored in Starfield's attributes. With bilateral agreements between the federal government and each province and territory under renewal, alignment through system design is a practical policy proposition that can be tested through implementation.

A System Rich in Frameworks but Poorly Aligned

Canada's primary care crisis reflects a persistent paradox. Over the past two decades, governments, professional bodies and health organizations have generated substantial evidence, developed team-based models, introduced accreditation standards and invested significantly in strengthening primary care. Yet an estimated 5.7 million adults, roughly 17 percent of the adult population, along with 765,000 children and youth, remain without a regular primary care provider (Canadian Institute for Health Information 2025). Despite renewed federal commitments under the 2023 Working Together plan, including $25 billion in bilateral agreements negotiated with each province and territory, large-scale transformation remains uneven across provinces and territories (Government of Canada 2023).

This implementation gap is not uniquely Canadian. International experience demonstrates that reforms frequently stall when initiatives operating at different levels of the system are not aligned toward common objectives (World Health Organization 2019; Aggarwal et al. 2023). In Canada, interprofessional education, organizational standards, payment reform, quality improvement initiatives and digital investments have often been developed independently rather than as parts of a coherent transformation strategy.

The challenge is not primarily one of insufficient innovation or professional resistance. Rather, it reflects both a policy coherence challenge and a system design challenge. Evidence and reform activity have not consistently been translated into aligned incentives, accountability structures and implementation mechanisms across system levels. As a result, primary care transformation has often been layered onto existing structures rather than redesigned around shared outcomes.

In this paper, micro, meso and macro refer to interacting levels of primary care system design. The micro level encompasses patients, providers and care teams and the competencies,

relationships and behaviours that shape care delivery. The meso level refers to organizational and regional structures, including governance, accreditation, quality improvement systems and operational management. The macro level includes policy, legislation, financing arrangements, intergovernmental agreements and system-wide accountability mechanisms. Health systems behave as complex adaptive systems in which change at any level is emergent and non-linear rather than mechanistic (Braithwaite et al. 2018). Sustainable transformation therefore requires alignment across all three levels, because reforms introduced at one level are often constrained or reinforced by conditions at the others.

The persistence of fragmentation across these levels is itself diagnostic. Individual organizations and jurisdictions have often optimized within their respective domains. Yet no actor has been explicitly responsible for ensuring that workforce development, organizational accountability, financing and measurement evolve together toward common goals. Meaningful reform therefore requires an explicit approach that aligns interventions across micro, meso and macro levels. Without such alignment, incremental initiatives are likely to continue generating localized gains without sustained system-wide impact.

The 5+2 Blueprint for Aligning Primary Care Reform

Canada does not lack evidence-informed approaches to primary care reform. It has built strong foundations in education, standards, measurement and policy innovation. The challenge lies in connecting these foundations into a coherent implementation strategy.

The 5+2 blueprint is not intended to catalogue all frameworks relevant to primary care reform, nor does it propose a new theory of integrated care. It is representative rather than definitive. Each framework was selected because it occupies a distinct position in the architecture, pairing a system level with an implementation lever: workforce development, public expectations,

outcome definition, organizational accountability and structural diagnosis (Table 1). Other credible frameworks could substitute within any given position. This logic converges with Boelen's social accountability framework, whose partnership pentagram holds that health systems meet priority societal needs, such as access to primary care, only when policymakers, health administrators, health professionals, academic institutions and communities act in concert (Boelen 2000). Convergence across traditions reinforces the case for a multi-level, multi-factorial approach to reform. What matters is that every level and lever is covered and directed toward shared outcomes anchored in Starfield's attributes of high-performing primary care (Starfield 1998).

Five complementary frameworks make up the blueprint.

The D'Amour-Oandasan Interprofessional Education for Collaborative Patient-Centred Practice Framework provides the conceptual foundation for collaborative care and workforce development (D'Amour and Oandasan 2005); its multi-level architecture has recently been independently corroborated through concept mapping research on Canadian interprofessional primary care teams (Galvez-Hernandez et al. 2026).

The OurCare Standard articulates what Canadians expect from primary care through national public engagement, including accessible, continuous and person-centred care (Kiran 2024). Starfield's primary care attributes, first-contact access, continuity, comprehensiveness and coordination, delivered through person-focused care over time, provide the shared outcome framework for reform efforts (Starfield 1998).

The Health Standards Organization Primary Health Care Services Standard provides an organizational accountability mechanism through accreditation and quality improvement processes (Health Standards Organization 2020), with a renewed edition expected in 2026.

The Aggarwal-Hutchison analysis provides empirical insight into the structural and governance barriers that have limited primary care transformation across Canada (Aggarwal et al. 2023). Historically, Wagner's Chronic Care Model helped demonstrate how organizational redesign can improve care delivery for people living with chronic illness (Wagner et al. 1996). More recently, the World Health Organization's Population Health Management in Primary Health Care framework has expanded this perspective by emphasizing proactive population health approaches, integrated service delivery and coordinated action across system levels (WHO 2023). These models inform the blueprint as context; they are not among its five frameworks. Two cross-cutting enablers support implementation across all levels of the blueprint: payment reform and digital integration. Drawing from the International Foundation for Integrated Care's Nine Pillars of Integrated Care, these enablers create the conditions that make alignment across system levels achievable in practice (IFIC 2021).

Table 1 summarizes how each component contributes to a shared reform architecture, clarifying how existing approaches can function as complementary implementation levers rather than competing frameworks.

Ontario as Illustration: Policy Vision and Implementation Alignment

Ontario's experience over the past two decades illustrates the challenges of translating policy ambition into sustained system transformation. The province introduced interprofessional education initiatives, expanded scopes of practice, implemented Family Health Teams, adopted chronic disease management approaches and invested in digital infrastructure. Each initiative was grounded in evidence and addressed a recognized system need (Government of Ontario 2007; Hutchison and Glazier 2013). Reform continued after 2013. The Patients First Act, 2016 consolidated home and community care planning within regional health networks; the

Connecting Care Act, 2019 established Ontario Health and Ontario Health Teams as the vehicle for integrated care, with primary care expected to anchor each team; and from 2023 the province funded successive rounds of new and expanded interprofessional primary care teams and extended pharmacists' scope of practice (Government of Ontario 2016; Government of Ontario 2019; Government of Ontario 2023). Digital investments have supported primary care electronic medical records and patient-facing platforms. Examples include ConnectingOntario for authorized provider access across participating hospitals and home and community care services, and ConnectMyHealth for patient access to records from hospitals across southwestern Ontario (Office of the Auditor General of Ontario 2016; eHealth Ontario n.d.; ConnectMyHealth n.d.). These reforms generated important advances. However, implementation often occurred through multiple streams of activity that were not consistently aligned through shared accountability structures, financing models or performance measurement approaches. Payment models continued to prioritize physician enrolment more than team accountability. Accreditation and quality improvement activities were not systematically linked to funding and reporting mechanisms. Digital systems expanded but did not consistently support shared performance monitoring across providers and settings. These observations are consistent with prior analyses describing Ontario's reform trajectory as incremental and structurally fragmented despite significant investment and policy innovation (Hutchison and Glazier 2013; Aggarwal et al. 2023).

Ontario's recent policy direction demonstrates important evolution. The Primary Care Act (Government of Ontario 2025b) and Ontario's Primary Care Action Plan (Government of Ontario 2025a) establish a clearer provincial commitment to improving access, accountability and

performance measurement. Together, they provide a stronger policy foundation and signal a renewed focus on access for every Ontarian.

The remaining challenge is implementation. Policy vision alone cannot transform care delivery unless workforce development, organizational accountability, financing and measurement systems are aligned in support of common goals. Ontario therefore serves not as evidence of policy failure but as an illustration of the relationship between policy direction and system design. The next phase of reform will test whether stronger policy commitments can be translated into coordinated implementation across system levels.

Measuring What We Claim to Value

Current accountability mechanisms often mirror the fragmentation they seek to address. Canada measures provider supply, service volumes and wait times, yet rarely assesses whether reforms at different levels of the system are contributing to shared outcomes.

Starfield's attributes provide a coherent outcome framework for evaluating primary care performance: first-contact access, continuity, comprehensiveness and coordination, grounded in person-focused care (Starfield 1998). Despite their broad acceptance, these attributes have not been adopted consistently as a common measurement anchor across jurisdictions and organizations (Canadian Institute for Health Information 2025).

A more aligned measurement architecture would connect indicators across system levels (Starfield 1998; Canadian Institute for Health Information 2025). For example, continuity of care could be measured simultaneously as:

- a workforce capability supported through training and professional development at the micro level;

- an organizational performance expectation reflected in accreditation and quality improvement activities at the meso level; and
- a provincial or territorial accountability indicator reported publicly at the macro level.

Coordination of care could be assessed in the same way: as a team competency, through organizational care pathways and within provincial performance frameworks.

The challenge is not simply measuring more indicators. It is ensuring that indicators across system levels are connected to a shared definition of success. Until alignment itself becomes visible and measurable, fragmentation will remain a rational outcome of system design.

Policy History and Lessons for Reform

Canada's primary care reform efforts have long reflected a shared recognition of the importance of strengthening community-based care. The Romanow Commission emphasized primary care renewal as a cornerstone of a sustainable health system and recommended greater collaboration across governments to accelerate reform (Romanow 2002).

In response, the Primary Health Care Transition Fund (Health Canada 2007) supported experimentation and innovation across provinces and territories. The fund generated valuable learning and demonstrated the feasibility of team-based care, expanded scopes of practice and new approaches to service delivery. However, many initiatives remained localized, and mechanisms for spreading and sustaining successful innovations varied considerably across jurisdictions.

This history suggests that Canada's challenge is not a lack of reform activity. Rather, it is the difficulty of translating successful local innovations into durable system-wide transformation. The lesson is not that previous reforms failed. The lesson is that innovation alone is insufficient without structures that support alignment, implementation and accountability over time.

Three Policy Tests for Aligned System Transformation

If primary care reform is fundamentally an implementation challenge, it must be tested through implementation.

The first test is definitional. Canada requires a shared understanding of what constitutes high-performing primary care. Starfield's attributes provide a credible and widely recognized foundation. These attributes should function not merely as aspirational language but as a common outcome framework across federal, provincial and territorial initiatives.

The second test is structural. Funding agreements should encourage alignment across workforce development, organizational accountability, payment reform, measurement systems and digital infrastructure. Investments that support isolated initiatives may generate local success, but are less likely to produce sustained transformation at scale.

The third test is governance. Responsibility for primary care currently spans governments, professional regulators, accreditation bodies, educational institutions, quality improvement organizations and healthcare organizations. Each actor holds important levers. Yet responsibility for alignment is often diffuse.

The federal government can play a convening role by supporting common outcome definitions, pan-Canadian learning and shared measurement approaches. Provinces and territories retain responsibility for implementation through financing arrangements, regional planning and accountability structures. Pan-Canadian organizations such as CIHI, Healthcare Excellence Canada and Health Standards Organization can provide supporting infrastructure for measurement, improvement and accreditation, while academic and health profession education institutions align workforce development with system priorities.

Rather than concentrating authority in a single organization, the goal is to strengthen alignment among existing actors. The question is not whether Canada needs more frameworks. The question is whether the actors responsible for reform can work toward shared outcomes using complementary levers and common measures of success.

Conclusion

Canada's primary care transformation efforts have produced substantial innovation, evidence and investment. Yet many of these efforts have evolved in parallel, limiting their collective impact. The 5+2 blueprint proposes an alignment architecture that connects workforce development, organizational accountability, policy direction, financing and digital infrastructure around a shared vision of high-performing primary care. Its contribution is not a new theory of reform but a clarification of how existing approaches function together as complementary implementation levers.

Recent policy developments, including renewed bilateral agreements between the federal government and each province and territory, and provincial primary care reforms, create an opportunity to test this proposition. The central question is no longer whether Canada possesses the knowledge required for transformation. It is whether existing frameworks, policies and institutions can be aligned to translate ambition into durable change.

The answer may determine whether the next decade delivers incremental improvement or meaningful transformation in primary care access and performance.

Table 1. The 5+2 blueprint as an alignment architecture: components, system levels, implementation levers and contribution to shared outcomes

Component	System level	Implementation lever	Distinct contribution to Starfield's attributes
D'Amour-Oandasan IECPCP Framework	Micro to macro	Workforce education for collaborative competence aligned with primary care practice and system reform	Capability: prepares providers and teams to deliver the attributes
OurCare Standard	Micro to macro	Public and patient expectations and social licence for reform	Demand: articulates the public priorities the attributes must satisfy
Starfield's primary care attributes	All levels	Shared outcome definition and common measurement anchor	Definition: specifies the attributes and their measures
HSO Primary Health Care Services Standard	Meso	Organizational accountability through accreditation and quality improvement	Conditions: embeds organizational requirements that make the attributes achievable
Aggarwal-Hutchison analysis	Macro	Structural and governance diagnosis informing health system policy design	Diagnosis: identifies macro barriers and enablers of the attributes
Enabler: payment reform	Cross-cutting	Aligns financial incentives with team-based practice conditions and outcome-oriented care	Incentive: rewards delivery of the attributes
Enabler: digital integration	Cross-cutting	Shared information and performance measurement infrastructure	Interactivity: enables information exchange that makes attribute performance measurable across levels

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