

Rapid Review 2

# Primary Care Reforms in Ontario, Manitoba, Alberta, and the Northwest Territories

A Rapid Review Prepared for the Canadian  
Foundation for Healthcare Improvement

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# Table of Contents

Introduction .....	1
Methods .....	1
Findings .....	2
Ontario .....	2
Manitoba .....	3
Alberta .....	3
Northwest Territories .....	4
Access .....	5
Connectedness .....	7
Accountability .....	9
Conclusion .....	12
References .....	13



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# Introduction

In response to the national objectives set out in federal-provincial-territorial health accords in 2000, 2003 and 2004, Canadian jurisdictions began to develop a variety of new approaches to primary care (Hutchison, Levesque, Strumph, & Coyle, 2011; Lazar, Lavis, Forest, & Church, 2013). In particular, provincial and territorial governments used various means to encourage a shift from the traditional solo practice (or small physician group practices) to interprofessional primary care practices, aimed at supporting a broader range of treatment, prevention, and health promotion activities (Hutchison & Glazier, 2013; Marchildon & Hutchison, 2016).

However, changes to primary care over the past 15 years have been slow, highly incremental and therefore more difficult to track. In addition, reforms have varied by jurisdiction, which is often described as a product of a decentralized federation where primary care policy is largely within the constitutional jurisdiction of provincial and territorial governments (Marchildon & Bossert, 2018). As such, the extent and depth of primary care reform efforts differ widely across Canada (Marchildon & Hutchison, 2016). Despite these variations, reform goals to improve access, broaden the scope of practice, and strengthen connections between specialist and social care services have been identified across the country. Specifically, jurisdictions have attempted to promote the following: improve care coordination, develop quality improvement strategies, and offer team-based care. However, despite these efforts, the pace and depth of these reforms vary significantly across jurisdictions.

A previous rapid review of all 13 provincial/territorial jurisdictions in Canada identified Ontario, Manitoba, Alberta, and the Northwest Territories as being the most innovative in pursuing primary care reform over the last decade (Peckham, Ho, & Marchildon, 2018). The purpose of the present rapid review was to explore these jurisdictions in greater depth in order to support the decision-makers' roundtable hosted by the Canadian Foundation for Healthcare Improvement (CFHI) on April 27, 2018. This review relies on available public indicators to determine how jurisdictions have improved access to after-hours care; worked to offer a broader scope of services through access to interdisciplinary teams; and improved communication and coordination through information technology and electronic medical records (EMRs) accessible to health and social service providers as well as patients and caregivers.

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# Methods

The North American Observatory on Health Systems and Policies (NAO) collaborated with academic partners to complete this rapid review. With the assistance of NAO academic network members who reside in each profiled jurisdiction, we examined in greater detail the system priorities that spearheaded changes in primary care, including improvements in access to, and coordination of, care across both specialist and social services. We also identified other critical factors present in these jurisdictions that either facilitate or challenge progress towards primary care reform. This review was based on the available public data, supplemented by key informants and experts in the field to fill in informational gaps.

This review was completed by an independent NAO academic expert in each jurisdiction, and relies on that individual's knowledge, interpretation of online resources and other key documents, and where necessary (and possible in the short time allotted) brief interviews from key informants.

Below we have broken the analysis into three domains as reviewed and approved by CFHI:

1. **Access:** What each jurisdiction is doing to improve timely access to primary (including after-hours care) and specialist care [Note: This section includes Nova Scotia which was also conducting a review for the purposes of the CFHI roundtable];
2. **Connectedness:** The extent to which primary care includes access to interdisciplinary teams, their links and communication with other health and social care resources, and whether patients and caregivers were privy to these types of communication; and
3. **Accountability:** Organizational and institutional structures and mechanisms facilitating appropriate accountabilities and responsibilities between primary care providers and their patients and system stewards, managers and funders.

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## Findings

For a more detailed overview of the following four selected jurisdictions and all other Canadian jurisdictions please refer to Peckham et al. (2018).

### Ontario

Ontario has a population of approximately 13.7 million people and 40 percent of the country's population. Total annual health expenditure per person in Ontario is \$6,109, just below the national average of \$6,291 (Canadian Institute for Health Information, 2017). Total health expenditure as a percentage of Ontario's GDP was 11 percent in 2015, just below the national average of 11.4 percent.

Since 2002, the provincial government has introduced several new physician compensation models (Family Health Networks, Family Health Groups, Comprehensive Care Models, and Family Health Organizations) and an interprofessional team model (Family Health Teams) that involved changing the predominant mode of fee-for-service (FFS) physician payment to blended versions of capitation, premiums, incentives, and FFS. Participation in these newly developed models was voluntary for patients and providers, and therefore did not require universal adoption.

The reform efforts have focused largely on changing payment incentives and encouraging interprofessional team-based care. These efforts have been hampered by a lack of alignment between governance and accountability structures. The Ontario government recently implemented the *Patients First Act*, which expanded the role of the province's Local Health Integration Networks (LHINs). These authorities are now responsible for the oversight of two types of primary care practices, Family Health Teams (FHTs) and Nurse Practitioner-Led Clinics (LHINs were already responsible for Community Health Centres – CHCs – which have been delivering team-based care to marginalized and uninsured populations since the 1970s). These two types of practices have slightly less than 3.5 million enrolled patients (out of a total patient population of slightly more than 13.7 million) with only 21 percent of family physicians practising in FHTs and CHCs (Marchildon & Hutchison, 2016; Rauscher, 2015). Therefore, this law does not impact the majority of primary care practitioners who practice outside these FHTs and the salary-based CHCs. In addition, in recent years, due to cost, the government has restricted physician entry into capitation-based practices (FHTs, Family Health Organizations, and Family Health Networks).

## Manitoba

Manitoba has a population of 1.2 million and 3.6 percent of the country's population. Per capita health expenditure in Manitoba is \$6,954 per person, above Ontario and the national average (Canadian Institute for Health Information, 2017). In 2015, Manitoba's total health expenditure was 13.7 percent of its GDP.

Primary care renewal began in the early 2000s, when efforts focused largely on the creation of publicly operated clinics with non-FFS physicians and interprofessional teams. The first *provincial* effort targeting FFS physicians was the Physician Integrated Network (PIN, 2006-12). This demonstration project encouraged FFS clinics to develop their own initiatives to promote access, quality, information use, and work-life balance. Clinics also received quality-based incentive funding. About 13% of FFS physicians participated, however, significant improvements in patient access and quality of care were not observed (Katz et al., 2014; Prairie Research Associates, 2012).

In 2011, Premier Greg Selinger promised that every Manitoban would be able to have a family doctor by 2015, creating an opportunity to make primary care reform a system priority. The political promise of a "doc for all" also turned the focus on *attachment to a provider* (leaving other outcomes, such as wait times for appointments, to later years), and to prioritize initiatives expected to deliver immediate improvements. As part of the 2011-15 strategy, policymakers introduced multiple linked initiatives – notably My Health Teams (a Primary Care Network model that involved formal partnership between FFS clinics and regional health authorities), a demonstration project that introduced interprofessional providers into 45 FFS clinics, and Family Doctor Finder (a service for connecting unattached patients to a primary care provider) (see Kreindler et al., *Why is 'soft integration' so hard?*, forthcoming, for a full description of initiatives). In 2016, the province launched Home Clinics, which requires patients to voluntarily enrol. Overall, efforts reflected two broad policy goals: (1) to expand the engagement of FFS physicians beyond the minority of early adopters, and (2) to move towards an "integrated primary care system" in which all clinics – whether led by FFS or alternatively funded providers – would provide a similar level of high-quality, accessible, and well-coordinated primary care (Kreindler et al., Forthcoming).

It is estimated that 24% of Manitobans are covered by a My Health Team, and 52% are enrolled in a Home Clinic. Thus far, 91,000 patients have been attached to a provider through Family Doctor Finder and 51,000 through My Health Teams and the Interprofessional Team Demonstration Initiative (including an unknown number of patients also counted in the figure for Family Doctor Finder). Plans are currently underway to assess outcomes other than attachment.

## Alberta

Alberta has a population of 4 million and 11.6 percent of the country's population. Alberta's per capita health expenditure was at a rate of \$7,057, above Manitoba, Ontario and the national average (Canadian Institute for Health Information, 2017). Total health expenditure as a percentage of Alberta's GDP was 9 percent in 2015, the lowest in the country.

Alberta has been attempting to reform primary care since the mid-1990s. Initially reform efforts focused on remuneration but since the early 2000s have broadened to include recruitment and retention, interprofessional care teams, and the use of electronic medical records. In 2003 Alberta Health, the Alberta Medical Association and the previous nine health regions established the Primary Care Initiative

to develop Primary Care Networks (PCNs) (Health Quality Council of Alberta, 2014a). The first PCN opened in 2005 and they are now the main model for primary care in Alberta (with 80 percent of primary care physicians registered), with the goal being to establish governance roles, structures, and processes and improve access and quality of care (Alberta Health, 2016b). Physicians are paid through FFS or capitation and PCN physicians are provided with additional funding incentives for after-hours coverage (Alberta Health, 2016a; Rauscher, 2015). While the original intent of these models was to improve access and team-based care, several reviews found that there was variability in service providers across the PCNs, inconsistency in accountability, poor team-based care, inadequate information infrastructure, and a lack of coordination with other sectors of care. In addition, current physician and PCN funding models remain a key challenge because neither is appropriate for care of patients with complex needs (Alberta Health, 2016b; Auditor General of Alberta, 2017; Government of Alberta, 2013; Health Quality Council of Alberta, 2013, 2014a).

In response to the challenges identified through these recent reviews, Alberta has launched a number of initiatives. These initiatives include the following: a new blended capitation funding pilot; a new governance structure for PCNs that aims to improve the integration of PCN services, Alberta Health Services (AHS) programs, and community-based services; Alberta Netcare (provincial EHR) for e-referral and specialist advice for non-urgent care; and AHS Connect Care (about to be launched), a single AHS clinical information system (CIS) that is based on Epic and includes a physician portal with e-referral and secure messaging capabilities. These IT solutions are part of a larger Community Information Integration initiative that is working to connect community EMRs with Alberta Netcare and Connect Care. In Calgary, a current CFHI initiative entitled Specialist Link is facilitating collaboration among 14 specialty groups and primary care providers. Patients currently have access to MyHealth Alberta, a website that provides health information and facilitates access to some health services.

## Northwest Territories

The Northwest Territories (NT) has a population of 41,462 and is the most populated of the three territories. The NT's per capita health expenditure of \$14,660 is the second highest in the country, behind only Nunavut (Canadian Institute for Health Information, 2017). Health expenditure as a percentage of NT's GDP was 13.4 in 2015.

The geography of the territory requires its government take a unique approach to meeting the health and social care needs of its population, one divided between Yellowknife (where half of NT's population lives) and the remote communities spread throughout the rest of the territory. In 2012, two clinics in Yellowknife consolidated into a single centre, the Yellowknife Primary Health Care Clinic. In Yellowknife, team-based primary care clinics include physicians, nurse practitioners (NPs), and licensed practical nurses (LPNs) who work together with other health professionals, including clinic administrators, to coordinate patient care. This is facilitated through a territorial-wide single patient-centric digital charting system shared by all health and allied health professionals (Yellowknife Health and Social Services Authority, n.d.). In rural and remote locations, geography tends to be the proxy for rostering (no options to seek care elsewhere). In communities outside Yellowknife, NPs/community health nurses work closely with community health representatives and a team of visiting specialists to provide care that extends beyond traditional medical approaches (e.g. Fort Resolution Community Health Centre Services).



In 2001, with one exception, all physicians went from FFS to a salary remuneration model and became employees of eight health authorities. In 2016, physicians became employees of a single authority, the Northwest Territories Health and Social Services Authority, which replaced the eight independent health and social services authorities. The amalgamation was prompted, in part, by the government's desire to remove "systemic barriers to innovation" and improve patient care (Northwest Territories Health and Social Services Authority, n.d.).

## Access

Using available comparative data, jurisdictions were assessed to determine if patients had timely access to primary and specialist care. Timely access was identified by patients to be an important element of primary care (Wong, Watson, Young, & Regan, 2008), and can reduce the use of unnecessary emergency department visits and improve continuity of care (Institute for Healthcare Improvement, 2012).

Based on the Commonwealth Fund's International Health Policy Survey's access indicators, Alberta scores better than Ontario and Manitoba (there was no comparable data for the Northwest Territories – see Table 1). In Alberta, when those with a regular doctor were asked how easy it was to actually obtain services from their doctor, 45 percent said "very easy" (Health Quality Council of Alberta, 2014b). Manitoba does better in terms of the "percentage of people who went to the emergency department for a condition that could have been treated by their regular doctor," while Ontario does better on the "percentage of the population who report having a regular primary health care provider." This is an interesting result given that Ontario has fewer practicing general practitioners (GPs) (109 practicing GPs per 100,000 population) than Nova Scotia (138) or Alberta (124).

When it comes to accessing specialist care, Ontario scores better than Manitoba and Alberta except for hip fracture repairs where Manitoba had a lower wait time. Ontario also reported the shortest wait time (6.7 weeks) to be referred by a GP to a specialist.

*Table 1 Access by Jurisdiction*

Indicator	Ontario	Manitoba	Alberta	Nova Scotia	Northwest Territories	Canadian Average
Percentage of people who needed medical attention and were able to get a same-day or next-day appointment to see a doctor or a nurse <sup>1</sup>	41.4%	44.3%	46.3%	32.2%	No data (only 6 interviewed across the 3 territories)	39.2%
Percentage of people who went to the emergency department (ED) for a condition that could have been treated by their regular doctor <sup>1</sup>	44.2%	39.7%	30.1%	48.1%	No data	41.1%
Older Canadians (55+) who went to the ED for a condition that could have been treated by their regular doctor <sup>2</sup>	39%	34%	39%	37%	No data	37%
Percentage of population who report having a regular primary health care provider (medical doctor) <sup>3</sup>	92.5%	83.9%	80.1%	89.4%	42.3%	85.1%
Percentage of people who report having a difficult time accessing medical care in the evenings or weekends <sup>1</sup>	49.5%	55%	49%	62.1%	No data	55.3%
Percentage of older Canadians (55+) who have a difficult time accessing medical care after hours <sup>2</sup>	47%	55%	45%	59%	No data	51%
Wait time to see a specialist – following a referral from a GP <sup>4</sup>	6.7 weeks	8.6 weeks	12.0 weeks	21.6 weeks	No data	10.2 weeks <sup>4</sup>
Number of practising primary health care providers per 100,000 population (2016) <sup>5 6</sup>	Physician (GP): 109 Nurse (NP): 19 Nurse (RN): 647	Physician (GP): 107 Nurse (NP): 11 Nurse (RN): 770	Physician (GP): 124 Nurse (NP): 9 Nurse (RN): 744	Physician (GP): 138 Nurse (NP): 14 Nurse (RN): 884	Nurse (NP): 48 <sup>7</sup>	Physician (GP): 116 Nurse (NP): 12 Nurse (RN): 707

<sup>1</sup> Commonwealth Fund’s International Health Policy Survey of Adults 2016 Data Table <https://www.cihi.ca/en/commonwealth-fund-survey-2016>

<sup>2</sup> Canadian Institute for Health Information (2015). How Canada Compares: Results from the Commonwealth Fund 2014. <https://www.cihi.ca/web/resou>

<sup>3</sup> CIHI (2014) [https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/001/have-a-regular-doctor;/mapC1;mapLevel2;overview;trend\(C20018,C600,C5001\);/](https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/001/have-a-regular-doctor;/mapC1;mapLevel2;overview;trend(C20018,C600,C5001);/)

<sup>4</sup> Fraser Institute using survey data from physicians <https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2017.pdf>

<sup>5</sup> CIHI (Regulated Nurses, 2016: [https://www.cihi.ca/en/access-data-reports/results?f%5B0%5D=field\\_primary\\_theme%3A2047&f%5B1%5D=field\\_professions%3A2010](https://www.cihi.ca/en/access-data-reports/results?f%5B0%5D=field_primary_theme%3A2047&f%5B1%5D=field_professions%3A2010))

<sup>6</sup> CIHI (Scott’s Medical Database) for 2016 ([https://secure.cihi.ca/free\\_products/Physicians\\_in\\_Canada\\_2016.pdf](https://secure.cihi.ca/free_products/Physicians_in_Canada_2016.pdf))

<sup>7</sup> Canadian Nurses Association (2016) *The Canadian Nurse Practitioner Initiative: A 10-year retrospective*. Ottawa: Canadian Nurses Association.

## Connectedness

Connectedness speaks to how well patients, carers, and primary care practitioners are linked to additional medical (specialist) and social (community based) programs. Assessing connectedness involves relying on data that tracks communication technologies and team-based care models. This is an attempt to understand what range of services primary care practices provide both inside and outside the office setting.

Ontario, Manitoba, and Alberta are either above or equal to the national average with respect to the use of both information and communication technologies and the use of electronic medical records in their primary care practices (Canadian Institute for Health Information, 2016). However, the Northwest Territories is the only jurisdiction with a fully interoperable and jurisdiction-wide EMR. While no jurisdiction (apart from small scale initiatives) offers EMRs that can facilitate information sharing between patients/caregivers and providers, the Northwest Territories allows all providers (beyond traditional medical professionals) to access information and engage in real-time communication through a digital charting system. In contrast, the development of EMRs and improvements to provider-to-provider communication are still in the planning stages in Ontario, Manitoba, and Alberta, with many of their efforts focusing on regional level demonstration projects. Alberta, through Netcare is working to improve patient access to health information. No jurisdiction has effectively improved information sharing between health and social care resources.

Team-based primary care is not the norm in any of the jurisdictions discussed here and team composition is variable within each jurisdiction. However, 25-30 percent of Ontarians now have access to team-based primary care (The Association of Family Health Teams of Ontario, 2015) as do 3.6 million Albertans through its Primary Care Networks (Alberta Health, 2018). Due to its patient-centric digital charting system, the NT offers the most consistent connectedness to providers and services beyond physician providers among the jurisdictions assessed.

*Table 2 Connectedness by Jurisdiction*

Jurisdiction	Ontario	Manitoba	Alberta	Northwest Territories
<b>Questions</b>				
<b>Are team-based models of primary care the norm in your jurisdiction?</b>	The majority of the population do not receive team-based care. One in four Ontarians has access to a primary care team.	They are not the norm. My Health Teams (MyHTs) and Interprofessional Team Demonstration Initiatives are two vehicles to enable team based care.	Primary Care Networks are the major vehicle to enable team-based care.  Team composition varies.	In Yellowknife clinics include physicians, NPs, LPNs, and Clinic Assistants. <sup>8</sup>  In remote communities, nurse practitioners work with community health representatives and visiting specialists. <sup>9</sup>
<b>How broad is the range of services offered by the majority of primary care teams in your jurisdiction?</b>	It varies greatly.  CHCs (primarily through co-location) offer access to health and social resources.  FHTs offer site-specific supports and some have	It varies greatly.  MyHTs take on a population health perspective to address population needs.	It varies greatly.  PCNs are required to deliver a variety of services (medical, psychological, prevention).	Family physician primary care teams support secondary hospital-based services.  In remote communities nurse practitioners

<sup>8</sup> <http://www.yhssa.hss.gov.nt.ca/health/clinics-and-health-centres/yellowknife/yellowknife-primary-care-centre>

<sup>9</sup> <http://www.yhssa.hss.gov.nt.ca/health/clinics-and-health-centres/fort-resolution>

	partnerships with community agencies to improve access to social resources.			provide first-level primary care services. <sup>10</sup>
<p><b>Are there jurisdiction-wide practices in place to support two-way communication and referrals between primary and specialist care?</b></p> <p><b>Do you know of any regional-level practices?</b></p>	<p>Ontario Telemedicine Network's eConsult allows primary care providers and specialists to discuss a patient's condition.<sup>11</sup></p> <p>Champlain BASE eConsult Service (web based).<sup>12</sup> eHealth is working to spread this program across Ontario.</p>	<p>Currently – No.</p> <p>Previously (2008-2015) – Bridging Generalist and Specialist Care.<sup>13</sup></p> <p>Bridging Generalist and Specialist Care was redeveloped into eReferral and eConsult.</p>	<p>Currently – No.</p> <p>AHS is implementing Connect Care (CIS) that will allow for e-referral and secure messaging.</p> <p>Alberta Netcare's e-referral technology service offers specialist advice for non-urgent questions.</p> <p>Specialist Link in Calgary (telephone based).<sup>14</sup></p>	<p>Jurisdiction wide communication through the enterprise Territorial EMR.</p> <p>eReferrals/consults occur for home care, rehabilitation, diabetic support, and remote support of nursing stations by physicians.</p> <p>Specialists have requested paper-based referrals be faxed.</p>
<p><b>Are there jurisdiction-wide practices in place to support two-way communication, specifically between primary care and other health and social care resources (managing patients together)?</b></p> <p><b>Do you know of any regional-level practices?</b></p>	<p>There are no jurisdiction-wide practices to connect primary care patients to social care resources.</p> <p>These connections vary and are often informal connections as a result of co-location or partnering with local organizations.</p>	<p>Access Centres (co-location of health and family services) exist in Winnipeg and one other health region.</p> <p>MyHTs may be a vehicle to support this communication – as they develop.</p>	<p>No jurisdiction-wide practices.</p> <p>Triple Aim Initiatives in Edmonton and Calgary facilitate two-way communication.</p>	<p>Yes.</p> <p>A digital charting system shared by all providers.</p> <p>Two or more providers can communicate in real time (physicians, nurse practitioners, social services, mental health, and specialists)</p>
<p><b>What is the percentage of primary care providers who use electronic systems to complete their professional tasks? What do these systems connect them to? Who else are they able to share these systems with?</b></p>	<p>GPs using both paper and EMRs 34.1%, GPs using only EMR 51.5%.<sup>15</sup></p>	<p>89% have an EMR within the clinic.</p> <p>Not all have access to eChart.</p> <p>eChart is not connected to other care resources, or to patients.</p>	<p>Currently, EMRs are not interoperable with other CISs in the province.</p> <p>Alberta Netcare functions as a health exchange to ensure physicians can access (labs, diagnostics, immunization, events history).</p> <p>Patients do not have access yet. Future – Connect Care patients and participating physicians will have access to shared information.</p>	<p>100% primary care providers use electronic health records.</p> <p>The Territorial EMR is shared by all healthcare providers.</p>

<sup>10</sup> <https://www.rnantnu.ca/sites/default/files/RNANTNU%20Practice%20and%20Prescriptive%20Guidelines%20for%20NPs%20NT%20Signed%20March%202017.pdf>

<sup>11</sup> <https://www.ontariomd.ca/products-and-services/provincial-econsult-initiative/faqs>

<sup>12</sup> <https://www.champlainbaseeconsult.com/>

<sup>13</sup> <http://news.gov.mb.ca/news/print,index.html?archive=&item=3334>

<sup>14</sup> <http://www.specialistlink.ca/>

<sup>15</sup> National Physician Survey (2014)

<p><b>Do a majority of primary care providers use electronic systems to connect their patients with other health and social care resources in order to facilitate patient care?</b></p>	<p>77.5% use information and communication technology.</p> <p>77.7% use EMRs in their practice.<sup>17</sup> Adoption varies widely.</p> <p>There have been site-specific efforts to support this communication and partnership.</p>	<p>89% have an EMR for within-clinic information sharing.</p> <p>A majority of these have access to eChart for immunizations, prescriptions, lab/di test results, and hospitalizations (does not have access to information on health and social care resources).<sup>16</sup></p>	<p>82.5% use information and communication technology.</p> <p>85% use electronic medical records in their practice.<sup>17</sup></p> <p>E-referral technology exists as part of Alberta Netcare.</p>	<p>Yes.</p>
<p><b>Do patients and caregivers have access to these methods of communication and are they able to contribute?</b></p>	<p>No.</p>	<p>No.</p>	<p>MyHealth Alberta is a website that provides health information and facilitates access to some health services.</p> <p>Future - Connect Care will be a patient portal to facilitate access to personal health information, scheduling, and secure messaging.</p>	<p>No.</p>

## Accountability

Accountability refers to organizational and institutional structures and mechanisms that enumerate and reinforce the responsibilities of primary care providers to their patient and system stewards, managers and funders and vice versa. Here we use the idea of “tight” patient rostering as an approach that has the potential to contain costs, improve accountability for the patient, provider and system, and ensure continuity of care. Understanding that accountability is a relational idea, we identify what jurisdictions have done to improve this relationship. Tight patient rostering, which formalizes the accountability between a primary care practice and a registered patient, was not common in Manitoba, Alberta, or the Northwest Territories. This form of patient rostering offers primary care providers greater responsibility for the coordination of care in return for payments that recognize these responsibilities and penalties if patients seek care elsewhere. Patient rostering falls on a continuum that involves notional ideas of patient registration at one end but is highly permissible in terms of patients continuing to access primary care services from those who are not their “registered” primary care provider. Tight patient rostering contractually binds patients and providers and, in particular, holds primary care providers accountable for offering a stipulated range of primary care services on a 24-7 basis and, potentially, for the health outcomes of their patient roster.

One form of patient rostering somewhere between the two extremes has been implemented in Ontario for those patient enrolment models that receive access bonuses – Family Health Networks (FHNs), Family Health Organizations (FHOs), and Family Health Teams (FHTs). Ontario’s experience with

<sup>16</sup> <http://www.echartmanitoba.ca/locations.html>

<sup>17</sup> [https://secure.cihi.ca/free\\_products/Primary%20Health%20Care%20in%20Canada%20-%20Selected%20Pan-Canadian%20Indicators\\_2016\\_EN.pdf](https://secure.cihi.ca/free_products/Primary%20Health%20Care%20in%20Canada%20-%20Selected%20Pan-Canadian%20Indicators_2016_EN.pdf)

rostering has been unpopular with some members of the medical profession, which has created a negative perception of rostering among Manitoba’s physicians. These negative perceptions will make it difficult for the Government of Manitoba to use rostering as a policy tool. This does not speak to the failed administrative initiative but rather to physicians’ overall negative perceptions towards rostering.

Two jurisdictions (ON and NT) stand out in terms of moving away from traditional FFS remuneration models. In 2001, the Northwest Territories was able to move all physicians (but one) to salary, making them employees of a single health authority rather than independent entrepreneurs. Ontario has similarly attempted to move away from FFS models and has made progress with 49.5 percent of physicians now working in an alternate payment model. Through the development of the 2016 *Patients First Act*, Ontario made Family Health Teams and NP-led clinics (Local Health Integration Networks were already responsible for Community Health Centers) accountable to the LHINs.

*Table 3 Accountability by Jurisdiction*

Jurisdiction	Ontario	Manitoba	Alberta	Northwest Territories
<b>Questions</b>				
<b>Tight patient rostering (formal connections between primary care practice and a registered patient); is patient registration mandated for primary care practices?</b>	<p>Tight patient rostering (those with access bonuses) FHN, FHO, FHTs.</p> <p>All models (except for those in fee-for-service) are enrolment models.</p>	<p>Patient enrolment is not mandated.</p> <p>For Home Clinics it is required but which patients are enrolled is at the discretion of the clinic.</p>	<p>Patient enrolment is not mandated. Although, capitation programs require enrolment.<sup>18</sup></p> <p>Approximately 70% of physicians have established or are working to establish panels.</p> <p>Future – Central Patient Attachment Registry (voluntary participation).</p>	<p>No territorial mandate for rostering.</p> <p>Patients are assigned to a practice team and to a physician in that team.</p> <p>Geography of remote community could be a proxy for rostering – no options to seek care elsewhere.</p>
<b>Do primary care practices get penalized if patients access other avenues of care?</b>	Those who receive access bonuses will be penalized.	No.	No. Two capitation programs have negation elements (Crowfoot and Taber)	No.
<b>Percentage of general physicians who are primarily (&gt;50%) remunerated (including blended payment) by:</b>				
<ul style="list-style-type: none"> <li>• Fee-for-service</li> <li>• Alternative Payment Models:                             <ul style="list-style-type: none"> <li>- Capitation</li> <li>- Salary</li> </ul> </li> </ul>	<p>FFS 50.6%</p> <p>APP 49.5%<sup>19</sup></p>	<p>Approximately 75% fee-for-service across Manitoba and about 95% in Winnipeg.</p> <p>No capitation alternate funding through salary or “contract” (a salary without any employment relationship so enforcing responsibilities is difficult).</p>	<p>The majority of physicians (84%) are remunerated by fee-for-service.<sup>20</sup></p>	<p>100% salary with 1 doctor on fee-for-service</p>

<sup>18</sup> Alberta Health (2018). Retrieved from: <http://www.health.alberta.ca/professionals/ARP-Clinical-capitation.html>

<sup>19</sup> Canadian Institute for Health Information National Physician Database

<sup>20</sup>Canadian Institute for Health Information (pg. 14) Retrieved from [https://secure.cihi.ca/free\\_products/Physicians\\_in\\_Canada\\_2016.pdf](https://secure.cihi.ca/free_products/Physicians_in_Canada_2016.pdf)

<p><b>Have there been recent organizational changes to the health system in your jurisdiction that change physician accountability? If so, how?</b></p>	<p><i>Patients First Act (2016)</i> FHTs allied professionals, CHCs, and NP-led clinics under the responsibility of the LHINs.<sup>21</sup></p>	<p>No.</p>	<p>A new Primary Care Governance Model is being implemented, bridging a divide between physicians and AHS. The election of physician executive leads who can speak on behalf of PCN physicians.</p>	<p>In 2001, physicians went from fee-for-service to salary and are now employees of the health authority.  Territorial Health Authority (2016) with enterprise physician bylaws.</p>
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<sup>21</sup> Ministry of Health and Long-Term Care of Ontario. (2017). Update: Health System Integration. Retrieved from

## Conclusion

With respect to populations having access to high-quality and connected primary care, all jurisdictions fall short. Assessing how each jurisdiction has improved access, connectedness, and accountability of primary care over the last decade was limited due to a lack of comparable national data. However, based on the data that was available, the jurisdictions profiled here each seem to have their strengths and limitations within each of the domains used for comparison.

Alberta performs the best out of the group (who had data) based on the Commonwealth Fund's International Health Policy Survey's data on *access* (Commonwealth Fund, 2016). Team-based care continues to remain an issue in all four jurisdictions. However, Ontario and the Northwest Territories both offer NP/RN-led clinics and have models of care that incorporate various health and allied health professionals that work to improve *connectedness* (although team composition varies within each jurisdiction). In the Northwest Territories, this *connectedness* is facilitated by its jurisdiction-wide EMR that allows all health and allied health professionals to receive patient information and engage in real-time communication with other members of the care team. However, data was not available for many other indicators in the Northwest Territories. Data specific to the Northwest Territories would improve the ability to evaluate the EMR system's impact and compare the territory's primary care outcomes with other jurisdictions. Alberta seems to be moving in a direction that will improve provider-to-provider *connectedness* as well as engaging patients and clients in these types of communications through the Netcare and Connect Care.

No jurisdiction has adopted truly tight patient rostering, although Ontario has implemented a more *accountable* form of patient registration than other Canadian jurisdictions (with over 10 million Ontarians formally enrolled with a primary care provider) for some primary care practice models. However, if the negative perception held by Manitoba's doctors concerning the experience of Ontario physicians with patient registration is also held by physicians in other provinces and territories, then pursuing tighter forms of rostering in other jurisdictions will be difficult.

Overall, the Northwest Territories made a major departure and Ontario is moving towards a departure from traditional FFS remuneration for primary care physicians. The Northwest Territories went further than the other jurisdictions in attempting to align physician *accountability* with its regional health authorities and (now) its single Territorial Health and Social Authority.

Although primary care reform demands significant changes on the part of FFS physicians, most Canadian physicians are highly independent and tend not to view themselves as part of the health system more broadly defined. The models that seem to achieve physician buy-in and accountability tend to be focused on incentivising behaviours (i.e., patient attachment, EMR adoption, after-hours care). Provincial and territorial governments continue to attempt to implement new models of primary care that balance the support of physicians while also holding physicians accountable for more system-wide goals (e.g., connectedness, access, continuity) and outcomes (e.g., health of their registered populations).



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