Report of the Knowledge Synthesis and Exchange Forum on the Impact of Primary Health Care Organizational Models and Contexts

Looking Backward to Move Forward: A Synthesis of Primary Health Care Reform Evaluations in Canadian Provinces

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LOOKING BACKWARD TO MOVE FORWARD: A SYNTHESIS OF PRIMARY HEALTH CARE REFORM EVALUATIONS IN CANADIAN PROVINCES

REPORT OF THE KNOWLEDGE SYNTHESIS AND EXCHANGE FORUM ON THE IMPACT OF PRIMARY HEALTH CARE ORGANIZATIONAL MODELS AND CONTEXTS

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FOREWORD

Primary Health Care (PHC) in Canada is currently at a crossroads with regard to its contribution to population health and health system performance. Various commissions and studies have highlighted the important challenges PHC faces. Gaps in population coverage and access have been clearly identified. Comparisons with other international health systems have highlighted the relatively unorganized state of PHC in Canada. In response to this diagnosis, Canadian provinces have engaged in a wave of reforms and reorganizations to address some of the structural causes of this relatively poor performance. As expected, the research community has closely looked at these reforms and the last decade has produced several important evaluation studies focusing on PHC organization and practice.

Although there have been important investments in PHC research, integrated knowledge about the impact of new models, the development of programs to improve patients' experience of care and the factors related to successful implementation remains limited. This report tries to bridge this gap by providing an integrated synthesis of selected studies from five Canadian provinces. In order to go beyond the limitations of published scientific literature, we organized a forum with the objective of better understanding the current knowledge about PHC reform in Canada. This forum brought together researchers and decision-makers from these five provinces. With a structured process of preparation and deliberation, both investigators and knowledge users identified potential lessons from the recent years' research.

This forum was organized by one of the participating provinces, Québec, as part of a research project (Pineault et al., 2010). The research project is a follow-up to research originally conducted in 2005. At that time, research in the two most populous regions of Québec (Montréal and Montérégie) measured the association between prevailing models of PHC and population-level experience of care. In 2010, a second study, the current research, set out to examine the evolution of PHC organizational models and their relative performance throughout the reform process (from 2005 until 2010) and to assess factors at the organizational and contextual levels associated with the transformation of PHC organizations and their performance. The forum, held on November 3, 2010, was intended to provide a broader context for this research.

The forum brought together researchers and decision-makers from different provinces to discuss factors influencing the reform process and the impact of the reforms. It complemented the Québec research project in three important ways. First, this exercise has provided complementary hypotheses and research questions to explore through the data currently being collected. Second, this knowledge synthesis has enabled the research team to better understand what is happening in other provinces and extrapolate the results more appropriately. Third, this understanding will facilitate the interpretation and application of results in the wider Canadian context.

We are deeply grateful to the experts from each province for having given their time and expertise to contribute to understanding these case studies and for presenting a critical perspective during the forum. We would also like to thank all participants for their time and their contribution to various discussions and debates that were held during the forum.

This forum could not have been held without the financial support of our sponsors. The forum was jointly financed by the Canadian Institutes of Health Research, the Fonds de recherche du Québec-Santé, the ministère de la Santé et des Services sociaux du Québec, the Agence de la santé et des services sociaux de Montréal, the Agence de la santé et des services sociaux de la Montérégie, the Institut national de santé publique du Québec, the Canadian Health Services Research Foundation, the Québec Population Health Research Network. In addition, the forum would not have been held without the support of the Direction de santé publique de l'ASSS de Montréal and the research team *Santé des populations et services de santé*.

ABSTRACT

Introduction

Primary Health Care (PHC) reform is currently underway in various Canadian provinces. Emerging models and policies are at various levels of implementation across differing jurisdictions. While there have been some evaluations of the impact of these reforms, there have been few cross provincial analyses. The aim of this project is to better understand the impact of emerging models and to identify the factors that have been facilitating or hindering their implementation.

Methods

A review of grey and published literature on primary care organisational models in Canada was achieved to describe the reform process in five Canadian provinces and understand the various contexts of reforms. Experts were asked to review these case studies and generate hypotheses with regard to potential barriers and facilitators of these reforms. A one-day deliberative forum was held on November 3rd 2010, bringing together researchers (n=40) and decision-makers (n=20) from each province involved to look at these case studies and identify the main factors influencing the implementation of these reforms and their main impacts.

Results

Despite a relative paucity of published evaluations, our results suggest that PHC reforms have varied with regard to the scope and levers employed to implement change. Some provinces used specific PHC model implementation, while other provinces designed overarching policies aiming at changing professional behaviours and practice. The main barriers to reform were the lack of financial investments in the reforms, resistance from professional associations, overly prescriptive approaches that lacked adaptability to local circumstances and an overly centralized governance model. The main facilitators were a strong financial commitment using various allocation and payments models, the involvement of professional associations throughout the process of reform, an incremental and strong decentralization of decisions and adaptation to local circumstances. Most benefits of the reforms so far seem to have occurred with regard to patients' experience of care and higher workforce satisfaction.

Conclusion

PHC reforms currently being implemented in other jurisdictions could be informed by factors identified as promoting or hindering change in the various provinces that have been most proactive. The cross-provincial view of recent reforms, presented during this panel, will highlight insights that go beyond the findings from individual provinces' evaluations in order to guide ongoing PHC reform.

KEY MESSAGES

- The environment of reform has really changed dramatically over the last decade. Structures put in place to promote collaboration between physicians and policy-makers have contributed to changes in this environment. Across the country, agents of change for PHC reforms vary between governments, professionals and academia.
- Funding and remuneration have a dual influence on the reform process: both too little, by not providing sufficient fund to implement various components, and too much money, by providing a level of support that cannot be sustained once the reform effort have subsided, have been identified as factors hindering the implementation of reform. Many provinces have had some success because enough money was allocated to support the reform process. While physician remuneration is a long-lasting problem and a significant hindering factor, the transformation of PHC for prevention activity and interdisciplinarity requires sufficient investments to be implemented.
- Numerous legislative policies have been implemented across provinces. Most notably, legislation redefining the role of other health professionals, such as registered nurses and nurse practitioners, has played a determining role in the development of multidisciplinary teams.
- While efforts are currently being made to strengthen PHC practices, system integration of PHC practices remains limited. PHC is mainly at the margin of the health system and this draw-back influences the collaboration between practices and the coordination of care with other services.
- Canada is far behind other countries in the implementation of electronic medical records (EMRs) and information technology (IT) in PHC practices; this influences the ability of providers to offer continuous care.
- Public and communities' engagement in the reform process is often identified as a key element to its success. While some argue that PHC and the current reform should be better explained to the general public, others argue that PHC reform remains too complex a subject for a population mostly concerned by access to services and continuity of care.
- Provincial and geographic contexts matter and while similar principles of PHC reform exist across Canada, the strategies employed to transform PHC vary. While some provinces have adopted a model-driven approach to organizational changes, many have opted for a quality and incentive-based approach to influence practices.
- Overall, there is a scarcity of publicly available evaluations of the impact of PHC reforms. So far, the few evaluations of PHC reforms have focused on implementation. There is a need for evaluation of outcomes and also for rigorous evaluations of models.
- On the whole, the available evaluations of PHC reforms have suggested some positive impact from PHC reorganization in terms of patients' experience of care and the work environment. However, little change has been observed in terms of access and some inequalities might have even been created.

EXECUTIVE SUMMARY

Since 2000, transformation in the delivery of PHC has occurred at varying levels across Canada. An important change in the policy environment is also occurring, driven by a better fiscal climate after years of cutbacks', increased federal transfers, including the Health Transition Fund and the Primary Health Care Transition Fund; and recommendations from major commissions such as the 2002 Romanow Commission (Hutchison, 2008). Furthermore, this transformation is occurring at a time when PHC in Canada is increasingly recognized as lagging behind that in other developed countries. Across Canada, collaborative and interdisciplinary models and quality improvement innovations in PHC delivery have been implemented in the last decade to improve the quality of care provided to the Canadian population.

At this point in time, questions remain about the impact of these reforms. What factors have facilitated or impeded changes occurring in PHC models of delivery and quality innovations in the different provinces of Canada? What evidence exists about the impact of these changes on population health and the performance of PHC?

The synthesis forum reported in this paper, on the contexts and impacts of PHC reforms in Canada, was organized as part of a larger research project. The forum was held on November 3rd, 2010, with the aim of bringing together researchers and decision-makers from different Canadian provinces to discuss the factors influencing the reform process and the impacts the reforms have had over the past decade.

The context of Primary Health Care reform in Canada

Health systems exist within structures that have to be considered and countries reforming PHC start at different points. For years, PHC in Canada was not included in healthcare reforms and has basically been operating at the margins of the system. However, PHC in Canada has been undergoing a crisis due to shortages of family physicians, lack of investments and poor integration with the rest of the system. Over the past decade, different provinces have undertaken PHC reforms, with differing strategies and within varied economic and political contexts.

The forum showed that, while policy instruments are part of the equation, they never provide the full solution. The principles guiding reforms were generally homogeneous, while different contexts generated a mix of factors that supported or hindered the reform process.

The environment of Primary Health Care reform has changed considerably over the last decade, with reform receiving sustained attention from professionals, governments and researchers. Collaboration between governments and local health jurisdictions and physicians has increased and structures have been put in place for policy-makers to work collaboratively with physicians on funding and programs. Medical education programs in recent years have also contributed to the reform process by helping to change attitudes. We have also seen in this environment of reform that the proponents of changes are not uniform: sometimes governments are more active, while other times professionals and communities have been more articulate in their demands or academia has taken on the advocacy role.

Professional associations are sometime seen as supporting this process and sometimes seen as slowing it down by strongly defending physicians' autonomy and remuneration.

Funding and remuneration: Increasing funding was identified as necessary. However, participants questioned whether governments will be able to sustain this kind of spending in the future, as the costs of reforms for higher-quality PHC will only increase. Furthermore, physician remuneration is a long-lasting problem and participants identified it as a question that must be resolved if other professionals are to be integrated in PHC. Participants also noted the necessity of blended remuneration, with capitation, fee for service, pay-for-performance incentives all playing a role.

Legislation to support the introduction of registered nurses in PHC was identified as a supporting factor in the development of interdisciplinary teams, but much remains to be done. Collaborative practices are still in development everywhere, with nurse practitioners in particular struggling to find jobs. The fact that little consideration is given to the new leadership role of physicians and its challenges was also discussed.

The lack of **system integration for Primary Health Care** was extensively discussed. Much is done to improve the delivery of care in clinics, but little is done to improve integration of and collaboration among clinics in the overall system. Local networks and structures are sometimes created, as in Québec, while reforms sometimes fail to integrate PHC, as in Ontario. Nonetheless, functional integration is often not in place and governments have to work to ensure integration is more than simply administrative and that parts of the system work coherently together. Professional education should be modified to take into account these new realities and reforms should be made to implement multidisciplinarity.

Canada is far behind other countries in terms of **information technologies and EMRs**; this has been identified as an impediment to system integration, coordination of care and chronic disease management.

There was also a debate over the necessity to better inform **the public**. Some believe the public should be better informed regarding the reform process but that academics have difficulty communicating with the public on this complex issue. Others said that the complexity of the issues being dealt with by PHC researchers means that the public does not want to know about it; what the public does want is services that are accessible and coordinated, and not just a well-designed PHC system. Nevertheless, public demands and media reports about these demands have been identified as playing a role in change and as influencing government decision. In addition, community ownership of, and participation in, decision-making and implementation processes were identified as key by many participants.

The forum participants agreed that context must be taken into consideration and there is a need for **adaptability and flexibility** in approaches, as a mix of factors will influence the process differently at different stages. It is thus difficult to synthesize which factors support or hinder reforms and which strategies are most appropriate in the Canadian contexts.

Furthermore, **drivers of changes** have not been the same in every province. In many cases, there has been a need to build a partnership with physicians to create an environment more conducive to the success of reforms. Overall, changes have been made on a voluntary basis and little has been imposed in a top-down fashion to physicians and private clinics.

Various provinces have taken up different **strategies for PHC reform,** focusing on model-driven, principle-based, quality-centered and incentive-oriented incremental changes all playing a role. Ontario, for instance, has a model-driven reform process and has invested heavily to attract physicians, support the transformation of practice and invest in structures for collaborative policy-making with physicians. Québec's solution for reforms resulted in one model with some flexibility according to context and the creation of local networks of services. British Columbia has also invested in structures to increase collaboration between government and the medical association, transform practice with continued training and increase physician remuneration so as to create the environment necessary for reform of PHC. In Nova Scotia and Manitoba, changes have been incremental and investments directed to population-based interventions, networking resources, assisting citizens in navigating the system and continued education and investment in group practices to transform the delivery of PHC.

Finally, participants were disappointed with **the paucity of evaluations publicly available** and the fact that, so far, few model evaluations have been conducted. Evaluations have also been concentrated on implementation and not on outcomes. The necessity of developing better PHC indicators was also discussed. Work is underway, under the leadership of the Canadian Institute of Health Information, to develop indicators that could be shared, but additional work has to be undertaken on the data sources for the development of PHC indicators. Improving patients' and providers' surveys and the implementation of EMRs will facilitate this work.

Participants outlined **a variety of impacts** resulting from PHC reforms: an increase in collaborative practices, openness to change and quality improvement, more patients being registered, changes in remuneration to more blended forms of payments and improvements in chronic disease management are all elements that have been observed to different degrees across the country. In some cases, there has been a reduction in the number of solo practices and in the use of walk-in clinics. However, some participants were dismayed that few changes are observed in accessibility, especially in the use of emergency services. In addition, there are concerns that reforms so far could have created some inequities and have done little to improve access for populations who are vulnerable because of multiple intersecting social determinants of health.

TABLE OF CONTENTS

LIST OF TABLES XIII

1 INTRODUCTION 1

2 METHODOLOGY 3

3 PRIMARY HEALTH CARE REFORMS INITIATIVES IN CANADIAN PROVINCES 5

3.1 Primary health care reform in Nova Scotia 5
3.2 Primary Health Care reform in Québec 10
3.3 Primary Health Care reform in Ontario 16
3.4 Primary Health Care reform in Manitoba 21
3.5 Primary Health Care reform in British Columbia 25

4 EMERGING AND CROSS-CUTTING THEMES RELATED TO PRIMARY HEALTH CARE REFORMS IN CANADIAN PROVINCES 31

4.1 Supporting and hindering factors in primary Health Care reforms 31
4.2 The impact of Primary Health Care reforms 37

5 CONCLUSIONS 41

REFERENCES 43

APPENDICE 49

LIST OF TABLES

Table 1 Summary: Primary Health Care organizational models and innovation programs–Strategic dimensions in Nova Scotia 9

Table 2 Summary: Primary Health Care organizational models and innovation programs–Strategic dimensions in Québec 15

Table 3 Summary: Primary Health Care organizational models and innovation programs – Strategic dimensions in Ontario 20

Table 4 Summary: Primary Health Care organizational models and innovation programs – Strategic dimensions in Manitoba 24

Table 5 Summary: Primary Health Care organizational models and innovation programs – Strategic dimensions in British Columbia 29

1 INTRODUCTION

The context of Primary Health Care reform

Since 2000, transformation in Primary Health Care delivery has been occurring in varying degrees across Canada. A change in the policy environment is also occurring, driven by a better fiscal climate after years of cutbacks; increased federal transfers, including the Health Transition Fund and the Primary Health Care Transition Fund; and recommendations from major commissions such as the 2002 Romanow Commission (Hutchison, 2008). In addition, this transformation has occurred at a time when the performance of Canadian PHC is increasingly recognized as lagging behind that of other developed countries (Lamarche, 2008; CSBE, 2009), as described by recent Commonwealth Fund and OECD surveys (Hutchison, 2008; CSBE, 2009). To a certain extent, this has been the result of years of budgetary cutbacks and the diminishment of family medicine as a profession, both of which have contributed to the imbalance in the health system towards hospitals and specialized care (Lamarche, 2008; Katz, 2008). Problems in the organization of PHC have also been highlighted by major federal and provincial commissions (Kirby, 2002; Romanow, 2002). These organizational gaps include: the fragmentation of care and inefficient use of providers due to lack of coordination; limited management and follow-up of vulnerable groups; access problems; the low priority given to health promotion and disease prevention; and problems related to the quality, collection and sharing of patient information (CSBE, 2009). A consensus has emerged on the necessity of offering PHC services on a 24/7 basis through interdisciplinary teams, who work with information technologies and electronic medical records (EMRs), undertake health promotion and prevention activities, and share links with public health and local governing bodies (CSBE, 2009).

Across Canada, new models and innovations in PHC delivery have been implemented in the last decade to improve the quality of care provided to the Canadian population. The implementation of collaborative and interdisciplinary models of PHC delivery and quality improvement innovations is among the main transformations implemented (Hutchison, 2008). New organizational and multidisciplinary models of PHC delivery are more predominant in Québec, Ontario and Alberta, while the focus in British Columbia and Saskatchewan has been more on quality improvement initiatives within the traditional models of PHC delivery (Hutchison et al., 2011). Another critical area of change has been the implementation of health information systems in PHC centres (Hutchison, 2008; Hutchison et al., 2011). On the whole, these changes have been implemented on a voluntary basis. They have been incentive-based and occurred by including organized medicine in the process while preserving the autonomy of physicians (Hutchison, 2008). Provincial levers for change are limited and mostly relate to finances, since changes are in general negotiated rather than imposed (Hutchison et al., 2011). Many new models are, however, criticized as limited and lacking the characteristics of performing models, having only limited interdisciplinarity and remaining physician-centred (Hutchison, 2008; Lamarche, 2008).

At present, questions remain about the impact of these reforms. What factors have contributed to or have impeded changes occurring in PHC models of delivery and quality innovations in the different provinces of Canada? What evidence exists about the impact of these changes on population health and PHC performance?

This report is divided into several sections. Following this introduction, the first section presents the methodology of the consultation and synthesis process. The second section presents PHC reform initiatives in five Canadian provinces: Nova Scotia, Québec, Ontario, Manitoba and British Columbia. The third section is the synthesis emerging from the forum held in November 2010. In this latter section, emerging and cross-cutting themes related to PHC reforms in Canadian provinces are presented, focussing particularly on the factors supporting or hindering reforms and on the impacts of reforms. An international perspective on PHC reforms is presented, as well as a vision for the future of PHC reforms.

2 METHODOLOGY

This synthesis on the impact of PHC organizational models and contexts was completed through a two-stage consultation process. Five case studies and reading materials were developed prior to holding a consultation forum. A description of reforms that had been completed or that were currently underway in Nova Scotia, Québec, Ontario, Manitoba and British Columbia were generated from a review of existing grey and published literature evaluating PHC organization. These provinces were selected on the basis of the existence of published evaluations related to PHC reform. The preparation of the case studies also involved consultations with selected experts from each province to adjust the case studies, generate hypotheses with regard to potential barriers and facilitators of reform and document the impacts of emerging models of PHC. This preparatory reading material, consisting of the case studies and some of the synthesis themes, was sent to all participants prior to the forum.

The *Knowledge synthesis and exchange forum on the impact of primary healthcare organizational models and contexts* took place on November 3, 2010, at the Public Health Department in Montréal. The list of participants and the schedule of the forum can be found in the Appendix along with the questions pertaining to PHC reform that were submitted to the provincial experts with the case studies as part of the initial consultations before the forum was held. These questions related to complementary information about the case studies, factors associated with changes in PHC, impacts of PHC and the main conclusions from each province's experience.

In total, four activities were held during the forum to synthesize the factors facilitating or hindering the process of reforming PHC and the impacts of recent reforms. Various experts and decision-makers from provincial governments or professional associations from Nova Scotia, Québec, Ontario, Manitoba, Alberta (which was not part of the synthesis due to a lack of published evaluations of PHC reform but still invited to the Forum due to the important changes that are occurring in PHC in this province) and British Columbia were invited to discuss these themes and share their own professional experience.

The five provincial case studies were presented to participants to provide a basis for discussion and debate. These presentations summarized the main lessons from each province's experience and put forward opening questions for discussion.

Following these presentations, small groups of 8-12 participants discussed two questions:

(1) Which factors would you say are the most important either in supporting or hindering changes in PHC organizations or implementing reforms? In your opinion, how do you see these factors evolving in the future?

(2) What are the most significant impacts of recent PHC reforms and introduction of new organizational models? In your opinion, how do you see these impacts evolving in the future?

One member of each group was designated as a reporter and summarized each group's answers during the following plenary session. An open discussion with all participants took these same questions further and attempted to clarify the most important factors and

impacts. Drawing upon the wealth of information obtained from the reading materials, case studies, and group discussion, participants were asked to identify the most important factors and impacts based on their own research and/or experiences.

Finally, a panel discussion provided international, national and provincial perspectives on the day's discussions. Short statements by panel members were followed by a general discussion with the audience.

This report is primarily based on the case studies that were prepared in consultation with key experts, as revised following discussions held as part of the forum. All exchanges and debates of the forum were recorded; they are presented in section four, focussing on the emerging and cross-cutting themes related to PHC reforms across Canada, as well as in the conclusion, which also includes the international perspective and vision for the future.

3 PRIMARY HEALTH CARE REFORMS INITIATIVES IN CANADIAN PROVINCES

3.1 PRIMARY HEALTH CARE REFORM IN NOVA SCOTIA

Nova Scotia is divided into nine district health authorities, with the Capital District Health Authority (Halifax and area) combined with a specialized children's tertiary hospital (IWK). In 2006, 93% of the population aged 15 and more declared having a family physician, leaving 7% without one (CHSRF, 2010a). Still, Nova Scotia is the province with the highest supply of family physicians per capita in Canada. Overall, the majority of PHC is still delivered in regular, private, fee-for-service (FFS) practices. Nova Scotia's population is small compared to other provinces and 50% lives in Halifax. The province also has high proportions of certain morbidities. For example, Nova Scotia has the highest incidence rate of cancer and the highest self-reported proportion of heart disease in the country.

In Nova Scotia, PHC reforms have been carried out through a consultative and collaborative process for planning and implementation with the main stakeholders, even though the conception and driving force has remained the Health Ministry (Wilson et al., 2004; Martin-Misener et al., 2004). Rather than developing new models of PHC, the government's focus has mostly been on promoting certain strategic areas, including collaborative practice in PHC, alternative payment mechanisms, population health interventions by PHC providers and electronic record systems (Wilson et al., 2004). However, transformations have been incremental and have mostly started at the local level in sites that do not require significant investment. In addition, recent initiatives have been more community oriented than based on practice redesign.

The province has successfully completed a program entitled the **Strengthening Primary Healthcare Initiative** (SPCI) that was initiated in 1998 with the first Health Transition Fund and continued through the Primary Health Care Transition Fund (Wilson et al., 2004; Martin-Misener et al., 2004; Graham et al., 2006). This initiative was launched by the Government of Nova Scotia to evaluate patient-centred PHC, responsiveness to community needs, improved access, health promotion and illness prevention in clinical practice, team collaboration and accountability (Martin-Misener et al., 2004). It was introduced in four sites (one inner-city and three rural clinics) for a three-year period between 2000 and 2002, with the purpose of supporting providers and their communities in improving PHC delivery and quality (Government of Nova Scotia, 2004). Hence, the project's main components were to introduce nurse practitioners (NPs) into collaborative practices with one or more family physicians, experiment with alternative payment mechanisms (in one site only, as others had already negotiated with the government), implement EMRs, involve volunteers from the community in governance and build relationships with community organizations to target specific groups (Martin-Misener et al., 2004; Government of Nova Scotia, 2004).

Initially, there were disagreements among key stakeholders about the role of NPs, as well as concerns about professional ethics and rules for this new profession (Martin-Misener et al., 2004). However, these disagreements were resolved and gave way to the *Registered Nurse Act* in 2001 which provided a legal framework for the introduction of NPs in the province (Martin-Misener et al., 2004). Overall, the presence of NPs has increased in Nova Scotia and

there are now about 40 working in collaborative practices (personal communication, September 2010).

The SPCI had a substantial evaluation component that showed positive outcomes for the model and revealed a number of successes and lessons learned (Government of Nova Scotia, 2004). In varying degrees, the benefits of this initiative included:

- improved quality of patient care
- good introduction of NPs
- increased readability and completeness of records due to the introduction of new information systems
- improved responsiveness to community needs and community participation
- increased access to interdisciplinary teams
- increased patient satisfaction
- enhanced services to under-served groups
- increased collaboration among organizations, health departments and professional organizations
- improved accountability.

Graham et al. (2006) have also reported a marked improvement in diabetes and hypertension care and outcomes resulting from this initiative.

On the other hand, the evaluation also revealed a number of challenges and little change in:

- patients' perception of access
- patients' use of emergency services
- levels of self-management
- the overall impact of prevention (although there was also little time to measure this component).

The introduction of information technologies proved challenging and, in some cases, not really appropriate; charting and date entry often increased the workload of practitioners. Finally, the evaluation also underscored how introducing new roles and changing the way organizations operate require careful planning to be effective and avoid disruptions in patient services.

Since the end of the Primary Health Care Transition Fund, other initiatives have continued or been developed in Nova Scotia. Most notable are initiatives on continuing education, aboriginal health, chronic disease management, collaborative practices, telephone assistance and information technologies (Government of Nova Scotia, 2010a).

One strategy for supporting both new and established teams is through **Building a Better Tomorrow Together** (BBTT), a series of continuing education modules for healthcare providers based on a previous Atlantic Canadian initiative that ran from 2003-2006 (also called Building a Better Tomorrow). As stated by the government, the first phase of the BBTT was successful in creating leaders and champions for collaborative teamwork in primary

health care. Building on that success, Nova Scotia is currently investing in renewing the continuing education program specifically for interdisciplinary team development. The revised program uses information from the evaluation of the initial BBT program, a survey of primary health care managers, guidelines for inter-professional collaboration and provincial cultural competency guidelines (Government of Nova Scotia, 2010b).

Along the same lines, the **Family Practice Nurse Initiative** is an educational and practice support program for adding a family practice nurse (FPN) to existing PHC clinics. Initially this education and support program was provided by the Capital District Health Authority but it is now moving across the province. The program includes information for physicians, resource kits and comprehensive education for registered nurses and support for their integration in the practice. This program has supported the expansion of interdisciplinary teams, and evaluations are currently underway (CDHA, 2010a). It is a challenge to make FPNs work the full spectrum of clinical practice and this education program is one initiative aiming at improving their integration.

The Capital District Health Authority has also begun to implement **Community Health Teams** (CHTs) in geographic regions within its territory for the promotion of health and wellness. These teams have been constructed using population-based planning and community-engagement strategies. The project is about creating and regrouping resources for zones or other geographic entities. The model has two key components (CDHA, 2010b):

- Wellness Programming: Depending on community needs, the CHT provides support and access to a range of wellness programs that complement services and programs already available within the community.
- Wellness Navigation: The CHT works collaboratively with family physicians, community groups, specialty programs and other providers and groups to support individuals and families by creating links with the appropriate services, supports or programs needed to support health and wellness.

A **Social Inclusion and Cultural Competence Program** that provides continuing education and guidelines was also put in place to increase providers' awareness of multiculturalism and social diversity needs. The Nova Scotia **Health Link** system was also implemented for telephone assistance on a 24/7 basis. Finally, the **Primary Health Care Information Management and Electronic Medical Records** (PHIM) project continues to be implemented to support providers in implementing electronic medical record systems. With the current timeline, just over 50% of family physicians will be using EMRs by 2012–2013. There are currently about 350 practices, about 30% of the total, engaged in this process.

Other types of innovations on multidisciplinary teams and disease prevention are currently being developed as well in Nova Scotia. The **ANCHOR** project (**A Novel Approach to Cardiovascular Health by Optimizing Risk**) is a collaborative research initiative by the government, Pfizer Inc, and the Heart and Stroke Foundation of Nova Scotia in two demonstration sites (ANCHOR, 2010). This project aims to improve prevention for cardiovascular disease and health using multidisciplinary teams in PHC settings.

Other projects include some health cooperatives that are currently being implemented with much public debate, most notably in Pictou Health Authority (Jacobs, 2004; Payne, 2005). Private FFS providers are currently experimenting with this new organizational method of management for their practices, with a community administrative board and fees for patient enrolment, as a way to improve their workload.

Generally speaking, transforming PHC in Nova Scotia has mainly been carried out through quality and performance-based programs rather than changes in organizational models for delivery. In many instances, health authorities have looked at where the needs are and who the innovators are and have worked to enable and support them. A few programs in demonstration sites were aimed at promoting organizational characteristics associated with improved PHC performance, while other complementary programs were implemented to promote information technologies, access and the use of multidisciplinary teams. Related to these efforts, there was also important work done to introduce and increase the role of registered nurses and nurse practitioners in Nova Scotia. Nova Scotia is also working to introduce alternative payment mechanisms. Still, the province faces a number of challenges in making more substantial investments and commitment to new models of care, including their governance, financing and implementation.

Table 1 Summary: Primary Health Care organizational models and innovation programs–Strategic dimensions in Nova Scotia

Dimensions		Professional FFS solo or group providers	SPCI	BBT & BBTT	Telecare/ Health link 811	PHIM	ANCHOR project	Family practice nurse	Interdisciplinary collaborative teams	Community Health teams
Year		—	1998 & 2000-2002	2003–2006 & Ongoing	2009	Ongoing - 2012	2005	2007	2002	2010
Structure	**Governance**	Private	Private	Private	Public	Private	Private	Private	Private & health authority	Health authority
	Administration	Physicians	Physicians with volunteers from the community	Physicians	—	Physicians	Physicians	Physicians	Physicians, NPs & health authorities	Health authority
	Physicians' remuneration	FFS	FFS and alternative payment mechanisms	FFS	—	FFS	FFS	FFS	FFS & alternate payment	—
	Patient enrolment	—	—	—	—	—	—	—	—	—
Resources	**Multidisciplinary teams**	—	Introducing NPs	Continuing education program from the Government of NS to promote multidisciplinary teams development	—	—	Yes	Family physicians and family practice nurses	Family physicians, NPs & others	Dieticians, registered nurses, psychologist, physiotherapist, kinesiologist
	Information technologies	—	Implementation of EMRs and information system	—	—	A Government of NS initiative to support private providers in implementing EMRs	—	—	—	—
Access	**Extended hours**	—	—	—	Telephone health information 24/7	—	—	—	—	—
	Walk-in	—	—	—		—	—	—	—	Self-referral, professional referral
Services	**Chronic disease management**	—		—	—	—	CVD	Yes		Yes
	Prevention & Health promotion	—	Yes	—	—	—	CVD prevention and risk assessment	Yes	Yes	Yes
	Coordination	—		—	—	—	—	Yes	Yes	Yes
	Continuity	—		—	—	—	—	—	Yes	
Vision	**Responsibility**	Individuals	Population/ Building links with the community	—	—	—	—	—	Individuals & community	Health authority
Context of change		Consultative and collaborative process. Successful completion of SPCI. *Registered Nurse Act*, education programs and their implementation in the province. A series of other initiative currently ongoing to improve PHC.								
Local health authorities		Nine local health authorities (District Health authorities) and one specialized tertiary care centre in Halifax.								

Sources: Wilson et al., 2004; Martin-Misener et al., 2004; Jacobs, 2004; Payne, 2005; Government of Nova Scotia, 2004, 2010a, 2010b; ANCHOR, 2010.

3.2 PRIMARY HEALTH CARE REFORM IN QUÉBEC

The major challenge for PHC in the province of Québec is the shortage of general practitioners. Québec has the highest proportion of the population without a family doctor in Canada: approximately 25% for the province as a whole and 40% in Montréal (CSBE, 2009; CIHI, 2009; CHSRF, 2010a). The shortage is due to reductions in the number of family physicians being trained, incentives for retirement offered to physicians in the late 1990s and the increased burden on practices due to aging populations, multiple morbidities and chronic conditions, all of which affect the delivery of PHC (CSBE, 2009). In addition, many family physicians also devote some of their time to hospital practice. At the beginning of the 1990s, a policy of shifting care from the hospital to the ambulatory sector was undertaken by the government to relieve pressures on hospitals and re-orient patients towards PHC, but was not accompanied by the necessary shifts in budgets or resources.

Québec also differs from other provinces in that one government ministry is responsible for both health and social services. So far, Québec's approach to changing the healthcare system has rested heavily on legislative actions. The earliest attempt to reform PHC in Québec was the 1972 *Act Respecting Health and Social Services*, which created the first **local community service centres** (CLSCs). These centres were opposed by physicians, mostly because of proposals to implement a salaried model of remuneration for them (Pomey et al., 2009; Levesque et al., 2007). Following the enactment of this law, a system of private clinics, in which services are reimbursed through the public system, grew in parallel to the CLSCs. In all, 147 geographically delineated CLSCs were created along with an estimated 800 private clinics (CSBE, 2009). There are no uniform services offered by all CLSCs; rather, they differ depending on local needs. Not all CLSCs offer general medical services and, where they are offered, they represent only a minor component of the model; the range of medical services offered varies greatly among centres and regions. Overall, medical clinicians have never really adopted and worked into the CLSCs on a broad scale (Pomey et al., 2009). Within the Ministry of Health and Social Services, CLSCs were the focus of health policy around PHC. It has been a continuing challenge to bring physicians into publicly administered health institutions.

Part of the difficulty in integrating physicians is that, in Québec, two different medical associations negotiate with the government: one for specialists and another exclusively for general practitioners. Ministry influence over physicians has been mediated principally through limitations and conditions on reimbursement of medical services. One example is the institution of Particular Medical Activities (AMP). Physicians are required to engage in a minimal proportion of priority clinical activities; these involve clinical activities in publicly administered institutions and target physicians in the first 10 years of practice.

In 1988, the Rochon Commission made a series of recommendations that paved the way for the creation, in 1991, of **Regional Departments of General Medicine** (DRMG), under the umbrella of the regional health authorities (CSBE, 2009). DRMGs exist in every social and health region and are composed of general practitioners elected by their peers. Their mission is to organize PHC in their respective territories, to make recommendations regarding human resources planning, including recruitment objectives, and to generate a region-specific list of AMPs. Part of the gradual PHC reform was to target all physicians, but also to tailor the

particular activities to specific regional health needs, as determined in consultation with DRMGs (CSBE, 2009).

In 2000, the Clair Commission painted a portrait of fragmented care and difficult access for PHC in Québec (CSBE, 2009; Pomey et al., 2009). At the time, PHC was overwhelmed by physician shortages and the shift to ambulatory care. The Commission agreed on the necessity of re-organizing PHC to ensure the sustainability and revitalization of Québec's health system (CSBE, 2009). The commission underscored the need for co-ordinated care with 24/7 access and a better integration of private clinics with the public system and social services. Its recommendations were well received by government and key stakeholders.

The Commission's main recommendation was the creation of **Family Medicine Groups** (FMGs); this new organizational model was quickly adopted and promoted by the Québec government (CSBE, 2009; Pomey et al., 2009). The FMGs represent a major innovation and a compromise between the government and organized medicine, as represented in this case by the general practitioners' union, the FMOQ (Pomey et al., 2009). An FMG consists of a group of 8-to-10 family physicians who practice in collaboration with registered nurses to offer services to registered patients. They function through contractual agreements with the regional health department and the local governing centres, the FMG doctors themselves and doctors and their patients (CSBE, 2009; Pomey et al., 2009). Individual physicians are required to have 1,300 patients registered.

The FMGs' objectives include patient registration, the coordination of services, reduced delays in appointments, extended hours, walk-in services available 365 days a year, on-call availability for complex and chronic disease cases, a more important role for registered nurses, contractual agreements and changes in remuneration. They also put an emphasis on increased availability to vulnerable patients.

At the beginning, there were serious disagreements on a number of FMG features, but the gradual, voluntary and flexible mechanisms employed for negotiations enabled the process to succeed (Pomey et al., 2009). From an initial proposal of 24-hour access 7 days a week for all registered patients, negotiations restricted the extended access to on-call availability only for patients with complex chronic conditions or severe loss of autonomy. Registered nurses are allocated to FMGs from the CLSC on their local service network as an additional strategy to integrate the public and private provision of PHC. There was initial resistance to the integration of registered nurses and frictions related to their roles and workload. However, the main disagreement was the issue of physicians' remuneration. The initially proposed capitation model of remuneration was later changed into a mixed payment model dominated by FFS but supplemented with bonuses for certain services and patient registration.

The fact that a new funding scheme was also granted to doctors in other types of practices for similar acts somewhat reduced the attractiveness of FMGs (Pomey et al., 2009). On the other hand, since the same financing structure became available to non-FMG clinics, it meant that registration could be extended to all patients, rather than only vulnerable patients. To some extent, negotiation mechanisms between physicians' association and the ministry had already had some effect prior to the reform process and differential funding promoted an

improved percentage of physicians working in rural areas. Expanding the remuneration structure to non-FMG clinics has allowed these organizations to function like FMGs but without the label and the accountability framework.

As of July 2010, there were 210 accredited FMGs for the entire province of Québec (MSSS, 2010b). Despite this success in creating a large number of new accredited organizations, the objective of 300 FMGs for 2010 had already been deemed unattainable (CSBE, 2009). Nevertheless, the demand and uptake for this model can be perceived as family physicians demonstrating a desire for change. Reducing the administrative burden to become a FMG and adjusting the allocated budget have helped the model to spread faster.

The FMG model is not exclusive to the private sector. A significant number of FMGs are located in CLSCs, sometimes in partnership with private clinics. Overall, the FMG approach is credited with having created more links between privately-owned family medicine organizations and the publicly administered system, encouraging the participation of doctors who were previously operating on the margins of health policy initiatives, and for having been a catalyst for a process of change (Levesque et al., 2007; MSSS, 2008; Pomey et al., 2009). Furthermore, negotiations with physicians' unions for supplements within the predominantly FFS system in FMGs were subsequently extended to non-FMG general practitioners. This initially decreased the attractiveness of FMGs for doctors but extended the incentives for coordinated and continuous care beyond the FMGs with potential for larger impact. There is, however, no accountability mechanisms accompanying this expanded remuneration other than professional ethics.

Early evaluations also point to increased accessibility of services without disruption of physician-patient relationships (Beaulieu et al., 2006; Tourigny et al., 2010; MSSS, 2008). Despite early difficulties, FMG registered nurses have, for the most part, assumed their expanded roles, but this happened more on an individual basis than system-wide. On the other hand, the burden of the administrative process, lack of implementation support and major disappointments related to information technologies and EMRs are among the main negative points stressed in recent evaluations (Beaulieu et al., 2006; MSSS, 2008). FMG evaluations are among the few evaluations in Canada that have reported significant and positive impacts for a new organizational model and its performance (Hutchison et al., 2011; Beaulieu et al., 2006; Tourigny et al., 2010 Pineault et al., 2008). Those evaluations, however, have mainly focused on implementation and a true model evaluation has yet to be conducted.

An alternative model, the **Network-Clinics,** was also created around the same period, first in the Montréal region. This model responded to urban realities, including the high percentage of the Montréal population that was unattached and relatively mobile. The clinics were created partly in reaction to dissatisfaction with the initial FMG process, but also to extend the role of PHC clinics in providing access to broad networks of clinics and to diagnostic and specialized services. Network-clinics make arrangements with other clinics in order to offer 24/7 access, access to extended diagnosis platforms and access to specialists. The Montréal branch of the FMOQ, the DRMG and Montréal's regional health agency proposed this alternative to overcome some accessibility and continuity challenges. The model was also seen as a solution to the problem of emergency room overcrowding, some of which was the

result of patients attempting to get faster access to specialist care and to diagnostic technical support services (Levine, 2005; CSBE, 2009). As of January 2010 there were 29 active Network-Clinics in the city (ASSS de Montréal, 2010). No evaluations on the implementation and performance of Network-Clinics have been made public so far.

Finally, in 2004, the provincial government implemented 95 **Local Service Networks,** under the *Act Respecting Local Health and Health Service Network Development Agencies (Bill 25)* (MSSS, 2010a; CSBE, 2009). The Local Service Networks are divided within each of the 18 Regional Health and Social Services Agencies. Within each area, there was an administrative merger of the management structures of residential and long-term care centres (CHLSDs), community health centres (CLSCs) and, in the majority of cases general and specialized hospital centres (CHSGSs), into single governance structure, the **Health and Social Service Centre** (CSSS). These local networks are mandated to improve the accessibility and the continuity of services for the population in their territory. The aim is to consolidate all publicly funded health and social services and professionals and create alliances with other organizations, including private PHC providers and community organizations. A recent study (Breton et al., 2009) has demonstrated that the population-based mandate was adapted and customized by health managers, who also developed agreements and alliances with different partners, including PHC providers.

PHC services in these new local networks are still delivered predominantly through the solo and group practices, as well as in community health centres and the two newest approaches, FMGs and network-clinics (CSBE, 2009; Pineault et al., 2008). However, between 80 and 85% of general medical services are still provided in physician-run private (solo or group) practices funded through FFS mechanisms (CSBE, 2009). One of the major challenges for PHC renewal in Québec has been the lack of integration of private models into public policy initiatives. In addition, the creation of the local service networks created some disruptions in the system because of the administrative fusions and new local population mandates.

Another important and recent development for PHC was the legal redefinition of the Professional Code (PL 90) in 2003, which expanded the definition of the nursing role and allowed medical acts to be delegated to designated nurse clinicians (OIIQ, 2003). When FMGs were created, with their expanded role for registered nurses, there was no nurse practitioner program in Québec. In 2005, the family physicians' union, the FMOQ, and the nurses' professional organization, the Ordre des infirmières et infirmiers du Québec (OIIQ) created a joint task force to allow registered nurses to function in an expanded role through the use of standing orders for prescribing, a mechanism where physicians in a practice collectively sign a care protocol allowing registered nurses to carry out diagnostic and therapeutic interventions. This mechanism, which is not limited solely to FMGs, allows registered nurses to have a locally defined and expanded role. In addition, the first training program for NPs to work in PHC practices was officially created in 2006 and the first cohorts of these MSc-trained NPs started to enter practices in 2009 (OIIQ, 2009, 2010). There are about 40 NPs currently working in PHC practices.

Overall, there have been important changes in recent years in the organization of PHC in Québec. Two new organizational models, the Family Medicine Groups and the Network-Clinics, were negotiated with physicians and implemented on a voluntary basis. These two

models were introduced to improve the delivery of PHC and meet the challenges of access, comprehensiveness, coordination, continuity, efficiency, population responsibility, chronic disease management and the needs of vulnerable and aging populations. The major reorganization of regional health authorities into local health networks seems to have created synergies to improve coordination, continuity of care and responsiveness to local population needs. The creation of FMGs opened the door to changes in physician remuneration that extended beyond the FMGs and allowed private physicians to enrol complex-care patients and receive protected time for coordinating care. Likewise, the mechanism for collective prescriptions allowed registered nurses to assume an expanded role in PHC models in the absence of a large contingent of NPs. Unfortunately, systematic follow-ups and evaluations of FMGs and these other initiatives remain sparse.

The regulatory framework is strong in Québec and a lot of transformations are top-down and mandated. Furthermore, the province still faces important challenges. The lack of accessibility of family physicians, despite favourable physician-to-population ratios, remains a major issue. It means that practicing physicians are often too overloaded to deal with changing their practices and there are no market incentives to do so. It also means that increasing accountability and performance evaluation in this context could prove a challenge. Finally, expanding multidisciplinarity and integrating and funding other professionals in PHC practices represent a work in progress, as in other provinces. Despite the introduction of new PHC organizational models in recent years, no fundamental changes in population access have been observed so far and some inequities might even have been created.

Table 2 Summary: Primary Health Care organizational models and innovation programs–Strategic dimensions in Québec

Dimensions		Professional FFS solo or group providers	CLSC	FMG	Network-Clinics	Collective prescription
Year		—	1972	2002	2005	—
Structure	**Governance**	Private	Public	Private	Private	Private
	Administration	Physicians	Public Local health authority	Physicians, administrator or manager	Physicians	Groups of physicians
	Physicians' remuneration	FFS	Time-based remuneration (Salary and sessional)	Mixed FFS, bonus and lump sums	FFS	—
	Patient enrolment	—	—	Yes	—	—
Resources	**Multidisciplinary teams**	—	Yes	Physicians with registered nurses and sometimes allied health professionals Collaborative practice Registered nurses employed by local health authority	Not required Group of physicians and complementary services together or in a virtual network	Mechanism to enable registered nurses to have an expanded role where physicians collectively sign specific prescriptions for registered nurses to use in their practice
	Information technologies	—	Financial support for implementing information technologies and electronic records	Required Financial and technical support for implementing information technologies and electronic records	—	—
Access	**Extended hours**	—	Yes	Yes	Yes	—
	Walk-in	—	Yes	Yes	Yes	—
Services	**Chronic disease management**	—	Yes	Yes	—	—
	Prevention	—	Yes	Yes	—	—
	Coordination	—	Yes	Yes	Local network Coordinated access to technical support services and specialists	—
	Continuity	—	Yes	Yes	—	—
Vision	**Responsibility**	Individuals	Population	Clientele	Individuals	—
Context of change		Early opposition to CLSCs in the 1970s followed by status quo. Recent reports and federal transfers enabled new initiatives on a negotiated and voluntary basis.				
Local health authorities		Ninety-five Local Service Network (divided between 18 Regional Health Authorities) headed by a CSSS and including residential and long-term care centres, CLSCs, general and specialized hospitals and PHC providers such as FMGs. Telehealth services also available 24/7.				

Sources: Beaulieu et al., 2006; Levesque et al., 2007; MSSS, 2008; Haggerty et al., 2008; Pineault et al., 2008; CSBE, 2009; Pomey et al., 2009; Government of Québec, 2010a, 2010b; ASSS de Montréal, 2010; Hutchison et al., 2011

3.3 PRIMARY HEALTH CARE REFORM IN ONTARIO

Ontario is one of the provinces where reforms and initiatives in PHC have been among the most far-reaching (Hutchison, 2008). Since 1979, the Government of Ontario has experimented with patient enrolment, diverse financing and payment models and organizational models for group and network practices. Various models were introduced in the 70s, 90s and 2000s, resulting in what Hutchison (2008) has called an "alphabet soup" of PHC models. These models focus, to varying degrees, on patient enrolment, community orientation, population-based prevention, chronic disease management, capitation and blended forms of payment, interdisciplinarity and extended hours of service (Hutchison et al., 2011; Wilson et al., 2004; Hutchison, 2008; Russell et al., 2010). These reforms were possible because of a favourable economic climate and were motivated by the dissatisfaction of family physicians with their workload and quality of life and the decline in medical students choosing family medicine as a career in the 90s (Hutchison et al., 2011).

Ontario has several different models of PHC organization. These models include: **Community Health Centres**, or CHCs (1979); **Health Service Organizations,** or HSOs (1975) and **Primary Care Networks,** or PCNs (1999), which were merged in 2007 into the new **Family Health Organizations** (FHOs); **Family Health Networks,** or FHNs (2001); **Family Health Groups,** or FHGs (2004); the **Comprehensive Care Model,** or CCM (2003); and **Family Health Teams,** or FHTs (2005) (Muldoon et al., 2006; Hutchison, 2008; Green et al., 2009; Russell et al., 2010). These do not include the regional, rural and northern funding plans as well as community centres focusing on aboriginal health, called Aboriginal Health Access Centres (AHAC).

This wide variety of models results in part from the competition that has historically existed between organized medicine, which wants to protect doctors' autonomy, and the government. Medical associations favour FFS payment schemes, while the government is trying to move away from such models. The result has been a voluntary and gradual step-by-step transition, with each new model adopting some of the changes sought by government (Muldoon et al., 2006). The lack of evidence for the superiority of any single model also motivates this "one-step-at-a-time" approach. The same authors have also underscored how this process has accelerated in recent years. Newer models often appear to be only a slightly different form of the preceding model. However, they represent an explicit attempt to shift away from FFS towards other forms of remuneration and payment incentives. They also represent a work-in-progress towards multidisciplinary teams. Newer models are changing a few organizational features at a time towards more comprehensive and community-oriented models of care.

Classic FFS solo and group practices are still found throughout the province (Russell et al., 2010) but few actually remain. As outlined above, even though new models do represent a departure from traditional solo or small-group practices, they are, for the most part, still physician-centred and governed with limited interdisciplinary resources (Hutchison, 2008). FHGs and the CCMs also retain many aspects of traditional FFS organizations.

Authors have also emphasized how CHCs and, to some extent, the FHTs, represent the most comprehensive and explicitly interdisciplinary models (Hutchison, 2008; Muldoon et al., 2010; Russell et al., 2010). Some authors have noted that chronic disease management is superior in CHCs, with physicians in this model having longer consultation times and better access to interdisciplinary teams, that typically include physicians, registered nurses, NPs, dieticians, pharmacists and social and mental health professionals (Russell et al., 2009; Hutchison, 2008). The FHTs are considered the "flagship" of Ontario's recent innovations in PHC (Hutchison, 2008). These two models also have the most extensive population orientation (Hogg et al., 2009) and focus on disease prevention (Hutchison, 2008; Russell et al., 2010). The most comprehensive services, best integration of interdisciplinary teams and most population-based vision are, nevertheless, mainly found in community-governed FHTs, which constitute only one fifth of all FHTs (Hutchison, 2008). CHCs are most likely to serve disadvantaged populations; one of the most recent innovations is the introduction of NP-led FHTs into underserved communities.

Overall, about 66% of Ontario's physicians are now in reformed practices and receive a blended form of remuneration (Hutchison et al., 2011). By 2008, 152 FHTs were approved, 129 were operational and 50 more were planned, while 13% of Ontario's population was enrolled in one of them (Hutchison, 2008). There are currently 101 CHCs in operation throughout Ontario (Government of Ontario, 2010b).

Some studies have underscored the benefits and challenges brought by interdisciplinarity in PHC practices in Ontario: the benefit of nurse practitioners in prevention performance (Hogg et al., 2008); challenges and benefits of integrating other professionals such as pharmacists into FHG practices (Pottie et al., 2008); the benefit of multidisciplinary care teams for older, at-risk patients (Hogg et al., 2009); and the challenges with the integration of physical activity counsellors (O'Sullivan et al., 2010).

One study by Green et al. (2009) has also looked at the gains made by physicians moving to newer models. They found an increase in physicians' remuneration for those practicing in newer models, with a one-third increase for those working in FHNs and a 12% increase for those practicing in FHGs. Most of the physicians who had transitioned to a reform model were also satisfied with the decision, leading the authors to conclude that non-FFS models benefit family physicians in Ontario. One doctor, who first engaged in the reform process with the FHG in 2004, has experienced many changes in his practice in the past six years.[1] Dr Hogg's patients are now rostered, which means he is able to have a community orientation in an urban environment, while his practice is now paperless. The transition was both expensive and difficult, but it was paid for and fully supported by the government. He is now paid in a blended form of remuneration: a substantial part of it comes from capitation based on registered patients, a little from FFS to incentivize him and some based on performance of preventive and population-based services. Finally, Dr Hogg works in a collaborative practice with an interdisciplinary team composed of nutritionists, registered nurses, NPs, extra administrative support, computer support and a co-located mental and social health team. He no longer performs annual check-ups on healthy adults anymore and his practice has teams for follow-up of chronic-disease patients.

[1] Dr. William Hogg, account of his experience in the reform process, presentation November 3, 2010.

The Ontario government also initiated various support programs in parallel to the above reforms by the Ontario government. The **ePhysicians Health Council** was established to support the introduction of information technologies in FHNs. A telephone health system was implemented and a **Quality Improvement and Innovation Partnership** was introduced in 2007 to support FHTs during their implementation.

The **Physicians Service Committee** (PSC) was established in 1996 by the Government of Ontario and the Ontario Medical Association (OMA) as a working committee responsible for negotiating the implementation of new models of PHC (Wilson et al., 2004). The PSC is co-chaired by representatives from the OMA and the Ministry of Health and Long-Term Care (MOHLTC); one of its specific responsibilities is the incorporation of peer-reviewed research and other tools to enhance evidence-based decision-making (Archibald & Flood, 2004). The committee also creates a better climate for negotiations with physicians. However, Archibald & Flood criticize the organization for its lack of public accountability and transparency and emphasize that there is little participation from other health professionals.

An unrelated but important and recent reform in Ontario is the introduction of local health authorities, known as **Local Integrated Health Networks** (LIHNs) in 2006 (Hutchison et al., 2011; Government of Ontario, 2010a). The LIHNs were created through the *Local Health System Integration Act* to coordinate health services and determine health priorities in each region (Government of Ontario, 2010a). Ontario is now divided into 14 LHINs. As far as the PHC sector is concerned, however, the LIHNs only have authority over Community Health Centres, which deliver a small portion of PHC services in Ontario. In effect, one of the biggest changes in the governing structure for the delivery of health services has left out PHC (personal communication, October 2010).

Overall, there is strong support and participation from the Ontario government and key stakeholders, even though the OMA is a strong player with the ability to block reforms and negotiations (Hutchison et al., 2011). Recent transformations were agreed upon through negotiations and were implemented on a voluntary basis (Hutchison et al., 2011; Wilson et al., 2004; Muldoon et al., 2006). Even though Ontario has been actively reforming its PHC sector in recent years, however, there was a long period where nothing happened in PHC. In 1994, the five chairs of the university family medicine programs published an article encouraging the reforms of PHC organizations (Forster et al.1994). The Ontario MOHLTC was convinced of the need for, and benefits of, the proposed reforms, but waited in order to avoid confrontation with the OMA. Nonetheless, Ontario should be given credit for the scale of reforms undertaken so far in PHC. All the changes were voluntary and based on financial incentives, with major financial investments to support these reforms and stimulate professional acceptance.

Furthermore, as in the rest of Canada, Ontario continues to face a number of different challenges in implementing new organizational models: the time required to effectively implement changes and information technologies; the integration of interdisciplinary teams and the adoption of collaborative practices; the availability of a sufficient number of PHC providers; community ownership of new models; the administrative burden imposed on physicians and the Ministry; and the possible lack of funding and sufficient support in the future (Wilson et al., 2004).

Family physicians in reform models are better paid than physicians in other models and find more satisfaction in their practice (Green et al., 2009). Overall, Ontario's PHC reforms have been addressed predominantly by introducing new organizational models to meet the challenges of comprehensiveness, coordination, continuity, efficiency, access, aging population and chronic disease management. In Ontario, various PHC organizational models co-exist as in no other province in Canada, and allow physicians choice and the ability to embrace reforms step by step. Physicians can be overwhelmed by the need to roster their patients, computerize their practices and adopt a collaborative and interdisciplinary style of care. Working in a collaborative practice is difficult and teams are still only learning to work as teams. Most will choose to transition into a model that requires only one of these changes at a time. Still, the proliferation of models has increased the complexity of the system and for some authors, more research and evaluations are warranted to better understand the current functioning and impact of existing models (Muldoon et al., 2006). Nonetheless, the Government of Ontario should be credited for the scope of its reforms in PHC. Physicians now compete to get into reform models; some three-quarters of the population is rostered, with half seeing a doctor who is remunerated in a blended form, while one-third see doctors who practice in interdisciplinary teams. A higher proportion of the population has been registered to a family doctor. Admissions to family medicine faculties have increased, at least in Toronto, and there are more family doctors available. Use of walk-in clinics has decreased, but there is still no sign of reduced use of emergency services. There are also fewer solo practices. Collaborative models have increased and networks of doctors are being established to link to specialists to improve coordination and relationships of patients to their PHC provider. The advantages of PHC reform are becoming clear.

Reforming PHC to this extent is expensive and can be discouraging as measurable impacts can take time. However, investments are starting to pay off, so the question remains as to whether the government will be able to maintain its course. Finally, practices compete and there is currently little cooperation. So far the Government of Ontario had some success in fine tuning existing practices. However, practices still function independently from one another and from the rest of the system. The next stage of reform will be to integrate PHC with the rest of the system.

Table 3 Summary: Primary Health Care organizational models and innovation programs – Strategic dimensions in Ontario

Dimensions		Professional FFS solo or group providers	CHC	FHG	FHO (HSO and PCN)	FHN	FHT
Year		—	1979	2004	2006	2001	2005
Structure	**Governance**	Private	Public	Private	Private	Private	Private
	Administration	Physicians	Community	Physicians	Physicians or community	Physicians or community	Physicians, community-based or mixed
	Physicians' remuneration	FFS	Salary	FFS , premiums and incentive funding	Blended capitation, FFS and incentive funding	Blended with capitation, FFS and incentives	Blended capitation or salaried compensation or complement-based funding
	Patient enrolment	No	Patients rostered by physicians	Optional	Yes	Yes	Yes
Resources	**Multidisciplinary teams**	No	Yes	Not required Group of physicians in virtual network or together	Yes Collaborative practice	Limited	Physicians with registered nurses and allied health professionals Collaborative practice
	Information technologies	Low Introduction	Low Introduction	Not required Support for implementation	Support for implementation	Support for implementation ePhysicians Council	Yes Support for implementation
Access	**Extended hours**	Not required	Yes	Yes	Yes	To enrolled patients	Yes
	Walk-in	Variable	Yes	Yes	Yes	To enrolled patients	Yes
Services	**Chronic disease management**	—	Yes	—	—	—	Yes
	Prevention	—	Yes	Some	—	—	Yes
	Coordination	—	Yes	—	Optional	Limited	Yes
	Continuity	—	—	—	—	—	Yes
Vision	**Responsibility**	Individuals	Population	Individuals	Individuals	Individuals	Population
Context of change		Numerous and far-reaching initiatives with organizational models of PHC. Favourable economic climate and physician dissatisfaction. Physicians Service Committee. Transformations negotiated and on a voluntary basis. Nurse practitioner educational program developed and role expanded throughout the province.					
Local health authorities		Fourteen LHINs and 31 Public Health Units. Telehealth services available 24/7.					

Sources: Wilson et al., 2004; Hutchison, 2008; Agarwal et al., 2008; Agarwal, 2009, Russell et al., 2010; Hutchison et al., 2011.

3.4 PRIMARY HEALTH CARE REFORM IN MANITOBA

Manitoba's health services are divided into 11 regional health authorities. The majority (67%) of the population and 90% of all providers are in the capital, Winnipeg and the majority of providers (60%) are in FFS practices (personal communication, October 2010.) In 2007, 85% of the population aged 15 years and over declared they had a family physician, leaving 15% without one (CHSRF, 2010a). Practices have not changed much in the last 15 years. Nonetheless, changes were slow and took a long time to come but Manitoba government has taken some actions to transform PHC.

The central government negotiates the provincial agreement with the medical association, but the delivery of services is decentralized by regions. This regionalization of health services affects how services are delivered and how programs are designed. Physicians work for, but do not receive payment from, the health authorities (except in the few cases where alternative mechanisms have been negotiated with regional health authorities to attract physicians to rural and isolated areas). Since 2001, there have been some positive changes and initiatives in PHC in Manitoba (Wilson et al., 2004; Hutchison et al., 2011). The environment for reforms has been positive, and initiatives have been in general welcomed, despite the fact that cooperation among the ministry, called Manitoba Health, regional health authorities and physicians was previously almost non-existent (Hutchison et al., 2011). On the other hand, the model approach to PHC reforms has been limited. Overall, the funds from the first federal transfers have been predominantly used for population health and less for the delivery of services. Furthermore, the driving force for change has been Manitoba Health, as physicians were initially not optimistic and very few met the eligibility criteria to participate in demonstration sites (Hutchison et al., 2011). Academia was not a driver for change either.

In 2002, the Government of Manitoba developed a **Primary Health Care Policy Framework** to give direction to PHC reforms (Wilson et al., 2004). The ultimate vision of the framework is for "Manitobans to have access to community-based, integrated and appropriate PHC services" based on community participation, focused population health, interdisciplinary teams, accessibility, suitability, continuity, efficiency, affordability and sustainability" (Manitoba Health, 2010). This policy recognition of PHC as the foundation of the healthcare system is one of the most significant changes in recent years.

A few initiatives have been undertaken so far under the Primary Health Care Policy Framework, involving call centres, patient or provider education, quality-based incentive funding and networks (Manitoba Health, 2010; Hutchison et al., 2011). In the first phase of this two-phased framework, the government supported different initiatives to address barriers to access by: establishing a provincial call centre; developing training programs for collaborative practices; promoting the use of information technologies; developing population-based awareness campaigns; and developing the emergency skills of rural and northern practitioners. For the second phase, the government is supporting regional health authorities by funding a variety of initiatives. Professional workshops are also currently given through the **Physician Management Institute** initiative to promote the acquisition of new skills and change practices to support the reform process.

Carelink was launched in 2008 to improve access for individuals with chronic diseases and to improve self-management. The **Manitoba Telehealth initiative** was launched in 2005 for after-hours PHC for the general population. The **Mother and Child Healthcare initiative** links patients with physicians, and general practitioners with specialists, to provide referral and support for Aboriginal, Inuit and Métis women via Telehealth, networks of practices and health programs.

An A**dvanced Access** program has been under development since 2007, and is currently being introduced into clinics to modify practices and workflow, and to enable patients to meet physicians in their local network at a time convenient for them. Community **Access Centres** were also built. However, this has consisted mainly of constructing multi-service centres where on-site availability of physicians has remained limited.

Finally, in 2007, the Government of Manitoba launched the **Physician Integrated Network** (PIN) program in selected sites. The goal was to facilitate improvements in the delivery of PHC among FFS practitioners (Katz et al., 2010). The project rationale is to re-orient the system to emphasize the importance of high-quality PHC, address family physicians' isolation and work-life balance, address the challenges of chronic disease management and current and future shortages of providers, overcome problems of access, establish predictable and stable funding for chronic disease management and quality care, and integrate decision-support tools (Manitoba Health, 2009). This is not a governance model but a program to transform the way care is delivered in large clinics. Funding for the PIN initiative is based on performance and quality-based indicators. Funding is not given to individual physicians, as is the case in Ontario, but rather is invested in the clinic.

So far, the project has supported traditional FFS family physicians in group practices in integrating inter-professional work, implementing EMRs and improving day-to-day patient management with quality-based incentive funding and pay for performance based on 27 clinical indicators (Hutchison et al., 2011). During Phase 1 of the project, three group practices participated as demonstration sites; each had to choose an area of focus: preventive practices and coronary artery disease, hypertension and diabetes, or information management and EMRs (PRA Inc., 2009). Overall, once the initial challenges were overcome, the different stakeholders involved were optimistic about the expansion of this program (PRA Inc., 2009). Phase 1 has also relied on a Primary Care Assessment Tool (PCTA) that includes patient and provider surveys and the use of the Canadian Institute for Health Information (CIHI) clinical process indicators.

The PIN project is now in Phase 2 and has expanded to 65 practices, with the addition of more indicators for measurement and funding (PRA Inc., 2009; Hutchison et al., 2011). Existing clinics in the program now have to address all indicators, while new participants are entering gradually. Baseline evaluations (Katz et al., 2010) have underscored the need to improve measurement indicators for future evaluations.

EMRs are also in process in Manitoba, and recent investments and support for them were recently announced. The EMR project also includes the development of quality indicators to be extracted from EMRs. There have also been efforts to integrate NPs and academic training programs for them are available in the province. To date, however, most NPs

struggle to find jobs and there are no clear mechanisms for their remuneration. A physician-assistant program developed in recent years also directly challenges NPs working under physician supervision.

Overall, in Manitoba the reform of PHC has been managed through quality- and performance-based programs, along with a number of complementary approaches. Instead of implementing newer organizational models of PHC delivery, Manitoba established a few demonstration sites to promote characteristics associated with performance and quality care. Experiments with alternative payment mechanisms have been limited and mainly concentrated in rural regions to attract physicians to underserved areas. The government has also implemented a number of complementary programs to improve access and the networking of existing resources.

Table 4 Summary: Primary Health Care organizational models and innovation programs – Strategic dimensions in Manitoba

Dimensions		Professional FFS solo or group providers	PIN	Advanced Access	Telehealth & Carelink	MCHS
Year		—	2007	2007	2005 & 2008	2008
Structure	**Governance**	Private	Private	Virtual network of providers and multi-services centres	Public	Public Virtual network of providers
	Administration	Physicians	Physicians	—	—	—
	Physicians' remuneration	FFS	FFS, quality-based funding and pay for performance	—	—	—
	Patient enrolment	—	—	—	—	—
Resources	**Multidisciplinary teams**	—	Physician group practice to integrate inter-professional work	—		—
	Information technologies	—	Demonstration site focus on information management and EMRs	—	—	—
Access	**Extended hours**	—	—	Practice workflow to enable patients to see physicians in the network at times convenient for them	Telephone health information 24/7	Telephone health information 24/7
	Walk-in	—	—			
Services	**Chronic diseases**	—	Demonstration site focus on coronary artery disease & preventive practices or hypertension & diabetes in Phase 1/Phase 2	—	Carelink to improve access via Telehealth for individuals with chronic disease self-management needs	—
	Prevention	—		—	—	—
	Coordination	—		—	—	Support and referral to specialists
	Continuity	—		—	—	
Vision	**Responsibility**	Individuals	Individuals	Population	Population	Population Aboriginal, Inuit and Métis women
Context of change		Positive changes and initiatives welcomed. Collaboration but driving force is the government. Primary Health Care Policy Framework in 2002. Transformation in continuing education and quality- and performance-based funding. Most changes in demonstration sites.				
Local health authorities		Eleven regional health authorities.				

Sources: Wilson et al., 2004; PRA Inc., 2009; Manitoba Health, 2009, 2010; Hutchison et al., 2011.

3.5 PRIMARY HEALTH CARE REFORM IN BRITISH COLUMBIA

In British Columbia, the jurisdictional responsibility for primary health care is divided between the Ministry of Health Services (MoHS), which is responsible for overall funding and policies, and one provincial and five regional health authorities that are responsible for service delivery. At the time of this case study, a second health ministry, the Ministry of Healthy Living and Sport, is responsible for public health policies, including services that are generally thought of as part of PHC, such as immunization, prenatal and antenatal programs and infant and child development. Overall, there are approximately 4,000 general practitioners and family practice physicians who are considered PHC physicians in British Columbia. In 2007, 87% of the population aged 15 years and over declared they had a family physician, leaving 13% without one (CHSRF, 2010a). There are two predominant models of remuneration for physicians in BC and these dictate the two main models of PHC found in the province: the vast majority of physicians work in solo or small practices funded through the traditional FFS model, while a small number are paid through alternative payments plans that include salaries and sessional payments and are employed through a limited community healthcare model (Wong et al., 2010) known as the **Community Health Centre** (CHC) model. Wong et al. (2010) have numbered these centres at 29 in 2006 and 40 in 2008 for the whole of British Columbia. Several of these have now been taken over by health authorities, which have diluted the model. These health authority-run and funded CHCs are composed of interdisciplinary teams (public health nurses, social workers, dental experts, nutritionists) which are under contract with the MoHS. Physicians in this model are paid through salary and/or sessional payments and sometimes with a mix of contracts. However, several have either lost their alternative payment plan (APP) funding or, more often, lack of support from the health authority has resulted in their adoption of FFS.

Another newer practice model found in BC is that of **Primary Health Care Organizations** (PHCOs). PHCOs were developed by the MoHS with funding from the first Health Transition Fund in 1997–2001 to support interdisciplinary teams and to strengthen comprehensive and coordinated care with improved access to EMRs, educational programs and blended remuneration (Watson & Wong, 2005). Only seven PHCOs were implemented in British Columbia, largely because of opposition from the British Columbia Medical Association (BCMA). In terms of community and alternative organizational models, there are approximately 28-30 PHCOs and CHCs in the province (Government of British Columbia, 2004). Also, between 1996-97 and 2000-2001, there was a net gain of 10 group and community practices, with variations existing among regional health authorities.

The various PHC reforms and innovations in BC can conceptually be separated into four parts: the first Health Transition Fund (1997–2001); the 2000–2006 period with the Primary Health Care Transition Fund; the creation of the General Practice Service Committee (GSPC—see below); and the Primary Health Care Charter of 2007–2011, also below (Cohen et al., 2009).

With the first Health Transition Fund in 1997–2001, small-scale experiments in PHC were undertaken (including the PHCOs). Changes were resisted by the BCMA, however, mainly due to capitation (Cohen et al., 2009). And although the MoHS has maintained its policy and evaluation responsibilities, the majority of funds were allocated to health authorities and used

for a wide range of projects. With virtually no central policy direction, however, there has been no common approach developed across the various authorities and many projects ended when the funding ended.

Following this, in 2000–2006 the Primary Care Health Transition Fund paved the way to other small-scale projects, with specific attention now paid to chronic disease management (Cohen et al., 2009). Small-scale organizational model initiatives were implemented, such as **community collaboratives** or learning sessions, of which about 88 were held between 2003 and 2005, but these had limited sustainability once funding ended (Wong et al., 2010). At the same time, the Ministry began to work with the BCMA to improve the management of chronic disease, initially focusing on diabetes and congestive heart failure. Two small-scale collaboratives, partly funded by pharmaceutical companies, were held and judged to be very successful.

As the Primary Care Health Transition Fund came to a close, the Ministry shifted its attention to working more closely with the BCMA. In 2002, the Ministry and the BCMA established a **General Practice Service Committee** (GPSC); co-chaired by both organizations; this committee now manages more than 15 initiatives (GPSC, 2010). Large amounts of funding are now made available to the BCMA through this organization and the Physician Master Agreement. The GPSC has also served to develop an important relationship between the government and the medical association, creating an atmosphere for collaboration. Health authorities are not formal members, although representatives attend meetings and carry directions back to their respective territories.

Out of this collaboration came BC's first **Primary Health Care Charter** (Government of British Columbia, 2007) and a number of new initiatives for the 2007–2011 period (Cohen et al., 2009). The charter is setting the direction, targets and outcomes for a strong, sustainable, accessible and effective PHC system in BC (Wong et al., 2010). The work of the GPSC also led to the funding of Impact BC, a non-profit organization focused on enhancing clinical care and practice management (Hutchison et al., 2011), which has supported the GPSC quality initiatives as well as changes in the health authorities. The main delivery tool for this program has been the "Collaboratives," which include a series of learning sessions based on the US Institute of Health Improvement model.

More recently, the GPSC has introduced the concept of Divisions, which are currently being established (Divisions BC, 2010). The idea of **Divisions of Family Practice** is not new, as this concept has been used in the UK as well as New Zealand. They are voluntary local groupings of general practitioners who come together to create a non-profit society (which allows them to hold funds) to enable this collaboration to address community health issues, ensure representation within health authorities and possibly hire staff and services on behalf of the group. These divisions also contract with the Ministry to provide services such as inpatient care. Hence, family physicians must volunteer to work as partners with the authorities. There are currently 12 fully established Divisions operating in BC.

At the same time, a recent evaluation report by M. Hollander, commissioned by the BCMA (Young, 2010), has reinforced the fact that patients with chronic disease who are attached to a physician receive better care, but more importantly for the Ministry, also cost the system

less. Accordingly, the GPSC has launched an **Attachment Initiative**, which reportedly involves providing Divisions with funding to pay physicians an incentive fee for "attached patients" and also to develop programs to increase patient attachment.

To date, GPSC has not focused on increasing delivery or quality of prevention and education services, nor has it focused on the broad determinants of health. In recent years, the focus on PHC physicians has resulted in most PHC healthcare transformations in BC being centred around a system of payment incentives designed to pay physicians to deliver improved care according to clinical guidelines, with a special focus on people with chronic diseases, including mental illness, or requiring complex care. At the same time, these incentive programs have also resulted in increased remuneration for general practice. In addition to incentive payments, the GPSC has also championed office redesign and become involved in other matters, such as the introduction of EMRs. As a consequence, this has resulted in the majority of attention being focused on improving the quality of PHC delivered by physicians, and not experimentation with different organizational models (Hutchison et al., 2011). Or, as other authors have stated, funds were allocated to provide financial incentives to physicians in order to stimulate changes related to the way they operate rather than transforming the foundation of the system by funding province-wide initiatives for new models of care (Cohen et al., 2009).

On other fronts, the Ministry of Health is also driving most recent initiatives. The **Integration Initiative** has a centrally driven agenda in which health authorities have been directed to integrate the delivery of community services. Although the details are still under development, it appears that the goal is to integrate at least some services from mental health and addictions, public health and home and community care, as well as to develop a much stronger relationship with local Divisions of general practitioners. This new initiative appears to be replacing the **Integrated Health Network** (IHN) model, which was proposed by the Ministry of Health in a 2007 discussion paper (Cohen et al., 2009) but funded through the Ministry of Finance's Healthcare Innovation Fund. IHNs are "groups of family physician/general practitioner practices that coordinate and collaborate to serve a patient population" (Watson et al., 2009). For both the IHNs and the Integration Initiative, the goal is to increase the quality of care by increasing coordination for individuals with complex chronic conditions, seniors at risks, individuals with mental disorders and vulnerable groups, and to share information on patients.

Finally, the role of NPs has also been extended in BC with the *Health Professions Act.* Several projects funded by health authorities have aimed to integrate them into different PHC settings (Wong et al., 2010). In 2000, 12% of registered nurses worked in PHC settings (Wong, 2009).

The vast majority of FFS practices comprise only physicians providing medical care. Very few include other practitioners such as family practice registered nurses or NPs. In rural areas however, registered nurses have traditionally served as "physician extenders" or substitutes for some issues associated with limited physician capacity and shortages. The lack of dedicated funds has been identified as a major barrier to their integration, although the BC Medical Service Plan Fee Guide includes a provision for billing work done by other types of providers. Recently, health authorities have provided fully funded registered nurses

to some PHC practices as “chronic disease nurses” but reports have been mixed. However, quite separate from the GPSC initiatives, Interior Health has successfully piloted NPs in FFS primary care (CHSRF, 2010b).

GPSC is also currently exploring “multidisciplinary care” but options are limited given the small size of most practices and the expectation that other professionals would be fully funded but employed by the practice. A previous brief excursion into “virtual networks” (IHNs that develop “teams” by linking physicians to health authority-employed providers) did not gain traction and has largely been abandoned.

While NPs have actively been kept from delivering PHC services because of the very real barriers of who will reimburse them and how they will be reimbursed, larger acute-care organizations have recognized their value. For example, BC Children’s Hospital realized that more could be done to increase access to health services for vulnerable children and families. In the last two years, they have funded a “Social Paediatrics Initiative” that employs NPs to deliver PHC and work directly with paediatric development specialists.

For the most part, the main challenges faced by British Columbia include: the resistance to changes at the system and provider levels; the implementation of information technologies; the fragmentation of the system of care and issues in the scope of practices; limited funding and compensation for providers’ remuneration; and a system that is focused on acute care (Wilson et al., 2004).

Overall, British Columbia’s strategy for PHC renewal is based primarily on quality- and performance- based funding and programs aimed at PHC physicians. As detailed in this case study, so far there has been an almost exclusive focus on PHC (not healthcare) provided by physicians paid on a FFS basis and on improving the quality of chronic care by paying physicians incentives to work according to recognized guidelines. The government has worked hard to pay attention to physicians and listen to their demands as a way to strengthen PHC. It has also done a number of things to respond to their demands, most notably by the creation of the GPSC, training programs (Practice Support Program) and incentive funding programs. The government is also working to improve and implement new community models and networks of services. However, efforts towards new organizational models of PHC have not been as extensive as in other Canadian provinces.

Most notably, representation on important committees is mostly made up of PHC and specialist physicians, leading to an observed increase in the medicalization of PHC. The focus is now less on innovations in who delivers services or how these services are organized in order to deliver care to patients. Still, efforts have also been made to introduce and expand the role of nurse practitioners in PHC organizations.

Table 5 Summary: Primary Health Care organizational models and innovation programs – Strategic dimensions in British Columbia

Dimensions		Professional FFS solo or group providers	CHC	PHCO	Primary Care Practice Support Program & Impact BC	BC Health Primary Care Innovation Fund & IHN (Now Integration Initiative)	Divisions of Family Practice
Year		—	—	2006	2007–2010	2007	2009
Structure	**Governance**	Private	Public Contractual agreements with local authorities and the Ministry	Public	Public		Private - each division has a governing board
	Administration	Physicians	Community	Integration into Community Health Centres	—	Virtual network of physicians in different geographic locations	Governing board with physicians
	Physicians' remuneration	FFS	Contractual, salaried or sessional	Blended	Incentive payments for continuing education to enhance clinical and management practices		FFS with incentive payments for delivering "additional" services such as LTC, in-patient, attachment
	Patient enrolment	—	—	—	—	—	—
Resources	**Multidisciplinary teams**	—	Yes	Funding to support interdisciplinary teams	—	—	Some funding is supposed to support inter-professional teams
	Information technologies	—	—	Support for EMRs	—	—	—
Access	**Extended hours**	—	—	—	—	—	—
	Walk-in	—	—	—	—	—	—
Services	**Chronic diseases**	Rarely	—	Funding to support comprehensive and coordinated care and access to educational programs	—	To increase coordination and comprehensive care	
	Prevention	Rarely	—		—	—	
	Coordination	—	—		—	Share patient information and coordination Focus on seniors at risk, mental disorders and vulnerable groups	Divisions are supposed to support more coordinated services
	Continuity	—	—		—		
Vision	**Responsibility**	Individuals Rarely population	Population	Population	Population	Population	Population
Context of change		Transformations of PHC based on quality-based funding and educational programs. Primary Health Care Charter in 2007 on the vision and priorities for PHC. NPs' role extended and revised with the Health Practitioners Act and projects funded by health authorities.					
Local health authorities		Five regional health authorities under one provincial health services authority.					

Sources: Wilson et al., 2004; Watson & Wong, 2005; McKendry et al., 2006; Government of British Columbia, 2007; Cohen et al., 2009; Wong et al., 2010; Hutchison et al., 2011.

4 EMERGING AND CROSS-CUTTING THEMES RELATED TO PRIMARY HEALTH CARE REFORMS IN CANADIAN PROVINCES

Building on the development of provincial case studies presented in the previous section, a limited scoping of important emerging themes related to PHC reform was conducted with five experts participating in the synthesis forum. These five experts, one from each of the provinces studied, were questioned regarding the key elements that have played important roles in the emergence and implementation of new models and reforms of PHC, their documented effects and the main lessons to be learned from these reform initiatives. A variety of themes was summarized from these provincial experiences and was submitted for deliberation during the forum's group discussions and plenary sessions. This section presents the results of these reflections pertaining to factors supporting and hindering the reform process and the impact of reforms.

4.1 SUPPORTING AND HINDERING FACTORS IN PRIMARY HEALTH CARE REFORMS

A supportive socio-political context for Primary Health Care reforms in Canada

The policy environment has historically been neutral towards PHC and professionals generally opposed to the redesign of their practice. For a long period, PHC was left out of explicit policies aiming at re-organizing the healthcare delivery system. In addition, a conflict existed between provincial governments and professional associations that wanted to preserve the professional autonomy of their members. It is clear, however, that the current socio-political context has changed throughout the country. There is a greater openness to reforms, or even imposed changes, because of a perceived crisis PHC has undergone since the 1990s. The driving force for reform has come mainly from governments, with providers ranging from neutral to favourable. Although reforms are now accepted and seen as necessary, few cases of active lobbying from within the profession for new organizational models have been observed.

Major commissions at the provincial and federal levels have been identified as important influences in initiating a long-overdue reform process. As well, without massive federal transfers that was committed for PHC reform through the two Health Transition Funds, many initiatives or new models would not have been implemented or sustained. The federal transfers thus provided the impetus needed for the expansion of programs and models.

A strong desire for change has been observed in many provinces. Physicians, seeing their workloads increase because of the shortage of human resources relative to the increased complexity of clinical cases, are now more receptive to change. Notwithstanding this receptivity, PHC reforms are often perceived as having been possible because they were essentially based on the voluntary participation of physicians. Slow and incremental transformations are planned in many provinces, as few providers can (or want to) sustain large-scale transformations in practices. Perhaps learning from previous efforts at reforming PHC, when government and organized medicine were more in opposition, newer reforms are now based on consensus building and partnerships among stakeholders.

An emerging collaboration between governments and professional associations

A number of continuing education programs have helped support the transformation of PHC in recent years. They have contributed to changing norms and values and instituting a new climate for change and have changed attitudes among professionals. New committees, composed of physicians, and with some degree of decision-making power, have also helped change norms and values. These platforms may have helped to reduce resistance among physicians towards reforms by giving the profession a greater voice. This collaborative policy-building process was identified by participants as a major enabling factor.

As already mentioned, although resistance towards reforms has decreased in some cases, reforms have generally not been initiated from the bottom up. In most cases, the driving force behind recent reforms and initiatives has been health ministries and local or regional health authorities that have introduced enabling legislations and projects. From this perspective, professionals can be seen as important collaborators and professional associations as instrumental, rather than active agents of change. In every province, however, the presence of champions among PHC providers has been crucial and these have often acted as role models for other physicians in order to generate the necessary uptake for new models or initiatives. As illustrated in the provincial case studies, initiatives are first implemented, in some instances, in demonstration sites. In some cases, the provincial chapters of the College of Family Physicians, as well as the chairs of family medicine departments of universities across the country, have also taken an enabling and active role. Lack of support or involvement in some universities was also identified as a factor in the slow uptake of reforms. In addition, one of the main lessons learned so far from the reform process is the time required to implement changes effectively and to build consensus around them.

In many cases, the biggest change in recent years has been the increased collaboration between physicians and governments. Various platforms and committees have been created to negotiate and implement initiatives and new models, thereby ending a long period during which PHC physicians were essentially operating at the margins or in relative autonomy. In certain provinces, these platforms, which involve representatives of both physicians and government, have become powerful players. On the other hand, these collaborative committees have limited public accountability compared to initiatives led by health ministries or regional authorities and remain essentially physician-centred, excluding other health professionals. As well, the burden imposed on physicians by some of these committees and their interventions might also ultimately threaten their viability. The challenge to preserving this collaborative spirit lies in finding the necessary resources to facilitate change and implement new initiatives/models, and finding a balance that does not overburden physicians with administrative work and new responsibilities.

Few changes have been imposed on providers in recent years; incentives are now more common in many provinces. In many cases, the need to treat physicians as partners in reforms was identified as the key to success. Most reforms have been based on financial incentives. Huge sums of money have been injected to mobilize professionals in the past decade. In addition, quality-based incentive funding or increased remuneration was made available to physicians to attract them into new models, or key features of their practices were changed according to recognized guidelines. In some cases, reforms succeeded

because enough money was spent to support physicians in the process. This renewed interest in structuring PHC as part of the overall services provision system proved to be a challenge in most jurisdictions. There is a recognition that physicians, while they provide an essential service, remain private entrepreneurs. Governments have had little experience in dealing with this small-businesses market in healthcare. However, in the case of PHC as part of universal healthcare system, governments increasingly recognize the need to work with this sector. This poses challenges as most physicians, while not employees, are paid by the government. They are in this regard, different from registered nurses, pharmacists or social workers who can to a greater extent be deployed to do things the employer wants done, such as immunizations.

Developing collaborative practices in Primary Health Care

The new leadership role of physicians was raised by some participants as a factor supporting or, in some instances, possibly hindering the reform process. After being practically ignored by health reforms for many years, physicians are now expected to transform their practices, be agents of change, and to actively participate in the reform process. The role of family physicians is undergoing profound changes, from being centred on a patient-provider relationship to very often playing a leadership role in a multidisciplinary team and acting as a care coordinator. Without the appropriate training, this change can lead to a reduction in the impact of reforms.

This is happening at a time when the work culture among younger practitioners is very different compared to their older counterparts. Reforms have to take into account that young physicians value more quality of life and often work fewer hours. Their training may not be appropriate to the roles they are being asked to assume; education will also need to be transformed, to teach professionals to work together and prepare physicians for the leadership roles governments want them to adopt.

For the most part, legislation has consisted of various acts regulating the expanded role of other health professionals, particularly registered nurses and NPs, and has supported their introduction into PHC. This legislation has supported the development of interdisciplinary teams and collaborative practices, Legislation such as the *Health Professions Act* in British Columbia and the *Registered Nurses Act* in Nova Scotia and the establishment of collective prescriptions and the redefinition of the professional code in Québec were identified as major factors benefiting the reform process. In some cases, collaboration between nurses' unions and physicians' unions has made this legislation possible. Issues of remuneration and education, however, have hindered the implementation of interdisciplinary teams and collaborative practices.

Even though there have been some noticeable gains in collaborative practice and the implementation of interdisciplinary teams in the past few years, participants agreed that governments and practitioners are still just figuring out how to make it work. Furthermore, as stated earlier, education has to be transformed to support collaborative practices from the beginning of professional training.

A dual influence of funding mechanisms on the implementation of reforms

As stated above, the two Health Transition Funds gave a kick-start to many of the first reforms of PHC across the country and enabled many initiatives to start. Ontario's far-reaching reforms also resulted in financial incentives for physicians that increased their remuneration as well as for changes, such as the implementation of EMRs in reform models. These changes have to be maintained; participants questioned whether governments will have the capacity to sustain this process in the future, especially in a climate of financial restraint. Participants expressed concern about sustainability for increased funding in the future. In addition, participants noted that increased funding should not be about taking money from one place to put it in another. New money for PHC will be needed to allow changes to go beyond the introduction of reform models or new quality-based initiatives.

Participants also identified remuneration as an everlasting problem. Increased funding and physician remuneration can be both a supporting and hindering factor. Increased remuneration and financial incentives were necessary for physicians to buy into the reform process and have been successful in transforming practices and engaging physicians in the process. The cases of Ontario and, to some extent, British Columbia demonstrate the role they can play.

Remuneration can also, however, hinder PHC reforms. While increased remuneration can attract physicians into alternative remunerative methods, as in Ontario, physicians often resist changes to remuneration, in particular capitation, because of the potential for loss of income. Participants pointed out however, that FFS remuneration is often incompatible with the development of multidisciplinary teams in PHC. There are many examples of NPs having difficulty finding work in PHC practices or working the full spectrum of their practice because physicians might lose income if some tasks are delegated to them. There are also questions about who is responsible for paying the salaries of registered nurses and other allied health professionals, as governments promote their introduction without funding their salaries, for which practices do not want to be responsible for. It is essential that some of the new funding be directed towards other professionals in order to integrate them in the PHC system. The funding sustainability question also applies to the current remuneration methods, as some are concerned about the ability to continue to pay more for PHC service delivery. This concern is particularly acute given the need to provide incentives to registered nurses and allied health professionals as well as to physicians.

Participants also raised the issue of physicians working in solo or small-group practices, who do not receive support for moving into new organizational models of care or for transforming the way care is delivered in their practices, and thus who are being left out of the reform process.

Participants were also concerned that governments have put themselves in a difficult position by making economic incentives the main or, often, the only mechanism for change, stating that effort should also be directed into rewarding excellence and enabling innovators. For others, funding and remuneration are two components of PHC that government can aim to modify. Moreover, the issues related to remuneration can no longer be centred on physicians

alone as interdisciplinary PHC is one of the core reform elements currently being promoted either as a principle or as a prescription with new organizational models of care.

A role for information technology

Forum participants deplored that Canada is so far behind other countries in implementing information technologies and EMRs in PHC, even if advances are well underway in many regions, calling the problem a hindering factor to system integration in PHC. They also stated that EMRs would improve efforts towards continuity and coordination of care offered by PHC providers, as well as improve chronic disease management. Implementing information technologies has been identified in international surveys as an important characteristic of high-performing PHC systems and is also a necessary part of new organizational models focused on improving chronic disease management.

Harnessing community support

For a long time, Canada was recognized for the quality of its healthcare, but it has now lost this status. The population is starting to recognize the problems and realize how difficult it is to find a family doctor and navigate the system.

Forum participants suggested that little attention so far has been given to the public's voice. For many participants, there has been a failure to "sell" PHC reforms to the public and to highlight progress in transforming it. Community engagement in the reform process and the implementation of new models of care was identified as a critical factor, at the same time as the emergence of community ownership of some of these new models, such as the cooperative models. For some participants, communities clearly have to be involved in the decision-making process.

Other participants noted that PHC should be better defined. There are often disagreements about the definition of PHC; if decision-makers and researchers cannot agree on a definition, they said, how can it be communicated to the public? A definition is necessary to inform the public as to what has been done so far and what needs to be done to transform PHC. Governments have to ensure better communication with the public about progress and consider the pressure that public opinion can put on the system. An uninformed public can lead to unrealistic public expectations, which, coupled with the power of the media, could push governments to take reforms in the wrong direction.

Still others believed that PHC is complex, with many interrelated elements affecting a patient's experience. It is suggested that it would not be necessary to define PHC formally. They claim the public does not want to be informed of the details of PHC; rather the public's main concern is about having access to a physician and services with relational continuity of providers.

Integrating Primary Health Care in the wider health system

During the forum, participants emphasized the importance of integrating PHC into the larger healthcare system. The healthcare system in Canadian provinces is fragmented, with PHC in particular functioning almost in parallel to the rest of the system. As stated earlier, private clinics have been left out of reforms for many years. This fragmentation in the system affects

the capacity of family physicians to ensure continuity of care and establish links with other lines of service; it also makes collaboration among PHC clinics difficult and integration between levels of care almost nonexistent. Practices have to be linked to the rest of the system with greater collaboration, not left out, as was the case in Ontario. There is a need not only to emphasize modernizing and upgrading existing practices, but also to create systems of PHC that can be integrated and harmonized with the rest of the system. Investments are being made to upgrade existing practices, but there is a lack of investment in a system of PHC and the integration of PHC to the rest of the system.

In some provinces, such as Québec and British Columbia, structures to integrate the system have been established in the last decade. For participants, it then becomes a matter of how well the system functions. Overall, participants emphasized that governments have to be careful not to make system integration simply administrative and should aim to make every part of the system actually work together harmoniously.

Principles versus prescriptions: Governments' choice of strategies

Provinces have, so far, selected two different routes for reforms, principle-based or prescriptive. In some cases, quality-based incentive programs based on identifying certain guiding principles were set in place to encourage physicians to transform their practices. In other instances, new models of delivery were implemented, either at the provincial level or sometimes in a few demonstration sites for evaluation purposes, based on prescriptive policies. Not all provinces have opted for the same policy levers. Participants debated the merits of these two approaches, in particular as they related to the need for flexibility to adapt to local circumstances.

Many provinces have opted for quality-based incentive funding and pay-for-performance instead of large-scale redesign. Other provinces are more advanced in redesigning PHC through the introduction of new models. In many cases, the need to approach reforms in a slow and incremental fashion was chosen in order to mobilize providers and gain their support. Enthusiasm for new organizational models is present if funding is made available to support providers in transforming their practice. PHC reforms are made on a voluntary basis but often they succeed only with significant incentives. In some cases, governments have started to establish frameworks and visions for PHC reforms. This is the case for the British Colombia's Primary Care Charter and Manitoba's Primary Health Care Policy Framework. Perhaps many provinces needed to first create the necessary environment for PHC reforms before implementing the system-wide efforts required to succeed. In provinces where PHC reforms are based on incentives, there is the question of whether saturation will be attained soon and what subsequent policy levers, prescriptive or model-based approaches to reforms will be employed. One element that was discussed by different groups is the necessity for a regulatory framework to ensure the success of reforms, although they also acknowledged that this is not sufficient to guarantee success. Participants also raised the issue of adaptability to context and the necessity for regulatory frameworks not to stifle local initiatives, since it is obvious that local circumstances are an influential factor in the impact of reforms. Across Canada, conditions such as minority or majority governments, budget restrictions or wealth affect how reforms are carried out. For example, it was suggested that, unlike other provinces, the financial resources of Ontario and Alberta provide them with the

means for more extensive support of the transformation of PHC practices and enable them to offer important professional incentives. Other provinces, for example the Maritime Provinces, which do not have the same financial resources, are more constrained by fiscal resources.

4.2 THE IMPACT OF PRIMARY HEALTH CARE REFORMS

A lack of published evaluations

Overall, across the country only a limited number of evaluations of PHC reforms or new organizational models have been made available publicly. In some cases, the challenges of privacy and confidentiality are obstacles impeding the availability of necessary data. Major barriers exist in producing empirical evidence that would better inform decisions. Given the timeline of PHC reforms in Canada, existing evaluations have mainly focused on the implementation phase and the care experience of the population in new models, rather than the outcomes of reforms. Finally, the few initiatives conducted by local government bodies have often lacked the necessary structure or financial resources to conduct evaluation studies.

Forum participants underscored the urgent need to conduct more evaluations and create better indicators to evaluate PHC, particularly given concerns that some reforms may have created inequities and gaps in access. In the short term, reforms do not appear to have improved accessibility, especially for youth and vulnerable populations, while few evaluations have provided evidence of noticeable reductions in emergency service utilization. There is a need to evaluate the impacts of these possible inequities and the outcomes of reforms to track the benefits of recent investments in reforming PHC. However, measuring the impact of PHC reform should be approached cautiously. It is not always the explicit policies that will transform the system and impact on population outcomes. A better understanding of the contexts into which PHC reform is occurring should also be the focus of the evaluation.

This review and the consultation process that was held suggest that reforms are often more about politics than evidence-based decision-making. Many past decisions are perceived as having followed the media headlines or as having been carried out only when PHC was in dire need. Research to guide reforms has not been conducted in every province. Furthermore, not all models introduced in recent years were accompanied by an evaluation component. Often there is heavy reliance on single studies to inform the process and few follow-up studies have been scheduled. More evaluation of reforms is warranted to increase transparency and inform decision-makers. Participants also emphasized that evaluation should be better integrated in the reform process.

Participants had extensive discussions about the need to improve indicators to better evaluate PHC, its processes and quality. Work has been undertaken by different agencies and research organizations to develop these indicators. However, many have come to the realization that little data is currently available to build PHC indicators that could be agreed upon and used across the country. EMRs should be used to obtain more data to evaluate PHC and could fill some of this data gap. The rest of the data gap could be filled by improved provider and population surveys.

Participants also raised the issue of confidentiality and its impact on the ability to gain access to administrative data. Participants perceived a desire to over-protect information coming from the public, with resulting difficulties in using administrative data for research and evaluation purposes. They also underscored how the public is often shocked to learn that most of this information is not used to improve healthcare. National polls have recently confirmed this.

Access, continuity of care, chronic care, interdisciplinarity and workforce satisfaction

To different degrees and in different contexts, participants observed some short-term positive impacts of reforms. Some early studies and evaluations are starting to be made available regarding the care experience of populations in various emerging models for PHC. Evaluations have suggested that the introduction of registered nurses and interdisciplinary teams is associated with better care and outcomes for patients. Practices are being strengthened and openness to collaborative practices is being observed. Physicians and other health professionals in PHC are starting to work the full spectrum of clinical practice. A change in the culture of quality improvement is also being observed, along with a willingness to participate in new training and an appetite for changing practices. Some participants also see improvements in the management of chronic diseases. The introduction of EMRs has been suggested as a factor that is improving the delivery of services, and a redesign of some practices has been associated with improved hours of access and greater access to therapeutic and diagnostic services. The most important impact of recent reforms, however, seems to have been the revitalization of the workforce and the mobilization of professionals. This is perceived as a major improvement as, for a long time, PHC providers have been operating at the margins with no direct influence on governmental policies. Recent reforms have served mainly to interrupt this state and perhaps create the necessary environment for a large-scale redesign. Furthermore, some participants also stated that some patients and the public are starting to see changes in PHC when they access it.

Lessons from international experiences

After this process of research, consultation with experts, debates and open discussions with researchers and those directly involved in the reform process, it is clear that strategies to reform PHC vary not just across Canada, but also at the international level.

The experience of the Commonwealth Fund in monitoring the performance of PHC across Canada, the US, the UK, Holland, France, Sweden, Germany, Australia and New Zealand was discussed during the forum. Countries labelled as having performing PHC systems, most notably, Holland, the UK and New Zealand, share some characteristics. For example, patients in these countries are most likely to report being able to obtain a same-day appointment or easily-coordinated care with specialists, while providers are most likely to use EMRs, have lists of patients for preventive care and functioning multidisciplinary teams. Those stronger in PHC share other common features as well: patient rosters; PHC doctors acting as gatekeepers for referrals; blended remuneration, with capitation, FFS and incentives all playing a role; nurses heavily engaged in patient care; and national policies requiring some PHC practices such as after-hour care or functioning EMRs. Countries chose (or naturally went through) different strategies to reform PHC, whether top-down (as in the UK) or bottom-up (as in Holland), but the result is the same: better performing PHC.

Patients in these high-performing PHC systems report characteristics related to the notion of a medical “home,” a concept increasingly being put forward by governments and medical associations across industrialized nations. These characteristics are not new; nonetheless, they represent a challenge for every country, even countries such as Holland and the UK. For Canada and the US, participants noted the need to continue work that has been done to enable doctors to transform their practices and do what is asked from them.

5 CONCLUSIONS

The environment of reform has really changed dramatically over the last decade. Structures put in place to promote collaboration between physicians and policy-makers have contributed to changes in this environment. Across the country, agents of change for PHC reforms vary between governments, professionals and academia. This synthesis on the impact of PHC organizational models and contexts was completed through a two-stage consultation process. Five case studies and reading materials were developed prior to holding a consultation forum. A description of reforms that had been completed or that were currently underway in Nova Scotia, Québec, Ontario, Manitoba and British Columbia were generated from a review of existing grey and published literature evaluating PHC organization. These provinces were selected on the basis of the existence of published evaluations related to PHC reforms. The preparation of the case studies also involved consultations with selected experts from each province to adjust the case studies, generate hypotheses with regard to potential barriers and facilitators of reform and document the impacts of emerging models of PHC. This preparatory reading material, consisting of the case studies and some of the synthesis themes, was sent to all participants prior to the forum. The knowledge synthesis and exchange forum on the impact of PHC organizational models and contexts took place on November 3, 2010, at the Public Health Department, Montréal.

This synthesis of reforms in the organisation of PHC in five Canadian provinces provides many insights into the impact of the recent provincial reforms. This synthesis has highlighted the dual influences of funding and remuneration were both too little, by not providing sufficient fund to implement various components, and too generous, by providing a level of support that cannot be sustained once the reform effort have subsided. These two opposite factors have been identified as factors hindering the implementation of reform. However, the importance of an appropriate funding of primary health care cannot be forgotten. In addition, the role of legislative policies has been highlighted in this synthesis, particularly with regard to redefining the role of other health professionals, such as registered nurses and nurse practitioners, and their impacts on the implementation of multidisciplinary teams. However, system integration of PHC practices remains limited with PHC still remaining at the margin of the healthcare system and collaboration between practices and the coordination of care with other services remain a challenge. In line with many recent surveys, our synthesis highlighted how Canada still lags behind other countries in the implementation of electronic medical records (EMRs) and information technology (IT) in PHC practices. Another aspect which positions Canadian provinces behind the current levels shown in other contexts is the public and communities' engagement in the reform process. An important finding of this synthesis is the realisation that provincial contexts matter for the success of PHC reform endeavours. While similar principles of PHC reform exist across Canada, the strategies employed to transform PHC are different. Some provinces have adopted a model-driven approach to organizational change, many have opted for a quality and incentive-based approach to influence practices.

This synthesis also shows that not enough evaluations of the impact of PHC reforms are currently available. Most evaluations of PHC reforms have focused on implementation and attention should be paid to better measure outcomes. However, the available evaluations

have suggested some positive impact from PHC reorganization in terms of patients' experience of care and the work environment. This is cause for enthusiasm for the continuation of PHC reform across the country.

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APPENDICE

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Forum schedule

Wednesday November 3rd, 2010

8 h – 8 h 30 **Registration and welcome**

Dominique Grimard, Audrey Couture – Participants are required to register at the entrance of the building. They will then be welcomed at the entrance of the auditorium. Programs and headsets will be distributed and teams will be assigned.

8 h 30 – 9 h **Opening address**

Jean-Frédéric Levesque – Opening address and current scenario of primary care reforms and contexts in Canada.

9 h – 10 h 45 **Presentations**

Frederick Burge	Primary care reforms in **Nova Scotia**
Jeannie Haggerty	Primary care reforms in **Québec**
William Hogg	Primary care reforms in **Ontario**
Alan Katz	Primary care reforms in **Manitoba**
Sabrina Wong	Primary care reforms in **British Columbia**

Moderator: Jean-Frédéric Levesque – Each speaker will have 15 minutes to expose the context of primary care reforms in his/her province. Each presentation will serve to expose what are the main lessons to retain from the province's experience in reforming primary care and what are the questions open for debate. Each presentation will be followed by a 5 minute question period. These presentations are based on the pre-conference reading materials and case studies.

10 h 45 – 11 h **Coffee break**

11 h – 12 h **Group Discussions**

Moderator: Jean-Frédéric Levesque – Discussions in small groups around the factors associated with reforms and impacts of new organizational models of primary care in Canada. The questions guiding the discussions and group assignation are listed on page 49. A participant in each group is assigned to take notes on the exchanges.

12 h – 13 h **Lunch**

13 h – 14 h 45 **Plenary Discussions**

Denis A. Roy – Plenary discussion on the main findings and open questions about the factors associated with reforms and the impacts of new models of primary care. A participant in each group is assigned to take notes and report on the exchanges. This will be followed by a collective debate to react to the morning's presentation and the group discussions.

14 h 45 – 15 h **Coffee break**

15 h 15 – 16 h 30 **Panel**

Panellists: R. Osborn, Susan Law, Yolaine Galarneau (Qc), **Jan Kasperski** (Ont.)

Moderator: Pierre Tousignant – This panel will put the main findings in an international and national context; as well as present the perspective of those directly engaged with the reform process in Québec and Ontario. Each panellist will have 5 minutes to summarize his views. An open question and exchange period with the audience will follow.

16 h 30 – 17 h **Synthesis**

Raynald Pineault

Question grid

Section 2: Primary care in ____ / Complementary information

1. Do you agree with this statement on primary care in your province? Are there important elements, models or innovations that were not addressed here?

2. Are there other studies and evaluations that have investigated primary care in your province that are not provided with this statement?

3. In your opinion, what are the main research and studies on primary care in your province?

4. In your opinion, what are the main challenges that your province faces in transforming primary care?

Section 3: Factors associated with changes in primary care

1. What are the main studies that have looked at the main factors responsible for the transformation of primary care in your province?

2. What are the main elements that can describe the current socio-political context of primary care reforms in your province? Is the environment of reforms favourable or pessimist?

3. What are factors that have contributed the most to the transformation of primary care delivery in your province? Or inversely, have these factors prevented or impeded transformations?

    a. Have there been any laws, regulations or policies at the provincial or federal levels that have contributed to transform primary care in your province?
    b. Are norms and values at the government or professional level been influencing the transformation of primary care in your province? Have professional associations been receptive to changes and have they actively participated in implementing them? Are there any education or continuing education programs that have contributed to change attitudes and shape norms in favour of primary care transformations and performance?
    c. Have there been any organizations or specific primary care providers that have served as role models in your province? Any organizations or primary care providers that have been playing a leadership role in primary care transformations?

4. Were there any other factors than the ones listed previously that have contributed to or impeded changes in the delivery of primary care in your province?

5. Overall, which of these factors was the most decisive; either positively or negatively? Which factors have been the most favourable? Or inversely, which factors have generated opposition from key stakeholders?

6. Overall, would you say that primary care providers in your province receptive to these transformations? Or inversely, are change resisted by primary care providers?

7. Overall, given what you have said previously, which factors have contributed the most to mobilize health professionals and physicians?

8. Given what you said previously, how would you describe the way changes and innovations were implemented in your province? Were changes voluntary and negotiated or were they rather imposed?

9. In your opinion, why explain your government's choice of strategy in transforming primary care in your province? What explain the choice between implanting new organizational models and implementing changes through quality and performance programs?

Section 4: Impact of changes in primary care

1. What are the main studies that have evaluated the impact of new organizational models and innovations on the health of the population and the delivery of services?

2. Describe the main impact of new organizational models or innovations on the *health of the population*? The impact on the control of various morbidities, on behaviours or unmet health needs?

3. Describe the main impact of new organizational models or innovations on the delivery of primary care?

    a. What were the main effects on the *accessibility* of primary care services? On geographic accessibility? Extended opening hours? Availability of physicians and registration with a family physician? Extended range of services available?
    b. What were the main effects on the *comprehensiveness* of primary care services? Availability of mental health or social work professionals and services? Availability of both clinical and preventive services? Coordination of services with specialists or allied health professionals?
    c. What were the main effects on the *continuity* of primary care services? Harmonization of services offered? Sharing patient's information? Sequence of services delivered? Contact of patients with professionals?
    d. What were the main effects on the *responsiveness* of primary care services? On patient's respect? Confidentiality? Information access? Autonomy? Infrastructures quality? Choice of providers? Access to social services? Emergencies? Waiting times moderate?

4. Were there any other important impacts that are worth mentioning here?

5. Overall, what was the most outstanding impact of these new models or innovations?

Section 5: Conclusion

1. Describe what are the main conclusions that can be drawn from your province's experience in primary care reforms?

2. What are the main lessons to be learned from you province's experience? What lessons could be generalized to other contexts?

3. What are the limits of current studies and evaluations of primary care organizational models and innovations? If applicable, what explain the lack of information and data available on the experience of primary care reforms and their impact in your province?

4. In you opinion are the strength and limits of the evidence existing on primary care, factors associated with changes and their impact? What are the limits and validity of the studies you have provided? If applicable, what are the limits and validity of study designs employed and samples generated.

In your opinion, what is the soundness of evidence-based decision making on primary care reforms in you province?

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