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Review

Policy Innovations in Primary Care Across Canada

A Rapid Review Prepared for the Canadian
Foundation for Healthcare Improvement

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Introduction and Background

This review explores the state of primary care reform across Canada. For this review we define primary care as being the day-to-day care that is provided by a physician or other qualified health care provider. Primary care providers are a patient's first point of contact with the health system and should provide on-going, continuous care including referrals to other, more specialized providers, diagnostic testing and access to prescription drug therapies. We aim to elicit which jurisdictions have progressed primary care most innovatively through the last decade. We have used six evidence-based criteria (see table 2) derived from the international scholarly literature (Rittenhouse, Shortell & Fisher, 2009; Salman, Rico & Boerma, 2006; Starfield, 1994; Starfield, 2009; Wei et al., 2015; World Health Organization, 1978) and the institutional environment in Canada (CICS, 2004; Marchildon & Hutchison, 2016; Romanow, 2002). These criteria are identified as necessary components for more effective and efficient primary care and its contribution to higher performing health systems.

The original bargain between provincial governments and the medical profession that was established during the formation of Medicare, institutionalized private fee-for-service (FFS) physician practices as the dominant model of primary care practice. This approach continues to prevail in most Canadian jurisdictions, with physicians remaining at the centre of care, either leading practice groups or individually maintaining their own FFS practices or in conjunction with other primary care physicians. There are exceptions. In Ontario, for example, new approaches have emerged through a variety of primary and blended remuneration models with base funding that is either FFS, capitated, or salaried (Marchildon & Hutchison, 2016). In the Northwest Territories and Nunavut, the majority of remote northern communities receive primary care services through nurse-led community health centres (CHCs), staffed by community health nurses with occasional visits from physicians who also offer remote support and consultations (but with physician-led primary care services offered in both territorial capitals).

Spurred by the economic downturn of the 1990s, all jurisdictions in Canada regionalized their health systems in an effort to create economies of scale and scope in service delivery and to reduce infrastructure costs. As such, over the last two decades, all provincial governments and one territorial government began to manage their health systems through regional health authorities (RHAs) or through more centralized provincial or territorial health authorities (PTHAs). As a result, RHAs and PTHAs are now mandated through provincial/territorial (P/T) laws and regulations to coordinate the delivery of healthcare services within their respective geographic boundaries (see Appendix B). Primary care physicians provide the bulk of primary care, yet they have largely been excluded from any recent changes to administrative governance. In one notable exception, Ontario's *Patient's First Act* explicitly states that Family Health Teams and Nurse Practitioner-Led Clinics are now accountable to the Local Health Integration Networks (Community Health Centers were already under the remit of the LHINs)

Methods

We collected and reviewed relevant information from government websites, published government documents and academic (secondary) literature published from January 1, 2007 through December 31, 2017. This time period was selected because 2007 marked a critical turning point in the history of Canada's regionalized healthcare, with the creation of the first operational LHINs in Ontario in 2006. One year later, Alberta's regional health boards were dissolved and the country's first provincial-wide authority – Alberta Health Services – was established. This report aims to provide an impression of provincial and territorial experiences with primary care reform and attempts to assess the Canadian jurisdictions that have made progress towards innovative approaches to primary care over the last decade.

Based on a review of the academic literature, the following six criteria were deemed to be the most critical in altering the status quo of primary care in Canada. Using these six criteria we were able to draw some preliminary judgments as to which jurisdictions have spearheaded the most innovative approaches to primary care:

1. Development of new models of primary care facilitating access to interprofessional teams
2. Introduction of tight patient rostering to contain costs, and improve accountability and continuity of care
3. Requirement that primary care practices provide patients with a comprehensive range of after-hour (24/7) primary care services
4. Effective investment in, and use of, information communications technology accessible to both patients and providers
5. Changes in primary care physician remuneration to encourage greater continuity and quality of care
6. Health system organization changes producing health system alignment for greater physician accountability to patients and health systems

From this analysis, we attempt to identify which jurisdictions have managed to innovate in primary care structures and how they have done so. The results are summarized in Table 2 where we grade each jurisdiction's progress (low, moderate, or high) towards integrating innovative approaches to primary care.

Analytic Overview

Here, we focus on an overview of primary care policy innovations in the 13 P/T jurisdictions. We have applied the above criteria to our findings in the environmental scan to determine which jurisdictions have been most innovative in implementing primary care reforms.

Interprofessional, Team-Based Primary Care

We identified the degree to which jurisdictions have (or have not) created team-based models of care that integrate physicians with other health professionals. As shown in Appendix A, over the last decade Ontario has adopted some of the country's most comprehensive interprofessional models – in particular the Family Health Team (FHT), led by executive directors who may or may not be a physician (most FHTs do identify a lead physician). Similarly, Alberta, Manitoba, and Prince Edward Island have developed more limited interprofessional “Primary Care Networks” (now My Health Teams in Manitoba), and to a lesser extent Nova Scotia, which has instituted “Primary Care Teams”. Alberta has 42 PCNs serving 3.6 million of the province's 4 million residents. Quebec's “Family Medicine Groups” (223 as of 2011, serving over 25% of Quebec's population) are similarly physician-led with access to other health professionals provided through the group. Newfoundland and Labrador created “Primary Healthcare Team areas” that offer access to team - based care.

Other provinces (such as New Brunswick) use a network approach in which physicians refer patients to externally based programs and health professionals. British Columbia's health authorities, the Doctors of BC and the province's ministry of health are attempting to develop a more integrated, team-based model through a Primary Care Network approach to be implemented in 2018. However, at this time British Columbians are provided with limited access to integrated team-based models. Interestingly, the Northwest Territories has adapted a unique approach to team-based care wherein community health nurses (registered nurses) are the clinic leads and access physician services (mostly through technology) on an as-needed basis through consultation. The other two territories Nunavut and Yukon, offer similar nurse-led models to service the more remote communities. Yukon offers a Community Health Centre (CHC) model, with centres staffed by primary healthcare nurses, yet a report noted the absence of team-based care as one of the challenges facing Yukon's model.

Tight Rostering

In order for rostering to be “tight”, i.e., accountable and effective, it must formalize the connection between a given primary care practice and a registered patient. Ideally, for reasons of accountability and cost-control, primary care practices should be financially penalized if patients seek care elsewhere. Tight patient rostering puts the onus on the lead primary care

provider to ensure collaboration and responsiveness among health professionals within and outside the practice. Given the sources available in this rapid review, we were unable to determine the depth of rostering in those jurisdictions (such as Ontario, Quebec, Alberta and the Northwest Territories) in which patient registration is mandated for at least some primary care practice models.

Access to Comprehensive After-Hours (24/7) Primary Care

Timely access to after-hours care is understood to be a key component to successful primary care systems. Based on our findings, nine jurisdictions offer primary care models that have access to some degree of after-hours care, although the extent of this access is not always clear. Alberta offers additional payments to primary care models that provide after-hour coverage. Ontario's models offer after-hours care, however, access to this care is limited. Furthermore, since 24/7 care is not a requirement for all practices it might be absent from some models in the province. Additionally, Family Health Teams offer after-hours access to a nurse via telephone. Similarly, Quebec's Family Medicine Groups offer patients after-hours telephone services that are staffed by physicians.

Beyond this, the level of access to after-hours coverage is unclear, except for the presence of Network Clinics (a private FFS physician-based model) that offer 24/7 access to diagnostic and specialist care. Manitoba, through its "My Health Teams" model intends to offer after-hour care. The Northwest Territories have community health centres that provide 24/7 access to care in eight communities, yet how this is applied on the ground would have to be further investigated. Similarly, Nunavut's CHCs have community health nurses on call 24/7 to provide residents with access to most basic health services. Yukon's CHCs offers 24/7 emergency services but lacks 24/7 access to basic health and social services. Accessing after-hour care is an indicator of success for the New Brunswick Health Council, yet the results of a 2014 survey comparing the results from 2011 revealed no real improvements in patients' access to such care. The details identified for Saskatchewan were quite vague and only suggested that some primary care models offer "extended-hour" clinics. Nothing specific came up in the review for British Columbia, although the province, like all other jurisdictions, provides access to a general patient resource phone line.

Investment in and Effective use of Information and Communications Technology (ICT)

Whether jurisdictions across Canada have developed primary care infrastructures that include the use of electronic medical records (EMRs) remains unclear. While most regions report the desire to implement EMRs to improve communication across team members and providers outside of the team, there is a lack of clarity regarding which jurisdictions have implemented effective ICT infrastructures that can be used to connect primary care to other avenues of the health and social care structure (hospital, diagnostics, specialist, long-term care, community care). Developing an effective ICT infrastructure is a critical component if primary care is to be at

the centre of the health system, managing and coordinating care on behalf of patients on an ongoing basis. The Northwest Territories seems to be the most successful jurisdiction in Canada in using ICT, including an EMR for every resident, which are major facilitators in the delivery of primary care in remote communities. Nevertheless, even in this jurisdiction, the extent to which patients and providers outside of the immediate team have access to these types of records remains unclear. Manitoba's My Health Teams are identified as working as a broad virtual network, but the extent to which they have implemented a shared ICT structure is unclear. Nova Scotia has focused on developing collaborative primary care practices using a Primary Health Care Information Management Program, which supports providers in implementing EMRs, but the extent to which this has been effectively implemented and used is again unclear. Quebec's Family Medicine Groups are required to implement EMRs, yet reports indicate numerous difficulties. Lack of EMRs was also identified as a challenge for Yukon's Community Health Centres.

Changes in Primary Care Physician Remuneration

Remuneration models – in whatever form they take – should aim to produce better patient and provider interactions as well as facilitate the continuity of primary care and coordination of care beyond primary care. Based on the rapid review, we try to identify those jurisdictions which have done the most to move from the status quo of FFS payment systems to reconfigured payment FFS, capitation, salaried and blended models to encourage and incentive behaviours which are currently not funded on traditional FFS models. These criteria look to see which jurisdictions have implemented payment models that encourage improved access, coordination, connectedness, and consistency in care.

At this time, all provincial jurisdictions maintain, to a greater or lesser extent, traditional FFS models of payment for primary care physicians. The exceptions are Nunavut and the Northwest Territories, where it appears that primary care physicians are salaried although the bulk of primary care outside the two capital cities of Iqaluit and Yellowknife is provided by community health nurses. New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, and Quebec all have primary care models that allow for primary care physicians to be paid by salary although the majority of primary care physicians in those jurisdictions remain on FFS. Only two provinces (Alberta and Ontario) have capitation-based models. In Ontario roughly 36% of physicians are in a capitated based model. Alberta's Primary Care Networks employ 80% of primary care physicians in the model offering remuneration by FFS or capitation. Uniquely, Manitoba offers "alternate funding" for its Primary Care Network physicians, but does not clearly state what this entails. Alberta also offers incentive and performance-based funding for its "physician-integrated network" model. Table 1 below notes the percentage of physicians (for the 8 provinces who have reported data) who are in the traditional FFS model or an alternative payment program (APP). Even Ontario, which has gone further in developing blended and non-FFS payment approaches, still has less than 50% of its GPs in alternative payment models (CIHI 2015-16).

Table 1. Payment Models for General Practitioners in Eight Provinces with Data

		N.L.	P.E.I.	N.S.	N.B.	Que.	O.N.	Man.	B.C.
Percentage of GPs	50-100% FFS	69.5	55.4	55.4	61.3	75.1	50.6	61.5	83.3
	50-100% APP*	30.3	45.1	44.3	38.4	24.8	49.5	38.4	16.5

*Physicians receiving exactly 50-50 split are counted as APP.

Health System Organization Changes: Structural Alignment and Accountability

Accountability regimes should reflect the system-wide responsibilities of primary care providers. This can be done through Provincial/Territorial (PTHAs) and Regional Health Authorities (RHAs) which may be given the tools, including payment, to facilitate greater system connectivity between primary care providers and the organizations and individuals delivering other forms of health care. Another approach may be to provide physicians with the organizational structures and accountability mechanisms to promote greater system connectivity, similar to those established in the United Kingdom where primary care providers were rolled into primary care fund holding (Price, Baker, Golden, & Hannam, 2015).

If PTHAs or RHAs enter into accountability contracts with primary care physicians, the PTHAs and RHAs will have mechanisms to enforce accountability and require cooperation of other health care providers and organizations. If provinces remain the primary fund holder for physician payment, we will continue the status quo that offers little opportunities for system-accountability that would encourage connectivity. There is a disconnect when the negotiation of physician remuneration and the primary care working environment remains centralized even while health service planning, management and facilities are delegated to PTHAs and RHAs. While there is no such apparent conflict in Nunavut and Yukon, all other jurisdictions in Canada have delegated the responsibility of managing their respective health systems to PTHAs (Alberta, Saskatchewan, Nova Scotia, Prince Edward Island and the Northwest Territories) or RHAs (Ontario, Quebec, British Columbia, Manitoba, New Brunswick, and Newfoundland and Labrador).

Change in governance and accountability structures are generally effected through legislation. If there is a change in governance, this will generally be reflected in changes in law and regulation. Appendix C speaks to the roles and responsibilities of the PTHAs and RHAs in terms of how they address primary care and promote access to quality health services in order to meet the needs of defined populations. However, our review revealed that only the law in Ontario specifically addresses primary care or physicians providing primary care. The Ontario government recently implemented the *Patients First Act*, which expanded the role of the 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). These two types of practices have

slightly less than 3.5 million (out of a total patient population of slightly more than 13.7 million) enrolled patients. However, this law does not impact the majority of primary care physicians who practice outside these FHTs and CHCs.

Table 2 summarizes which provinces have or have not attempted to address and implement the criteria for innovative primary care. The gaps in information obtained through this rapid review of secondary and grey sources are indicated by two asterisks **. These gaps can only be addressed through a deeper review involving qualitative interviews with key informants.

Table 2. Jurisdictional Comparison Across 6 Categories of Innovative (L=low, M=medium, and H=high) Primary Care Reforms

Categories	Inter-professional Primary Care Teams	Tight Rostering*	After-Hours Access	Electronic Medical Records	Remuneration	Structural Alignment and Accountability
Alberta	M	M	M	**	H (FFS, capitation, incentive-based funding)	L
British Columbia	L	**	**	**	L	L
Manitoba	H	**	M	M	L (FFS, alternate funding, incentive-based funding)	L
New Brunswick	L	**	L	**	M (FFS, salary)	L
Newfoundland and Labrador	M	L	**	**	M (FFS, salary)	L
Nova Scotia	M	L	**	M	M (FFS, salary)	L
Ontario	FHTs – H Other models – L/M	M	M	**	H (FFS, capitation, salary)	M (FHT, CHC, NP-Led)
Prince Edward Island	H	**	**	**	**	L
Quebec	H	M	L	L	M (FFS, salary)	L
Saskatchewan	L	**	M	**	**	L
Northwest Territories	M+	Geographically determined	H	H	H (salary)	H
Yukon	M+	Geographically determined	H	L	M (FFS, salary)	**
Nunavut	M+	Geographically determined	H	**	H (northern allowance, salary with compensation for remote and 24/7 work)	H

* Formal registration of patients with a primary care provider

** Based on the rapid review of secondary and grey sources this could not be unquestionably determined

+ Nurse-based primary care teams with limited involvement of other professionals due to remoteness of communities

Conclusion

This rapid review attempts to identify those jurisdictions that have been most innovative in moving beyond the status quo in primary care. As summarized in Table 2 above, we conclude that the four jurisdictions which have initiated the most ambitious primary care reforms, worthy of deeper study, are Alberta, Ontario, Manitoba, and the Northwest Territories. Although Nunavut scores highly in some categories, its most innovative features are also present in the reforms undertaken in the Northwest Territories. The recent reforms in Alberta, Ontario, and the Northwest Territories are different enough from each other that they constitute very diverse approaches in terms of changes in governance, administrative structure, payment and accountability of providers, and coordination with other health sectors.

Appendix A: Jurisdictional Summaries

ALBERTA

Governance and Accountability

In the 1990s approximately 200 hospital boards were consolidated into 17 Regional Health Authorities (RHAs) and in 2003 that number reduced to nine. It was in 2008, when Alberta became the first jurisdiction in Canada to centralize its health system when its nine RHAs merged to create a single provincial authority known as Alberta Health Services (AHS) (Alberta Health Services, n.d.). This reorganization also included three geographically based health authorities: the Alberta Alcohol and Drug Abuse Commission, the Alberta Mental Health Board, and the Alberta Cancer Board (Alberta Health Services, n.d.). The *Alberta Health Act* does not explicitly align primary care services with the roles and responsibilities of the AHS.

Primary Care Policy

Following this reorganization, the provincial ministry of health (Alberta Health) and Alberta Health Services (AHS) announced health policy strategies aimed at primary care, and in particular the priority of developing primary care teams (Suter et al., 2014). Alberta's Primary Care Strategy proposes integrated, team-based primary care involving a broad range of services, including public health, wellness, social services, and community-based services (Suter et al., 2014).

Alberta Health, AHS, and the Alberta Medical Association (AMA) are the key actors involved with primary care reform (Suter et al., 2014). Like other jurisdictions in Canada the relationship between the AMA and the provincial government can be tumultuous, meaning that some reform efforts may yield unintended consequences or experience resistance to scale and spread (Suter et al., 2014). For example, the original plan for the introduction of Family Care Clinics in 2012, that can be led by either an NP or a physician, was to expand them to 80 sites. This plan was obstructed due to opposition from the AMA (Suter et al., 2014).

Primary Care Innovations

The main model of primary care in Alberta are **Primary Care Networks (PCNs)** with approximately 80% of family physicians operating under this model (Alberta Health, n.d.-a). PCNs were established in 2003 following the Primary Care Initiative (Rauscher, 2015) that supported the use of primary healthcare teams to improve access and quality of care (Suter et al., 2014).

The PCNs have four high-level categories of objectives including: “accountable and effective governance”, “strong partnerships and transitions of care”, “health needs of the community and population”, and “patient’s medical home” (Alberta Health, n.d.-a). A key operational goal is to provide 24/7 access to primary care (Suter et al., 2014).

PCNs are comprised of groups of physicians working with other health professionals, including nurses, dietitians, and pharmacists (Alberta Health, n.d.-a). There are no set requirements for team composition and the structure of PCNs varies—they can be one clinic with physicians and other health professionals, or several clinics within a specific geography with many physicians and other health professionals (Alberta Health, n.d.-a). PCN teams usually have a physician lead, in addition to a director or executive director (Wranik, Korchagina, Edwards, Levy, & Katz, 2015). The province has 42 PCNs with more than 3,800 physicians and 1,000 full-time-equivalent non-physician health professionals who serve about 3.6 million of 4 million Albertans (Alberta Health, 2016a, 2016b, n.d.-a). To date, Alberta has invested more than \$1 billion on PCNs (Alberta Health, 2016b).

There are two governance models that PCNs can operate within, but both approaches have physicians establishing a not-for-profit corporation that has a joint venture agreement with the AHS (Scott & Lagendyk, 2012). In one model, PCN funding goes to the physician's not-for-profit entity or AHS, and other health professionals and administrative staff are employed by either the physician's not-for-profit entity or AHS. In the other model, the physician's not-for-profit entity and AHS may form a separate PCN not-for-profit corporation where funding goes to the corporation, which hires employees directly (Scott & Lagendyk, 2012). In the latter model, the PCNs are governed by the PCN's not-for-profit corporation's Board of Directors (members are PCN physicians) (Wranik et al., 2015).

PCN physicians are paid a base remuneration fee (fee-for-service [FFN] or capitation), and additional payments for after-hours coverage and other activities (Rauscher, 2015). Baseline block funding for PCNs is determined by the number of physicians in the network and the number of patients attached to these physicians—a funding model that blends capitation and payment-per-provider (Wranik et al., 2015). PCNs are also paid a \$62 per capita amount that supplements costs like administration, equipment, rent, chronic disease management programs, and 24/7 access (Rauscher, 2015). Alberta Health also pays grant funding to PCNs for non-physician health providers (Wranik et al., 2015). There is no allocated funding for nurse practitioners (NPs) so PCN NPs are paid through the PCN's operational budget (Canadian Nurses Association, 2016). The Canadian Nurses Association (2016) reports few NPs work in PCNs.

In 2012, in a general review of the PCNs, the auditor general report recommended that more systemic oversight was needed to ensure that the PCNs complied with financial and operating policies (Suter et al., 2014). In response to the review, Alberta Health developed a Primary Health Care Evaluation Framework and a Primary Care Network Evolution Framework (Suter et al., 2014). In 2016, Alberta Health produced a formal review of the financial operations and service delivery approaches of 13 PCNs (Suter et al., 2014). This review found there was variability in service delivery and financial practices across these PCNs, with specific findings that included inconsistency in financial management and accountability, poor development of team-based care, and limited coordination with other sectors of healthcare (Suter et al., 2014). The review

also noted there was insufficient evidence (a result of limited evaluations) that the PCN program produced improvements in population health outcomes (Alberta Health, 2016b).

On June 13, 2017, the AMA and the government agreed to a new governance framework for PCNs (Government of Alberta, 2017). This governance structure aims to improve the integration of PCN services, AHS programs, and community-based services. Additionally, this governance structure is attempting to address cross-boundary issues to align planning within zones and across zones (Alberta Health, n.d.-b). The PCN governance structure will now be comprised of a Provincial PCN Committee (which will provide governance, leadership and strategic priorities) and five Zone PCN Committees (Alberta Health, n.d.-b). Alberta Health, the PCN physician leads, AHS, and the AMA comprise the membership of the new governance structure (Alberta Health, n.d.-b).

BRITISH COLUMBIA

Governance and Accountability

There are five RHAs in British Columbia (BC) and a provincial health authority responsible for province-wide initiatives including the BC Cancer Agency, BC Centre for Disease Control, BC Renal Agency, BC Transplant, Cardiac Services BC, BC Emergency Health Services, BC Mental Health and Substance Use Services and Perinatal Services BC (Ministry of Health British Columbia, 2015). The Provincial Health Services Authority is also responsible for the management of the quality, coordination, and accessibility of health services in the province (Ministry of Health British Columbia, 2015). The boards of the RHAs are appointed by, and responsible to, the provincial government as per the authority of the *Health Authorities Act* (Suter et al., 2014). The *Health Authorities Act* does not address, directly, the responsibility of the RHAs to manage physicians or primary care models in British Columbia.

Primary Care Policy

In 2007, BC adopted a Primary Health Care Charter, which states that physicians are the first point of contact in primary care for patients (Suter et al., 2014). The Charter also implies that funding and incentives should focus on physician care with services designed around attachment to a family physician (Suter et al., 2014).

The province has experimented with the implementation of various primary care initiatives. In 2006, the Shared Care Committee—a partnership between Doctors of BC and the Government of BC—was formed as a result of the Physicians Master Agreement. The Shared Care Committee’s mandate is to provide funding and project support for initiatives that improve the flow of primary care to specialist care. Between 2008 and 2010, 25 Integrated Health Networks (IHNs) were created with \$24 million in spending by the Ministry of Health of British Columbia (MOHBC) and the Health Authorities (Cohen, 2014). After this funding ended in 2010, the IHNs were either discontinued or significantly scaled back (Cohen, 2014). Between 2007 and 2013, BC invested \$240 million in the Complex Care Initiative that included incentive payments to family physicians who offered comprehensive, continuous, guideline-informed care for patients with two or more chronic conditions (Lavergne et al., 2016). A study by Lavergne et al. (2016) suggests that the incentive-based program for caring for complex patients did not improve primary care access, continuity, or diminish the use of other health system resources.

Primary care is mainly delivered by the 3,500 GPs (family physicians) in BC (Ministry of Health British Columbia, 2015). In early 2013, the MOHBC announced the GP for Me Attachment initiative that aims to attach all BC patients to a family physician (Ministry of Health British Columbia, 2015). The initiative earmarked \$60.5 million over two years for new family physician fees, including an attachment participation code, telephone management fee, expanded complex care fee, management fee, conference fee, and unattached complex/high-needs patient attachment referral fee (Ministry of Health British Columbia, 2015).

The Canadian Nurses Association (2016) reports that NPs are hired by RHAs and are fully funded by the MOHBC for NP positions. Another model for NPs involves RHAs receiving partial funding for NPs from the MOHBC, and covering the remainder of the salary through their global budget (Canadian Nurses Association, 2016). The NPs *Statutes Amendment Act* that was introduced in 2011 supports NPs to work to their full scope of practice and to be the first point of contact in primary care (Suter et al., 2014). The NP for British Columbia Initiative announced in spring, 2012, had the goal of optimizing the use of NPs for high-needs patients and the development of a collaborative relationship with other providers (Suter et al., 2014).

BC's primary care policy aims to achieve care that is patient-centered, integrated, comprehensive, high quality, and high value for money (Ministry of Health British Columbia, 2015). There are two priorities identified by the MOHBC: 1) implement a primary and community care system built around interprofessional teams, and 2) strengthen the collaboration between primary and specialist care (Ministry of Health of British Columbia, 2014).

BC's primary care framework notes RHAs, in collaboration with the Divisions of Family Practice and with the support of the MOHBC and Doctors of BC, will implement integrated, interprofessional primary care models based on the characteristics and local needs of their communities. Regional Practice Support Leadership teams were created by the RHAs to help implement these new models (Ministry of Health British Columbia, 2015). The MOHBC'S 2015 discussion paper, states the plan is to revitalize primary care through operational changes rather than structural reform. An operational approach entails providing incentives and bonuses for "full-service" family doctors, training and family practice redesign, as well as recruitment incentives (Ministry of Health British Columbia, 2015, p. 86).

The main actors involved with primary care reform are the Government of British Columbia, Doctors of BC and the RHAs (Suter et al., 2014). As a joint committee of physicians and government established in 2002, the General Practice Services Committee (GPSC), is unique in Canada (Suter et al., 2014). The GPSC began with disease-based initiatives and has evolved to address system-wide issues of coordination and population health (Tregillus & Cavers, 2011). The MOHBC states that they will collaborate with Doctors of BC and the standing GPSC to incrementally replace solo physician practices with team-based family practices (Ministry of Health British Columbia, 2015).

The MOHBC's 2015 discussion paper notes that the MOHBC will establish public reporting for primary and community care that includes impact/outcome assessment mechanisms. While the report did not outline a framework, the document highlighted that a Health Services Quality Framework is under development and that the MOHBC would conduct a review of relevant statutes, regulations, policies, standards, and guidelines to ensure they are aligned and support the proposed changes to primary and community care. The framework suggests that the GPSC might evolve into an interdisciplinary primary and community care committee, and the MOHBC will work with Doctors of BC regarding expanding the membership constitution. The MOHBC

proposes aligning compensation with guideline-based care, that would fund chronic disease management, palliative conferencing, acute care discharge conferencing, complex care, The Maternity Network, the Mental Health Initiative, and palliative care (Ministry of Health British Columbia, 2015).

In response to the discussion paper, Doctors of BC released a document which was in support of the direction of the Framework; however, the group raised concerns about changing the membership of the GPSC as it could “dilute the physician voice” (Doctors of BC, 2015, p. 7).

Primary Care Innovation

A major initiative by the GPSC was establishing **The Divisions of Family Practice**, which involved the formation of 35 local networks of family physicians to address common healthcare goals and find new strategies to collaborate and serve over 230 communities (Divisions of Family Practice BC, n.d.; Suter et al., 2014). The Divisions of Family Practice are not-for-profit organizations that are funded by the provincial government and Doctors of BC, with each Division led by an executive director and a physician lead (Dale McMurchy Consulting, 2015). The Divisions create an environment where family physicians work in partnership with RHAs (Aggarwal & Hutchison, 2012). The Divisions also create groups of family physicians within a defined geographic area who advocate, recruit other physicians, and support each other in practice and education initiatives (Dale McMurchy Consulting, 2015). As of 2010, funds were provided for physicians to contract with other healthcare providers to provide care for target populations (Suter et al., 2014).

Most GPs support The Divisions of Family Practice approach (Tregillus & Cavers, 2011), and most are members of a local division (Ministry of Health British Columbia, 2015). A research study on one division showed positive results, including greater interactions amongst physicians, more ownership and accountability for the implementation of projects, increased engagement in decision-making, and better implementation of community-based initiatives (Ministry of Health British Columbia, 2015). Tregillus and Carver (2011) report that physicians who participate saw an increase of 11.8% in earnings (about \$27,000 per physician).

MANITOBA

Governance and Accountability

Manitoba is divided into five RHAs (Ministry of Health, Seniors and Active Living of Manitoba, n.d.). The majority of the population (67%) is in the capital, Winnipeg (Levesque et al., 2012). The RHAs operate in accordance with *The Regional Health Authorities Act* (1996) (*RHA Act*) and are accountable to the Minister of Health, Seniors and Active Living. The *RHA Act* for Manitoba does not explicitly address alignment between the RHAs' mandate and accountability of primary care.

Primary Care Policy

According to the province's website on primary care, the aim was to guarantee all Manitobans have access to a family physician and primary care team by 2015 (Province of Manitoba, n.d.). We were unable to determine whether Manitoba was able to achieve this goal.

Manitoba introduced a Primary Health Care Policy Framework in 2002 that documented the following goals: community participation, population health, interdisciplinary teams, accessibility, suitability, continuity, efficiency, and suitability (Levesque et al., 2012). The first phase of initiatives launched by this Framework were call centres, patient and provider education, quality-based incentive funding and physician networks (Levesque et al., 2012). The second phase of initiatives will see the Ministry of Health fund the RHAs towards physician change management initiatives (Levesque et al., 2012).

According to Levesque et al. (2012), Manitoba's road to primary care reform has lagged behind other provinces as the ministry (Manitoba Health, Seniors and Active Living), the RHAs, and physicians have not had a collaborative working relationship. Manitoba has a large number of solo and small practice family physicians, which presents a challenge in implementing integrated models of care (Mable, Marriott, & Mable, 2012). A review of regionalization in Manitoba recommended that RHAs implement incentive-based models to improve the delivery of integrated primary care models (Lavis & Shearer, 2010).

Initially, Manitoba had focused primary care reform efforts on quality- and performance-based programs and other complementary programs (improving access to primary care), rather than reorganizing models of care (Levesque et al., 2012). The province has experimented with alternative payment schemes for physicians. However, these approaches focused primarily on the recruitment of physicians to practice in rural and underserved areas, leaving the majority of physicians who practice in Winnipeg (60%) in fee-for-service (FFS) models (Levesque et al., 2012). The fee schedule for physicians is determined by the Master Agreement between the Ministry of Health and Doctors Manitoba.

Primary Care Innovation

The Physician Integrated Network (PIN), first introduced in 2006 as a demonstration project that has not concluded, was a physician-led clinic involving a specific team of health professionals (Wranik et al., 2015). The four main objectives of a PIN were: improve access to primary care, improve access to and the use of information by primary care physicians, improve work life for family physicians, and demonstrate quality in managing chronic diseases (Health Intelligence Inc. and Associates, 2017). The PIN model was originally created to have FFS physicians work in group practices. Thirteen PINs received blended funding and quality-based incentives (Mable et al., 2012; Katz et al., 2016). There is no designated baseline funding for PINs and supplementary funding was through quality-based incentives that support chronic disease management and prevention (Wranik et al., 2015). The primary method of provider payment was FFS and the clinic received quality-based incentive funding (Levesque et al., 2012).

Primary Care Networks (PCNs that have now been transitioned to My Health Teams presented below) are partnerships between RHAs, primary care practices, and community organizations to provide coordinated primary care (Government of Manitoba, 2013a). The first PCN was established in 2014 and the initial plan was to create 14 of them (Kusch, 2014). The annual budget for each PCN is \$750,000 (Kusch, 2014). PCNs aim to enhance continuity of care, improve access to primary care for patients, and focus on improving person-centered care (Government of Manitoba, 2013a). A PCN is governed by a steering committee comprised of members from the RHA, primary care providers and community organizations that reflect the stakeholders in the area (Manitoba, 2013). PCNs aim to engage the community by aligning with local priorities, partnering with community organizations that serve marginalized persons (Government of Manitoba, 2013a).

PCN physicians may be paid via three different models: FFS, alternate funding, and blended funding (Dinh, 2012). PCNs may collaborate with other FFS physicians in the network's area (Government of Manitoba, 2013b). Funding the PCN initiative depends on quality-based indicators that are invested in the clinic rather than individual physicians. Non-physician members of a PCN team may include: nurses, NPs, physician assistants, exercise specialists, pharmacists, mental health workers, social workers, and spiritual care providers (Government of Manitoba, 2013a). Although, the introduction of the physician assistant program does reduce the availability of opportunities for NPs to work under physician supervision.

My Health Teams (MyHT) were introduced as a partnership model in collaboration with the PCNs. MyHTs are interprofessional primary care teams (Health Intelligence Inc. and Associates, 2017) that involve partnerships between RHAs, primary care practices, and community organizations (Province of Manitoba, n.d.). MyHTs are set out to be the first point of contact for patients and should offer accessible primary care, including after-hours care (Chateau et al., 2017). The team member composition of MyHTs vary and may include physicians, nurses, NPs, community developers, exercise specialists, physiotherapists, and occupational therapists who

work together in a broad virtual network (Chateau et al., 2017). MyHTs aim to help patients access the “right providers, with coordinated referrals to other providers and services” (Chateau et al., 2017, p. 9). A MyHT serves a catchment area’s population and may also be linked to a remote community that is cared for by a NP or physician assistant (Health Intelligence Inc. and Associates, 2017).

MyHTs are not-for-profit organizations that are governed by the providers under the MyHT Agreement (Wranik et al., 2015). Details of this agreement were not offered within the publicly available documents identified in this review. MyHTs, in partnership with the RHA, are tasked with service planning and deciding on the team’s composition. Ultimately, all decision-making is subject to approval by the RHA (Wranik et al., 2015). The MyHT approach may include salaried physicians and non-physician providers who hold contracts with the RHA or are funded by the clinic.

Manitoba has also implemented other innovations in primary care, including **The Advanced Access Model**. The Advanced Access Model was introduced in 2007 by the Government of Manitoba to help clinics modify practice and workflow in an effort to have patients seen in a timely manner by physicians (Levesque et al., 2012). This model uses a team approach to the planning, implementation, and evaluation of changes that aim to reduce wait times and facilitate same-day access to care (Health Council of Canada, 2013). Primary care clinics in this model enroll in a 12-month improvement program that includes training on change management (Health Council of Canada, 2013). This model of quality improvement has enabled clinics to reduce wait times (Health Council of Canada, 2013).

NEW BRUNSWICK

Governance and Accountability

In 1992, New Brunswick established eight RHAs. Then, in 2008, the province reorganized and transitioned into two RHAs based more on language than geography: Vitalité Health Network and Horizon Health Network (Province of New Brunswick, n.d.). The RHAs are governed by boards appointed by the Minister of Health (Province of New Brunswick, n.d.). The two RHAs have a broad mandate to manage and deliver health services including hospital, Community Health Centre (CHC) services, Extra-Mural programs, addictions and mental health services and most public health services, yet there is no specific mention of primary care or physician services (beyond that of the community health centres) (Province of New Brunswick, n.d.).

Primary Care Policy

Although 93% of New Brunswickers had a family physician (based on 2011 data), timely access to a physician remains a challenge (Province of New Brunswick Department of Health, 2012). In one study, only 30% of respondents to a survey could get a same-day or next-day appointment with their family physicians, a result which is 15% below the national average (Province of New Brunswick Department of Health, 2012). Since the early 2000s, New Brunswick has made several investments in primary care, including: establishing seven CHCs with physicians and other health professionals; providing interdisciplinary education programs; creating collaborative family physician-NP models; expanding telecare; and introducing primary care paramedics (Province of New Brunswick Department of Health, 2012).

In 2006, the province established a working committee known as the Primary Health Care Steering Committee to provide advice to government on effective models of primary care delivery for the province (Primary Health Care Advisory Committee, 2010). In 2012, a Primary Care Framework was developed and had the following high-level recommendations: 1) integrate primary health services; 2) establish community-specific team-based models of care; 3) implement an accountability framework; and 4) bolster leadership for system transformation (Province of New Brunswick Department of Health, 2012).

The results of a 2014 primary care survey conducted by the New Brunswick Health Council compared to the 2011 survey reveal improvement in physician communication and satisfaction in services. However, accessing after-hours care had not improved. The 2014 survey also revealed considerable variation across New Brunswick communities in indicators of quality for primary care (New Brunswick Health Council, 2015).

The government has been working with the New Brunswick Medical Society (NBMS) to develop a plan to enhance access to team-based care. In 2013, the NBMS released a document titled, “Fixing New Brunswick’s Healthcare System, New Brunswick’s Doctors Have a Plan, Care First”, that made three main recommendations: 1) create primary care teams; 2) implement electronic

patient records; and 3) “end the bureaucratic prohibition on allowing doctors to practice where patients need them” (New Brunswick Medical Society, 2013, p. 3). The document further suggests that it is important for physicians to be members of RHA boards, which is otherwise prohibited by the NBMS.

The Primary Health Care Advisory Committee (2010) reported that NPs play a key role in primary healthcare changes in New Brunswick. As of 2010, there were 51 NPs that were employed by RHAs, including 38 NP-physician collaborative teams (Primary Health Care Advisory Committee, 2010). In 2017, the provincial government cited three key initiatives to improve primary and acute care in the province: 1) implementing a team-based approach to primary care that is led by physicians; 2) developing a model of integrated and coordinated care; and 3) supporting individuals to receive care in appropriate settings (Province of New Brunswick, 2017a).

Primary Care Innovations

The Extra-Mural Program is a province-wide program that was scheduled to launch on January 1, 2018 (Government of New Brunswick, 2017). This program will be delivered by a privately owned organization, Medavie Health Services New Brunswick. The Extra-Mural Program is part of a larger effort by the government to manage primary healthcare needs by integrating the services of Ambulance New Brunswick, the Extra-Mural Program and Tele-Care 811 (Government of New Brunswick, 2017). Usually, upon referral by family physicians, the Extra-Mural Program delivers interdisciplinary home care to patients. The teams include nurses, respiratory therapists, occupational therapists, physiotherapists, social workers, and other health professionals (Primary Health Care Advisory Committee, 2010). In 2016, New Brunswick introduced legislation that allows NPs to refer patients to the Extra-Mural Program and order diagnostic services (Province of New Brunswick, 2016).

In 2017, the Government of New Brunswick announced its partnership with the New Brunswick Medical Society to develop a new primary care model known as **Family Medicine New Brunswick**. In this team-based approach, physicians will roster their own patients and provide services during evenings and weekends. The New Brunswick Medical Society will manage the program (Province of New Brunswick, 2017b).

In the early 2000s, CHCs were established in New Brunswick. CHCs are composed of an interprofessional team that includes: family physicians, nurses, a dietitian, a social worker, and rehabilitative therapists. The key features of CHCs are: 1) team-based care; 2) 24/7 access through a telephone line; 3) management of chronic diseases; 4) health promotion and illness prevention; 5) voluntary participation by providers and patients; 6) monitoring of program performance; and 7) a focus on change management (Primary Health Care Advisory Committee, 2010). There were nine CHCs across the province in 2012 (Mable et al., 2012). In some of the CHCs, physicians are on salary while in others physicians are remunerated via a FFS model (Primary Health Care Advisory Committee, 2010).

NEWFOUNDLAND AND LABRADOR

Governance and Accountability

There are four RHAs in Newfoundland and Labrador: Western Health, Labrador-Grenfell Health, Central Health and Eastern Health. The RHAs are mandated under the *Regional Health Authorities Act* to supervise, direct, and control the delivery of health and community services. These services include health promotion, continuing and long-term care, community health, mental health and addiction services, community supports, hospital care, evaluation and quality assurance, health screening, protective interventions, and road ambulance services. There was no mention of the RHAs mandate to manage primary care or physician services.

Primary Care Policy

In the late 1990s and early 2000s, Newfoundland and Labrador prioritized physician recruitment and retention, especially in rural areas, and had the highest rate of salaried physicians in the country. Despite this effort, Tomblin and Jackson (2009) stated that Newfoundland and Labrador's primary care system lags behind other jurisdictions mainly due to organized medicine's strong opposition to reform in the province (Tomblin & Jackson, 2009).

The province's Department of Health and Community Services' current strategic plan commits to expanding primary care services and interprofessional teams across the province (Department of Health and Community Services of Newfoundland and Labrador, 2017). In 2015, the Department published a document stating a more effective primary care sector is needed to improve population health and reduce inefficiencies (Department of Health and Community Services of Newfoundland and Labrador, 2015).

The Department's framework for primary care calls for patients to be attached to collaborative primary healthcare teams and plans to achieve this goal by: providing a "health home" to every citizen, expanding access to primary healthcare teams, developing strong governance, management, and accountability structures for teams, expanding training for primary healthcare professionals to work in teams, and implementing recruitment and retention initiatives to reduce health professional turnover (Department of Health and Community Services of Newfoundland and Labrador, 2015, p. v). The Department plans to measure the success of primary care expansion based on the following indicators: "established primary healthcare services and interdisciplinary teams; introduced remuneration schemes (e.g., fee codes for physicians) to facilitate cross-discipline collaboration; increased use of Electronic Medical Records; number of patients accessing primary healthcare services at select sites; and reduction of emergency department visits by the same patients at select sites" (Department of Health and Community Services of Newfoundland and Labrador, 2017, p. 10).

Primary Care Innovations

As of 2012, there were three **Community Health Centres (CHCs)** in Newfoundland and Labrador that included interprofessional healthcare teams, NPs, and alternative funding (Mable et al., 2012). As of 2012, Newfoundland and Labrador have **7 Primary Healthcare Team** areas that span across the four RHAs with a plan to expand to 30 Team areas (Dinh, 2012; Mable et al., 2012). There is no rostering of patients and physicians are remunerated through a FFS or salary model (Dinh, 2012). Members of the team include physicians, coordinators, nurses, community health staff, social workers, occupational therapists, pharmacists, physiotherapists, and psychologists (Dinh, 2012).

NOVA SCOTIA

Governance and Accountability

In 2001, the four regional health boards established in 1996 were reshaped into nine district health authorities. In 2015, Nova Scotia established one provincial health authority, known as the Nova Scotia Health Authority and the IWK Health Centre. The single health authority, has no clear mandate to manage primary care or physician services (Department of Health and Wellness of Nova Scotia, n.d.)

Primary Care Policy

Levesque et al. (2012) suggest that Nova Scotia's primary care reforms have been implemented in a consultative and collaborative manner with key stakeholders. However, they also suggest these changes have been incremental and implemented at the local community level, leveraging quality and performance-based programs rather than a larger reform that would entail structural changes at the provincial level. The focus in Nova Scotia has been on developing collaborative primary care practices, alternative payment schemes, population health interventions and an electronic medical record system (Levesque et al., 2012; Mable et al., 2012).

One of Nova Scotia's key objectives has been to support the development of team-based primary care, reduce wait-times and improve chronic disease management and prevention (Wranik et al., 2015). Nova Scotia partnered with other Atlantic provinces with funds from the federal Primary Health Care Transition Fund to implement initiatives such as self-management care programs, telecare, and the Building a Better Tomorrow Initiative (an education program on establishing primary care teams) (Mable et al., 2012). Nova Scotia has a Primary Health Care Information Management Program that supports primary care providers in implementing electronic patient records and health promotion initiatives in team-based care (Mable et al., 2012).

Nova Scotia also has a Nursing Strategy that aims to enhance the role of the nurse in team-based primary care (Mable et al., 2012). The Family Practice Nurse Initiative offers education and support to add a family practice nurse (FPN) to existing primary care clinics (Levesque et al., 2012). The key aims of this program are to integrate FPNs into primary care and to support FPNs to work to their full scope of practice (Levesque et al., 2012).

As a follow-up to the 2003 report, "Primary Health Care Renewal: Action for Nova Scotians", the Nova Scotia Health Authority (NSHA) published a review in April 2017 on "Strengthening the Primary Health Care System in Nova Scotia". The review recommends "health home"—a model based on interprofessional collaborative family practice teams. The vision of this model is based on a population health approach that focuses on wellness and chronic disease management and incorporates team-based care (Nova Scotia Health Authority, 2017).

The proposed health home model includes interprofessional and collaborative family practice teams or networks of providers (Nova Scotia Health Authority, 2017). Team members may

include: “family physicians, NPs, family practice nurses, and other providers such as dietitians, social workers, occupational therapists, physiotherapists, pharmacists, learners, behaviourists, medical office assistants, and/or community mental health providers, and other team members based on the needs of the community” (Nova Scotia Health Authority, 2017, p. 12). The review details the composition of team members for health homes as a ratio relative to 10,000 patients: “4-5 family physicians, 1-2 NPs, 2-3 family practice nurses, 1-2 community adaptive team members (e.g., dietitians, social workers, occupational therapists etc.), a community pharmacist, and other resources aligned to the broader community cluster, including clerical support, leadership/management support, linkages with care coordinators, paramedics, other primary and secondary care resources” (Nova Scotia Health Authority, 2017, p. 13).

In 2017, Doctors Nova Scotia called for new models of care and physician payments to advance primary care reform, which they characterize as lagging behind other jurisdictions. The paper suggests that Nova Scotia should implement a form of patient rostering with physicians compensated through a combination of FFS and capitation (Doctors Nova Scotia, 2017).

Primary Care Innovations

Primary Care Teams (PCTs) is a model of primary care that was in place prior to 2014 (the exact date of inception could not be identified in this review). PCTs aimed to coordinate care for patients by providing team-based interprofessional care in conjunction with community services. PCTs vary in their service offerings and interprofessional team composition, which may include physicians, an NP, midwives, dietitians, counselors, public health nurses, and other health providers (Wranik et al., 2015).

PCTs negotiate funding with their respective District Health Authorities. Annual budgets are based on the geographic patient panel and the disease profile of patients, in addition to the salaries of non-physician providers and administrative staff, and clinic rents (Wranik et al., 2015). PCT patients are not required to be rostered; however, patients are geographically attached to physicians (Wranik et al., 2015).

Physicians working in sparsely populated regions tend to be salaried, and those in more densely populated areas are paid FFS. Salaries and fees are negotiated between the physician union, Doctors Nova Scotia, and the Ministry of Health as set out by the Provincial Master Agreement. Physicians are eligible for additional pay-for-performance incentive programs like the Chronic Disease Management Program and the Complex Care Visit Fee Program. Non-physician providers and staff receive salaried remuneration by the District Health Authority. For a unionized non-physician provider, their respective professional association negotiates their wage rate with the Ministry of Health (Wranik et al., 2015).

PCTs are accountable to the District Health Authorities, which, in turn, are accountable to the Ministry of Health. The District Health Authorities work with the PCTs in strategic planning and the PCTs are responsible for submitting annual reports and expenditure reports. Both salaried

and fee-for-service physicians are accountable to the Ministry of Health's Physicians Services Department (Wranik et al., 2015).

A ministry-inspired model of primary care, the **Collaborative Family Practice Team** is comprised of family physicians, NPs, family practice nurses, and other health professionals. There are approximately 50 collaborative family practice teams (Nova Scotia Health Authority, n.d.). This is a new model of primary care, the details around its organization, funding, and administration are limited.

ONTARIO

Governance and Accountability

In 2007, Ontario established its own unique version of RHAs, known as Local Health Integration Networks (LHINs), as mandated by the *Local Health System Integration Act*, S.O. 2006. In December 2016, Ontario passed *Bill 41, The Patients First Act*, mandating the reorganization of home care services in the province. *Bill 41* also mandated the creation of LHIN sub-regions in the 14 LHINs, which are responsible for health system planning, performance improvement, and service integration. With the passage of *The Patients First Act*, certain models of primary care (Family Health Teams, Community Health Centres, and NP-led clinics) have been explicitly included under the responsibility of the LHINS (Ministry of Health and Long-Term Care of Ontario, 2017).

Primary Care Policy

Unique in Canada, Ontario has implemented a multitude of co-existing primary care organizational models that provide physicians with a variety of choices to work in team-based practices (Levesque et al., 2012). The primary differences between models are around such things as physician remuneration, interdisciplinary team composition, and team priorities (Rauscher, 2015).

Ontario's models of primary care reform include: Community Health Centres (CHCs), Health Service Organizations, Primary Care Networks that merged into Family Health Organizations, Family Health Networks, Family Health Groups, the Comprehensive Model, and Family Health Teams. Additionally, there are community centres that focus on aboriginal health called Aboriginal Health Access Centres (AHAC) and NP-Led clinics (NPLCs) (Levesque et al., 2012).

Due to Ontario's wide-ranging scope of reforms, 75% of the population belong to these primary care reform models, with half of this population receiving care from physicians who are remunerated in a blended-funding model. One-third of this population receives care from physicians who practice as a part of an interdisciplinary team (Levesque et al., 2012). Marchildon and Hutchison (2016) report that approximately 88% of Ontario's physicians are in practices where they receive blended remuneration. The Association of Family Health Teams of Ontario reports that 25-30% of Ontarians have access to team-based primary care delivered through AHACs, CHCs, FHTs, and NPLCs (Association of Family Health Teams of Ontario, 2015). Results of Ontario's primary care reform efforts include decreased use of walk-in clinics, fewer solo physician practitioners, and increased collaborative models of practice (Levesque et al., 2012). Ontario has also focused on expanding the roles of NPs in primary care (Moat et al., 2014).

FHTs and CHCs are both interprofessional team models and are frequently the focus of reform efforts in Ontario. Twenty-one percent of family physicians in Ontario practice in CHCs and FHT models (Rauscher, 2015). There has been conflict between the Ontario Medical Association (OMA) and the Ministry of Health and Long-Term Care (MOHLTC) (Marchildon & Hutchison,

2016). The OMA also opposed the introduction of *Bill 41, The Patient's First Act* (Grant, 2016; Ontario Medical Association, 2016).

In 1996, The Physician Services Committee (PSC) was introduced by the Government of Ontario and the OMA, and is responsible for planning the implementation of new models of primary care. This committee is co-chaired by the OMA and the MOHLTC. While some report that the committee provides a good platform for physician engagement, others have argued that there is a lack of public accountability and transparency, and little participation of non-physician health professionals (Levesque et al., 2012).

Ontario does not have any explicit governance or legal frameworks for primary care. Thus, the agreements between the OMA and the government forms the basis of the primary care policy framework for the province (Moat et al., 2014). The OMA Representation Rights Agreement stipulates the recognition of the OMA as the exclusive bargaining agent of physicians. In addition, the agreement states the parties are to consult and negotiate in good faith on physician compensation and related accountability (Office of the Auditor General of Ontario, 2016).

Recent studies have evaluated the performance of primary care and primary care reform models. In Ontario roughly 36% of physicians are in a capitation-based model (Rudoler et al., 2015). Patients in blended capitation models were healthier and wealthier than patients in FFS and enhanced-FFS models. The models of primary care in Ontario are associated with lower total health costs of patients compared with FFS models (Laberge, Wodchis, Barnsley, & Laporte, 2017). There is unequal access to primary care in Ontario; in northwestern Ontario, 87% of people have access to a primary care provider, while in a region in southern Ontario, 97% have access to a primary care provider (Wilson et al., 2016)

Ontario's Auditor General Report (2016) noted that Ontario physicians are the highest paid in Canada and Ontario remunerates physicians more than other provinces who have similar patient enrollment funding models. One study reports that family physicians are better paid in team models of primary care, in addition to reporting improved work satisfaction (Levesque et al., 2012). Many Ontarians have difficulty accessing after-hours care since 24/7 care is not mandated in primary care reform models (Wilson et al., 2016). In 2015-16, 57% of Ontarians waited two days or more to see a family physician, compared to 51% in 2006-2007 (Office of the Auditor General of Ontario, 2016).

Primary Care Innovations

A reform that stems back to the 1970s, **Community Health Centres (CHCS)** were early proponents of multiprofessional primary care. Approximately 74 CHCs serve 500,000 Ontarians (Association of Ontario Health Centres, n.d.). CHCs are community governed and not-for-profit primary healthcare organizations (Association of Ontario Health Centres, n.d.). CHC teams include physicians, NPs, health promoters, counsellors and other health professionals who are all paid on a salary basis by the LHINs.

Family Health Networks (FHNs) were established in 2001 and have little interprofessional collaboration. FHNs are comprised of five or more family physicians who are remunerated on a blended funding model that is composed of capitation and additional financial incentives (Rauscher, 2015). FHN physicians are responsible for a panel of patients (Rauscher, 2015). As of 2010, 34% of Ontarians were enrolled in FHNs or FHOs (Rauscher, 2015).

Family Health Organizations (FHOs). A study by Kralj & Kantarevic (2013) suggests that physicians in FHOs provide 6-7% fewer services and have fewer visits per day than physicians who work in a FFS model, but are 7-11% more likely to achieve preventative care quality targets than FFS model physicians.

Family Health Groups (FHGs) were introduced in 2003 and are comprised of three or more family physicians who are paid on a fee-for-service basis with bonuses (Rauscher, 2015). FHG physicians are responsible for a panel of patients and include few non-physician health professionals in these practices (Rauscher, 2015).

Family Health Teams (FHTs) were established in 2005 to improve access to primary care, improve quality and continuity of care, increase patient and provider satisfaction and increase the cost-effectiveness of primary care service (The Conference Board of Canada, 2014). As of 2014, there were 185 FHTs in Ontario (The Conference Board of Canada, 2014). Approximately 2 million provincial residents are enrolled in the FHT model and 22% of Ontario's physicians practice in the FHT model (Marchildon & Hutchison, 2016).

The size and composition of the teams vary across FHTs but include a combination of physicians, NPs, other nurses, pharmacists, dietitians, chiropractors/podiatrists, social workers, mental health workers, health educators and occupational therapists (Dinh, 2012). FHTs serve a roster of patients and aim to provide comprehensive, coordinated care (Wilson et al., 2016). Additionally, FHTs provide after-hours access to a nurse via telephone (Rauscher, 2015).

Physicians who practice in FHTs sign contracts with the MOHLTC that stipulate they will provide a broad range of services and agree to a blended funding model that includes a base capitation payment, FFS, bonuses for achieving prevention targets, and special targeted payments in prenatal and intrapartum care, inpatient care, home visits, and palliative care (Rauscher, 2015).

An evaluation of FHTs by the MOHLTC revealed that FHTs improved access to most health services, reduced wait times, improved patient satisfaction, and improved access to a range of wellness and prevention programs (The Conference Board of Canada, 2014).

PRINCE EDWARD ISLAND

Governance and Accountability

Health PEI, Prince Edward Island's single health authority, was established in 2009. Health PEI provides health services in the province under the guidance of The Department of Health and Wellness. The *Health Services Act* specifies that the following health services fall within the responsibility of the Health Authority: public health programs, long-term care facilities, home care services, primary care networks, health centres, and mental health and addictions services (Health PEI, 2017a). Based on the Act, Health PEI has no explicit mandate to manage physician or primary care services.

Primary Care Policy

One of the strategic priorities for Health PEI's 2017-2018 Business Plan is to improve access to primary care services (Health PEI, 2017a). Health PEI's key priorities also include the expansion of primary care delivery to achieve same day/next day access to care, and the implementation of interprofessional health teams (Health PEI, 2017b).

Ninety-five percent of PEI residents have a primary care provider (Health PEI, 2017a). The province implemented a Provincial Patient Registry and recruited health professionals (with an emphasis on NPs) resulting in the matching of 7,400 people to primary care providers over a two-year period (2011-2013) (Health PEI, 2015b). Health PEI reports that wait times to access primary care physicians have improved from 2014-2015 (average of 21.8 days) to 2015-2016 (at or under 7 days).

Primary Care Innovations

There is little publicly available information with respect to primary care models in PEI.

Family Health Centres (FHCs) were established under the Federal Primary Care Transition Fund and have an annual cost of \$6 million (Corpus Sanchez International Consultancy, 2008). Family Health Centre team members include physicians, NPs, nurses, counselors, community workers, social workers, and dieticians (Corpus Sanchez International Consultancy, 2008).

Primary Care Networks (PCNs) include family physicians, NPs, registered nurses, diabetes educators, licensed practical nurses, and clerical staff. There are 12 primary care networks (also referred to as primary health centres) in PEI (Health PEI, 2015a).

QUEBEC

Governance and Accountability

In 1971, the Castonguay-Nepveu Commission recommend that Quebec’s healthcare system be divided into 12 regions, each under a Regional Health and Social Service Council (*Conseils régionaux de la santé et des services sociaux*—CRSSSs). However, the CRSSSs only had the authority to advise the Ministry of Health on the organization and regional planning of services (Martin, Pomey, & Forest, 2006). In the early 1990s, CRSSSs were replaced by Regional Health and Social Services Boards (Régies régionales de la santé et des services sociaux —RRSSS), which had the authority to plan, organize and implement health services (Martin et al., 2006).

In 2003, *Bill 25, Respecting Local Health and Health Service Network Develop Agencies Act*, was introduced and passed resulting in the creation of 95 Local Health and Service Services Networks (*Réseaux locaux de services de santé et de services sociaux*—LSNs), which represented the merger of healthcare organizations in a geographic area. Also, new institutions called Health and Social Service Centres (*Centre de santé et de services sociaux*—CSSS) were formed that had a board of directors responsible for the agreements with health and social services organizations in the LSNs (Martin et al., 2006).

In April 2015, Quebec introduced Bill 10, which centralized all healthcare services and dissolved regional health boards, giving the Ministry of Health and Social Services control of healthcare administration (Gore, 2017). The implications of Bill 10 include the dissolving of about 200 boards, and the cutting of 1,300 full-time jobs, leading to \$220 million savings a year. Quebec’s two medical associations (primary physicians’ union—FMOQ, and specialists’ union—FMSQ) opposed Bill 10 (Vendeville, 2015).

Primary Care Policy

Low physician-to-patient ratios limits the accessibility of primary care in Quebec. The province also experiences challenges with integrating physicians into various publicly administered health structures as a result of having to negotiate with two medical associations (Levesque et al., 2012).

A major reform in primary care was passed in 2015, Bill 20, which the government plans to implement by the end of 2017. It is an omnibus bill that promotes access to primary care. Bill 20 will require primary care practices to adhere to targets that include work hour requirements (at least 12 hours a week) and a minimum number of patients seen (as many as 1,512) (Young, 2015). If these targets are not met, financial penalties may be imposed, including a 30% cut in fees (Gore, 2017).

In 2015, the Canadian Medical Association (CMA) and the Quebec Medical Association (QMA) produced a brief that discussed Bill 20. The brief characterizes Bill 20 it as an “attack on the professional autonomy of physicians” (Quebec Medical Association and the Canadian Medical Association, 2015, p. 3). They offer to work with the government to improve access to care by

implementing electronic patient records, expanding the role of other health professionals in teams, and working towards mixed forms of funding models.

Primary Care Innovations

Family Medicine Groups (FMGs) were introduced in 2000 with the aim of addressing problems with access and quality in Quebec's primary care system (Aubin & Quesnel-Vallée, 2016). FMGs are interprofessional, team-based practices that are required to offer extended hours and implement electronic patient records (Aubin & Quesnel-Vallée, 2016). FMGs have after-hours telephone services that are staffed by physicians 24/7 (Breton, Lévesque, Pineault, & Hogg, 2011). The non-physician providers include nurses, nutritionists, psychosocial experts, physiotherapists, pharmacists and other health professionals (Pomey et al., 2009). The team composition and size of the FMGs vary, but usually have about 10 family physicians, two nurses and two administrative staff that serve approximately 15,000 rostered patients (Breton et al., 2011).

There are 3,784 family physicians who work in the FMG model. Physicians are paid FFS by Quebec's health insurance board, RAMQ (Breton et al., 2011). FMGs have allocated global budgets based on patient enrolment (Aubin & Quesnel-Vallée, 2016). The regional health and social service agency allocates funding annually based on the number of patients enrolled, the salary of administrative staff, the rent of the practice space, and the cost of hiring staff and nurses. FMG physicians agree to contracts with regional health and social service agencies who represent the Ministry of Health and Social Services (Breton et al., 2011). The contracts stipulate the services the FMG will offer, in addition to the hours of service delivery. The average funding envelope is \$270,000 (Breton et al., 2011).

A key component of the agreement was that FMG physicians had to register patients and in effect this was a type of capitation arrangement. Pomey et al. (2009) suggest that this agreement between government and physicians represents a major milestone as it "opened the door to the State asking doctors to adopt specific care practices and take responsibility for the health of their patient population" (Pomey et al., 2009, p. 41).

By 2011, there were 223 FMGs in the province that served over 25% of Quebecers (Breton et al., 2011). The initial plan by the Quebec government was to expand to 300 FMGs but as of 2014, they were not able to reach this target (Forget, 2014). Moreover, the initial target of 1,200-1,500 patients per family physician has also fallen short with an average of only 837 patients per physician. FMG patients experience better continuity of care but accessibility has not improved (Aubin & Quesnel-Vallée, 2016).

Research on the FMG models reveals challenges in the administrative process and difficulty with implementing electronic patient records (Levesque et al., 2012). Forget (2014) noted challenges faced by the FMG model, such as little financial incentive to enroll more patients for established FMG physicians; the role of after-hours coverage is unclear and competes with demands on

family physicians who wish to work in emergency rooms; difficulty with team-based environments; and lack of public understanding of this model.

An alternative model to the FMG that was implemented concurrently was the **Network-Clinic** model (Levesque et al., 2012). The Network-Clinics were a primary care model first established in urban areas, such as Montreal, and Quebec City. Network-Clinics are typically larger than FMGs and are privately owned primary care group practices (Rauscher, 2015). Network-Clinics extend the role of primary care practices as they provide access to 24/7 diagnostic and specialized services (Levesque et al., 2012). As of 2010, there were 29 Network-Clinics in Montreal (Levesque et al., 2012). Physicians are remunerated through the FFS model (Rauscher, 2015).

Centre Local de Services Communautaires (CLSCs) were introduced in the 1970s and are primary health and social service centres that serve a defined geographic population. CLSCs are community governed and interprofessional (Coyle, 2012). The government intended that CLSCs become the dominant model of care in Quebec (Hutchison et al., 2011). The implementation of CLSCs received strong opposition from Quebec's medical associations, as they opposed the salaried model (Breton et al., 2011). As of 2014, 15.7% of family physicians practice in the CLSCs.

SASKATCHEWAN

Governance and Accountability

Saskatchewan was the first province in Canada to introduce universal hospital coverage (1947) and universal medical care coverage (1962) after a 32-day doctors' strike. Following the strike, the governance and accountability relationship established between the Government of Saskatchewan and the doctors working in the province became the template for the rest of Canada, including the status of doctors as independent contractors working for FFS and periodic bilateral bargaining between provincial medical associations and provincial governments (Marchildon 2016).

This basic arrangement was not changed despite the division of the province into 32 health districts in 1992 and the consolidation of these districts into 12 health regions plus the Athabasca Health Authority ten years later. In 2017, a single provincial health authority—the Saskatchewan Health Authority (SHA) —was created (Liebenberg, 2017). While the *Provincial Health Authority Act* notes that the provincial health authority is responsible for health services, there is no mention of primary care. In addition, the new Act does not create a new accountability relationship between physicians and the SHA.

Primary Care Policy

Primary care in Saskatchewan has developed in a highly incremental manner (Abrametz, Bragg, & Kendel, 2016). In 2001, Saskatchewan's Action Plan for Health Care introduced an alternate physician remuneration model, but the majority of primary care physicians are still paid through FFS (Suter et al., 2014). During the 2000s, RHAs invested in primary care through new leadership positions that oversaw the expansion of a new program for diabetes, HealthLine 811, and the introduction of NPs, midwives, and pharmacists into primary care teams (Abrametz et al., 2016). Saskatchewan's Health Plan from 2012 and 2013 noted that indicators such as access and patient attachment to primary care teams would be monitored (Suter et al., 2014).

The Saskatchewan Primary Health Care Framework (2012) proposed that every person in Saskatchewan have access to a primary care team (Abrametz et al., 2016). The Framework specified the establishment of innovation sites and collaborative emergency centres that extend access to primary healthcare, and urgent and emergency services, however little is defined in terms of the core functions of the primary care teams or whether family physicians are expected to lead the teams (Suter et al., 2014).

In 2016, the report of the Saskatchewan Advisory Panel on Health System Structure stated that primary care is foundational to good patient care (Abrametz et al., 2016). The report presented a vision of high performing primary care in the province that includes: “1) patient-and family-centred care that involves patients in their care plan with tools that support self-management; 2) an engaged leadership with a defined quality improvement strategy; 3) patients having a regular care provider within a team-based care environment which supports coordinated,

continuous, seamless and comprehensive service; 4) providers utilizing an electronic medical record to ensure patient information is available to all team members; 5) appropriate and effective care using best practices coupled with health promotion; 6) the optimal use of resources, with team members working to the top of their scope of practice to ensure efficiency; and 7) enhanced access, such as extended hours, convenient service location and reduced wait times” (Abrametz et al., 2016, p. 18).

The report characterized primary care teams as comprised of: “various health professionals such as NPs, dieticians, pharmacists, social workers, paramedics, etc.” (Abrametz et al., 2016, p. 18). The report also recommended the full implementation of the Primary Health Care Framework (2012), including the implementation of team-based primary care (Abrametz et al., 2016).

Primary Care Innovations

As of 2016, Saskatchewan has established **20 primary care innovation “demonstration” sites** with alternative models of primary care delivery and interprofessional teams serving as sites for policy experimentation and learning (Abrametz et al., 2016; Suter et al., 2014). These sites piloted different primary care models that included extended hours clinics, collaborative emergency centres, and novel approaches to clinic management (Abrametz et al., 2016). There was no indication of any rigorous and independent evaluation of the results from these 20 innovation sites.

NORTHWEST TERRITORIES

Governance and Accountability

In August 2016, Northwest Territories' six health and social services authorities consolidated to become three entities including the the Northwest Territories Health and Social Services Authority (Government of Northwest Territories, 2017a) the T'licho community services agency, and the Hay River Health Authority. The T'licho community services agency and the Hay River Health Authority currently delegate the organization of primary care services to the Territorial Health Authority. Twelve Regional Wellness Councils will advise the new single health authority (Government of Northwest Territories, 2017b). Although the *Hospital Insurance and Health and Social Services Administration Act* does not overtly discuss the Northwest Territories Health and Social Services Authority (NTHSSA) mandate to manage physician or primary care services, the NTHSSA is directly responsible for the hiring and deployment of all primary care physicians and nurses in the NWT. Moreover, all physicians are salaried employees of the NTHSSA, a unique situation relative to all health authorities in Canada (although Nunavut's Department of Health plays a similar role to the NTHSSA in relation to physicians working in that territory).

Primary Care Policy

At the community-level, informal primary care teams are composed of nurses, mental health workers and community social workers who are supported by regional teams in regional centres (Mable et al., 2012). Community Health Centres provide 24/7 access to care in eight communities in the Northwest Territories (Mable et al., 2012).

There are 48 NPs who work in the Northwest Territories (Canadian Nurses Association, 2016). The majority of NPs are salaried and work for the government (Canadian Nurses Association, 2016). NPs and advanced practice nurses are the main primary care providers in most of the Northwest Territories (Mable et al., 2012). Family physicians work in Northwest Territories' hospitals and also provide obstetrics (Mable et al., 2012).

Primary Care Innovations

Although the NTHSSA's 2017-2020 Strategic Plan goals include the integrated and coordinated delivery of primary care services, it does not prescribe the strategies or models of care delivery that will be used to reform or improve primary care (Government of Northwest Territories, 2017a). There are, however, some individual examples of innovation in primary care.

The College of Family Physicians of Canada identifies the **Yellowknife Primary Health Care Clinic** service as a successful example of a "Patient's Medical Home" initiative. The Patient's Medical Home is "a family practice defined by its patients as the place they feel most comfortable—most at home—to present and discuss their personal and family health and medical concerns" (The College of Family Physicians of Canada, 2017, p. 8).

Home to half of the Northwest Territories' population, the capital of Yellowknife is the site for the Yellowknife Primary Health Care Clinic. Launched in 2012, two clinics consolidated into a single clinic and the Patient's Medical Home model was the guiding framework for its planning and implementation. A single electronic medical record was established along with the implementation of team-based interprofessional care, and the rostering of patients. The College of Family of Physicians of Canada (2017) reports that evaluations, using the Primary Care Home scoring tool, demonstrate improvements in care at the Yellowknife Clinic after its implementation (2017).

Yellowknife physicians use technology to serve remote communities. Care providers are supported by a single electronic medical record, an extensive system that was projected to serve 80% of Northwest Territories' residents by the end of 2016 (The College of Family Physicians of Canada, 2017).

NUNAVUT

Governance and Accountability

Nunavut has not undergone regionalization in health care administration and delivery. Nunavut's Department of Health is responsible for the management and delivery of health services in the territory (Department of Health of Nunavut, 2016). Four regional offices—Qikiqtaaluk, Kivalliq, Kitkmeot, Iqaluit—report to the Department (Department of Health of Nunavut, 2016). Under the *Nursing Profession Act* nurses are a self-regulated profession, where the Nunavut government provides the Registered Nurses Association of the Northwest Territories and Nunavut regulatory authority. While there is no specific mention of physician care or primary care in the *Hospital Insurance and Health and Social Services Administration Act*, the territorial government directly regulates and contracts with physicians. The community and regional health centres that provide the core of primary care services are under the direct management and control of Nunavut's Department of Health. Almost all primary care is nurse-led through community-based health centres.

Primary Care Policy

Nunavut faces challenges in delivering health services due to the size of the territory, extreme cold temperatures in winter, and the wide dispersion of its small population among many communities, which in turn necessitates a reliance on medical air transportation for secondary and tertiary care (Office of the Auditor General of Canada, 2017). The Department of Health recruits and hires physicians and nurses. Most nurses and all physicians originate from outside of Nunavut (Office of the Auditor General of Canada, 2017).

A 2017 Auditor General of Canada Report on Health Care Services in Nunavut found “the Department of Health did not adequately manage and support its health care personnel to deliver services in local and regional health centres in Nunavut” (Office of the Auditor General of Canada, 2017, line 126). The Report highlighted the following issues: health professionals were not trained and orientated consistently; quality assurance processes were seldom implemented; safety risks were poorly managed; and the recruitment of permanent nurses and other health professionals was ineffective. The Department of Health's 2016 -2017 Annual report notes that their Operations Division is developing a Quality Improvement Framework, implementation plan, and resource kit for the community health and public health nursing programs (Department of Health of Nunavut, 2016).

Primary Care Innovations

Community Health Centres (CHCs) provide most of the primary care services in Nunavut (Marchildon & Torgerson, 2013). CHCs are led by nurses and staffed by community health nurses who are employed by the Department of Health and Social Services (Marchildon & Torgerson, 2013; Office of the Auditor General of Canada, 2017). Physicians periodically visit the health centres or provide support remotely (Office of the Auditor General of Canada, 2017). As of March

2016, there were 69 community health nurses who provided primary and very basic emergency care to Nunavut's 24 remote communities. Community health nurses provide primary care, including pre- and postnatal care and they have an expanded scope of practice with functions delegated to them by a physician (e.g., suturing wounds, dispensing medications, performing X-rays, casting fractures) (Office of the Auditor General of Canada, 2017).

In Iqaluit, nurse practitioners at the Family Practice Clinic and GPs at the small Qikiqtani General Hospital provide primary care (Marchildon and Torgerson 2013). Outside of Iqaluit, there is no need for rostering. Community residents use their local CHCs as there is no other viable option, given the enormous distances separating communities and the lack of any road network connecting the communities. In such an environment, continuity of primary care and accountability between providers and users occurs without a formal system of rostering. 24/7 care is provided by community health nurses (CHNs) who remain on call after regular clinic hours. The mornings are reserved for clinical walk-ins while time in the afternoon is set aside for wellness clinics. Although the government set a goal of establishing electronic health records for all of its residents by 2012 (Marchildon and Torgerson 2013), this review was unable to determine progress on that goal.

YUKON

Governance and Accountability

Health care services in Yukon Territory have not undergone regionalization. The Yukon Department of Health and Social Services is responsible for the health and social services program in the jurisdiction.

Primary Care Policy

Yukon faces a number of health care challenges: including some Yukoners live in small, remote communities, an aging population, and increasing incidences of chronic diseases (Office of the Auditor General of Canada, 2011). Also, Indigenous people, who make up 25 percent of Yukon's population, experience significant health disparities compared with the rest of Canada (Office of the Auditor General of Canada, 2011).

A 2011 report by the Auditor General of Canada found the Yukon Department of Health and Social Services' planning on setting targets for health outcomes and developing key indicators is in its early stages (Office of the Auditor General of Canada, 2011). Other issues include an absence of a health information system to collect health data, and weak program monitoring and evaluation (Office of the Auditor General of Canada, 2011).

As set out by the territory's 2014-2018 strategic plan, one of the goals is to deliver integrated, quality services for all Yukon residents (Ministry of Health and Social Services of the Yukon, 2014). To achieve these goals, the Government of Yukon intends to integrate NPs in the health system (they have been allowed to practice since 2012) and increase the use of telehealth (Ministry of Health and Social Services of the Yukon, 2014; Government of Yukon, 2012).

Primary Care Innovations

As in Nunavut and the Northwest Territories, CHCs staffed by community health nurses (CHNs) are the main vehicle for delivering primary care in smaller communities (Ministry of Health and Social Services of the Yukon, 2014). There are 12 CHCs staffed by one or more primary health care nurses (Government of Yukon, n.d.). CHCs provide medical treatment, community health programs and 24/7 emergency services (Government of Yukon, n.d.). Physician visits to the CHCs are relatively infrequent (Health Intelligence Inc. and Associates, 2014).

However, some of the purported challenges facing CHC staff include: the time CHNs spend on non-nursing functions, the lack of electronic medical records, the absence of team-based care, the delayed introduction of NPs (Health Intelligence Inc. and Associates, 2014). Challenges related to service delivery in CHCs include: poor mental health and addiction resources, acute care needs at the community level, limited home and palliative care, and limited physician care, dental services, physiotherapy and occupational therapy (Health Intelligence Inc. and Associates, 2014).

The Referred Care Clinic is a model of primary care that targets populations with complex needs and provides them with access to mental health services, physician care, and an outreach worker (Ministry of Health and Social Services of the Yukon, 2014). The Department of Health and Social Services plans to incorporate nurse practitioners into this model of care (Ministry of Health and Social Services of the Yukon, 2014). There appears to be one referred care clinic at Whitehorse General Hospital (Government of Yukon, 2013). Given the dearth of information on this model of care, including the rostering of patients, the funding framework and the use of electronic health records, it is difficult to make any judgment on this particular innovation.

Appendix B: Core Features of Primary Care Models Across Canada

Province/Territory	Primary care model (year established)	Number and reach (where applicable)	Staff composition	Remuneration and funding	Governance features
Alberta	Primary Care Networks, PCN (2003)	42 serving 3.6 million of 4 million Albertans	80% of primary care physicians in this model; 3,800 physicians and 1,000 full-time-equivalent non-physician health professions	Base remuneration (Fee-for-service or capitation) and additional payments for after-hours coverage and other activities.	PCNs are independent and not-for-profit. Physicians are shareholders (governed by PCN Board of Directors) or contractors of services (entity of Alberta Health Services)
British Columbia	Divisions of Family Practice (n.d.)	35 local networks of family physicians for over 230 communities	Physicians	Funded by provincial government and Doctors of BC. Yielded increase in physician earnings by 11.8%	Each division led by an executive director and a physician lead. Division allows family physicians to work together in decision-making in partnership with RHAs.
Manitoba	Physician Integrated Network, PIN (2006)	13	Family physicians	Blended funding and quality-based incentives (based on various performance indicators) Also population-level bonus payments. No designated baseline funding. Clinic receives funding, not family physician directly.	PIN clinics are owned by physician shareholders who have discretion to administer program.
	Primary Care Networks, PCNs (2014)	14	PCN team may include physicians, NPs, physician assistants, exercise specialists, pharmacists, mental health workers, social works, and spiritual care providers	Fee-for service, alternative funding, and blended funding. PCNs may collaborate with other fee-for-service physicians in the network's area	PCN is governed by a steering committee comprised of members from the RHA, primary care providers and community organizations that reflect the stakeholders in the area

	My Health Teams, MyHT (n.d.)		Composition varies: physicians, nurses, nurse practitioners, community developers, exercise specialists, physiotherapists, or occupational therapists who work together in a broad virtual network	Salaried physicians and non-physician providers.	Not-for-profit organizations that are governed by the providers under the MyHT Agreement. MyHT and RHA tasked with service planning and deciding on team's composition, but all decisions subject to RHA approval
	Advanced Access Model (2007)	At inception, plan was to spread this to 75% of all primary health clinics in Manitoba by 2015			Primary healthcare clinics in this model enroll in a 12-month improvement program that includes training on change management
New Brunswick	Extra-Mural Program (2018)		Teams include nurses, respiratory therapists, occupational therapists, physiotherapists, social works and other health professionals		Program will be delivered by a privately owned organization, Medavie Health Services New Brunswick
	Family Medicine New Brunswick (2017)		Team-based approach		Managed by New Brunswick Medical Society
	Community Health Centres, CHCs (~early 2000s)	9 CHCs across the province as of 2012	Interprofessional team: a family physician, nurses, a dietitian, a social worker and rehabilitative therapists	Salary or fee-for-service	
Newfound land-Labrador	Community Health Centres, CHCs (n.d.)	3 CHCs as of 2012	Interprofessional healthcare teams, including physicians and NPs	Alternative funding	
	Primary Healthcare Team, PHT, areas (n.d.)	7 PHT areas that span the four RHAs as of 2012.	Physicians, coordinators, nurses, community health staff, social workers, occupational therapists, pharmacists, physiotherapists and psychologists	Fee-for-service or salary	Regional health authorities are key drivers of PHTs.

Nova Scotia	Primary Care Teams, PCTs (n.d.)		Team-based interprofessional care, which could include physicians, a nurse practitioner, midwives, dietitians, counselors, public health nurses, and other health providers	<p>PCTs negotiate funding with their respective District Health Authorities.</p> <p>Funding models based on location of physician's practice (sparse regions involve salary compensation, while dense regions involve fee-for-service).</p> <p>Salaries and fees are negotiated between the union that represents physicians, Doctors Nova Scotia and the Ministry of Health as set-out by the Provincial Master Agreement.</p> <p>Physicians are eligible for additional pay-for-performance incentive programs.</p> <p>Non-physician staff receive salaried remuneration by District Health Authority.</p>	
	Collaborative Family Practice Team (n.d.)	Roughly 50 teams with at least three primary healthcare providers from two or more professional disciplines	Family physicians, NPs, family practice nurses, and other health professionals		
Ontario	Community Health Centres, CHCS (1980)	74 CHCs that serve 500,000 Ontarians	Physicians, NPs, health promoters, counsellors, and other health professions	Salary basis by LHIN.	Community-governed and not-for-profit
	Family Health Networks, FHNs (2001)	34% of Ontarians as of 2010	5 or more family physicians	Blended funding model composed of capitation and additional financial incentives	
	Family Health Organizations, FHOs (n.d.)				
	Family Health Groups, FHGs (2003)		3 or more family physicians	Fee-for-service with bonuses	

	Family Health Teams, FHTs (2005)	32% of Ontarians enrolled in fee-for-service based FHT, and 16% in a capitation based FHT as of 2010. 185 FHTs as of 2014.	Physicians (varies, but usually at least 7) and non-family physician professionals (NPs, other nurses, pharmacists, dieticians, chiropodists/podiatrists, social workers, mental health workers, health educators and occupational therapists. Services are targeted toward community they serve.	Fee-for-service or capitation. Bonuses for achieving prevention targets and special target payments for prenatal and intrapartum care, inpatient care, home visits, and palliative care.	Physicians who practice in FHTs sign contracts with MOHLTC that stipulate they will provide a broad range of services and agree to blended funding model.
Quebec	Family Medicine Groups, FMGs (2000)	15,000 rostered patients per FMG. 3,785 family physicians in FMG model. 223 FMGs as of 2011, serving over 25% of Quebecers.	Physicians (~10) and non-physicians (varies, but could include nurses (~2), nutritionists, psychosocial experts, physiotherapists, pharmacists and other health professionals, and administrative staff (~2)	Physicians paid fee-for-service by RAMQ. FMGs are allocated global budgets based on patient enrolment. Regional health and social service agency allocates funding annually based on number of patients enrolled, the salary of administrative staff, the rent of the practice space, and the cost of hiring staff and nurses.	FMG physicians agree to contracts with regional health and social service agencies who represent the Ministry of Health and Social Services.
	Network Clinic (n.d.)	Primarily urban settings (e.g. Montreal). 29 as of 2010.	Primary care physicians	Fee-for-service	Privately owned primary care group practices
	Centre Local de Services Communautaires, CLSCs (~1970s)	15.7% of family physicians practice in CLSCs	Interprofessional teams	Salaried	Community governed
Saskatchewan	Primary Care Innovation 'Demonstration Sites' (2016)	20 as of 2016	Interprofessional teams		

Appendix C: Provincial/Territorial Health Authorities and Regional Health Authorities Acts by Jurisdiction

P/T	Law/regulation	Roles and Responsibilities of the Regional Health Authority
Alberta	<i>Alberta Health Act</i> , S.A. 2010, c. A-19.5	<p>Roles and responsibilities</p> <p>7(1) Subject to and in accordance with applicable enactments, regional health authorities established under the Regional Health Authorities Act are responsible for delivering health services.</p> <p>(2) Subject to and in accordance with applicable enactments, provincial health boards established under the Regional Health Authorities Act are responsible for carrying out their duties and functions in accordance with the enactment that established them.</p> <p>(3) Subject to and in accordance with applicable enactments, professional colleges are responsible for regulating the activities of their members.</p> <p>(4) Subject to the regulations, in addition to the Minister's other responsibilities in the health system, the Minister may clarify and co-ordinate the roles and responsibilities of persons referred to in subsections (1) to (3).</p>
British Columbia	<i>Health Authorities Act</i> , R.S.B.C. 1996., c. 180	<p>5 (1) The purposes of a board are as follows:</p> <p>(a) to develop and implement a regional health plan that includes</p> <ul style="list-style-type: none"> (i) the health services provided in the region, or in a part of the region, (ii) the type, size and location of facilities in the region, (iii) the programs for the delivery of health services provided in the region, (iv) the human resource requirements under the regional health plan, and (v) the making of reports to the minister on the activities of the board in carrying out its purposes; <p>(b) to develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan;</p> <p>(c) to administer and allocate grants made by the government for the provision of health services in the region;</p> <p>(d) to deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies;</p> <p>(e) [Repealed 2002-61-4.]</p> <p>(f) to develop and implement regional standards for the delivery of health services in the region;</p> <p>(g) to monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region;</p>

		<p>(h) to collaborate, to the extent practicable, with British Columbia Emergency Health Services, the Provincial Health Services Authority and societies that report to the Provincial Health Services Authority, facilities and other health institutions and agencies, municipalities and other organizations and persons in the planning and coordination of</p> <p>(i) the provision, in British Columbia, of provincially, regionally and locally integrated ambulance services, emergency health services, urgent health services and ancillary health services, as those terms are defined in the <i>Emergency Health Services Act</i>, and</p> <p>(ii) the recruitment and training of emergency medical assistants, within the meaning of the <i>Emergency Health Services Act</i>, and other persons to provide the services referred to in subparagraph (i).</p> <p>(2) In carrying out its purposes, a board must give due regard to the Provincial standards and specified services.</p>
<p>Manitoba</p>	<p><i>The Regional Health Authorities Act</i>, C.C.S.M. 1996, c. R34</p>	<p>Responsibilities of regional health authority</p> <p>23(1) A regional health authority is responsible for providing for the delivery of and administering health services to meet the health needs in its health region in accordance with this Act and the regulations.</p> <p>Duties of regional health authority</p> <p>23(2) In carrying out its responsibilities, a regional health authority shall</p> <p>(a) promote and protect the health of the population of the health region and develop and implement measures for the prevention of disease and injury;</p> <p>(b) assess health needs in the health region on an ongoing basis, and publish reports about the assessments on the authority's website as required by the minister;</p> <p>(c) develop objectives and priorities for the provision of health services which meet the health needs in the health region and which are consistent with provincial objectives and priorities;</p> <p>(c.1) prepare, implement and publish on authority's website a regional strategic plan that</p> <p>(i) includes the vision, mission and strategic priorities for the health region, and</p> <p>(ii) incorporates</p> <p>(A) the health needs in the health region as assessed under clause (b), and</p> <p>(B) the objectives and priorities developed under clause (c);</p> <p>(c.2) review and revise its regional strategic plan at least once every five years, and more frequently if required by the minister;</p> <p>d) prepare and implement a regional health plan in accordance with section 24;</p> <p>(e) review and revise the regional health plan at least once a year, and more frequently if required by the minister;</p>

		<p>(f) manage and allocate resources, including, but not limited to, funds provided by the government for health services, in accordance with this Act, the regulations, and the regional health plan;</p> <p>(g) in providing for the delivery of health services,</p> <ul style="list-style-type: none"> (i) ensure that the prescribed health services are provided or made available, (ii) comply with, and ensure compliance with, prescribed standards, and (iii) ensure that there is reasonable access to health services; <p>(h) ensure that health services are provided in a manner which is responsive to the needs of individuals and communities in the health region and which coordinates and integrates health services and facilities;</p> <p>(i) cooperate with other persons, including but not limited to government departments and agencies, to coordinate health services and facilities in the province and to achieve provincial objectives and priorities;</p> <p>(j) comply with any directions given by the minister; and</p> <p>(k) monitor and evaluate the delivery of health services and compliance with prescribed standards and provincial objectives and priorities, in accordance with guidelines provided or prescribed by the minister.</p>
<p>New Brunswick</p>	<p>Regional Health Authorities Act, 2011, c.217</p>	<p>Powers, duties and responsibilities of regional health authorities</p> <p>Responsibilities of regional health authority</p> <p>29(1) A regional health authority shall provide for the delivery of health services in and shall administer health services in the region for which it is established.</p> <p>29(2) Despite subsection (1), a regional health authority may deliver health services in another region if it is authorized to do so under its regional health and business plan.</p> <p>2002, c.R-5.05, s.29</p> <p>Determination of health needs</p> <p>30 A regional health authority shall</p> <ul style="list-style-type: none"> (a) determine the health needs of the population that it serves, (b) determine the priorities in the provision of health services for the population it serves, and (c) allocate resources according to the regional health and business plan. <p>2002, c.R-5.05, s.30</p> <p>Provision of health services</p> <p>31 A regional health authority may provide health services only if</p> <ul style="list-style-type: none"> (a) there is a need for health services, (b) the services are included in a plan approved by the Minister, (c) the services are consistent with the provincial health plan, and

		(d) sufficient resources are available. 2002, c.R-5.05, s.31
Newfoundland and Labrador	<i>Regional Health Authorities Act, S.N.L., 2006, c. R-7-1.</i>	<p>Responsibility of authority</p> <p>16. (1) An authority is responsible for the delivery and administration of health and community services in its health region in accordance with this Act and the regulations.</p> <p>(2) Notwithstanding subsection (1), an authority may provide health and community services designated by the minister on an inter-regional or province-wide basis where authorized to do so by the minister under section 4.</p> <p>(3) In carrying out its responsibilities, an authority shall</p> <ul style="list-style-type: none"> (a) promote and protect the health and well-being of its region and develop and implement measures for the prevention of disease and injury and the advancement of health and well-being; (b) assess health and community services needs in its region on an ongoing basis; (c) develop objectives and priorities for the provision of health and community services which meet the needs of its region and which are consistent with provincial objectives and priorities; (d) manage and allocate resources, including funds provided by the government for health and community services, in accordance with this Act; (e) ensure that services are provided in a manner that coordinates and integrates health and community services; (f) collaborate with other persons and organizations, including federal, provincial and municipal governments and agencies and other regional health authorities, to coordinate health and community services in the province and to achieve provincial objectives and priorities; (g) collect and analyze health and community services information for use in the development and implementation of health and community services policies and programs for its region; (h) provide information to the residents of the region respecting <ul style="list-style-type: none"> (i) the services provided by the authority, (ii) how they may gain access to those services, and (iii) how they may communicate with the authority respecting the provision of those services by the authority; (i) monitor and evaluate the delivery of health and community services and compliance with prescribed standards and provincial objectives and in accordance with guidelines that the minister may establish for the authority under paragraph 5 (1)(b); and (j) comply with directions the minister may give. <p>Authority's powers</p>

		<p>17. (1) An authority may</p> <ul style="list-style-type: none"> (a) purchase, lease or otherwise acquire personal property; (b) sell, lease or otherwise dispose of personal property; (c) accept grants, gifts, bequests and donations of real and personal property and, where the grant, gift, bequest or donation is made subject to directions or conditions, the authority shall, unless the person from whom it is received consents otherwise, comply with and give effect to the directions or conditions; (d) unless prohibited by the regulations, charge fees for health and community services directly to the person who received the services; (e) conduct research, provide education and training, and engage or collaborate with persons or other organizations in the conduct of research or the provision of education and training, in the field of health and community services; (f) establish, and apply to register, charitable foundations, as that term is defined in the <i>Income Tax Act</i> (Canada); and (g) exercise the other powers that are necessary to carry out its duties and responsibilities and exercise its powers under this Act. <p>(2) Subject to the approval of the minister, an authority may</p> <ul style="list-style-type: none"> (a) purchase, lease or otherwise acquire real property, or an interest in real property, that it considers necessary for its purposes; (b) construct, renovate, expand, convert or relocate buildings or structures; and (c) sell, lease or otherwise dispose of real property or an interest in real property where the real property is no longer required for its purposes. <p>(3) An authority may borrow money</p> <ul style="list-style-type: none"> (a) for the purpose of carrying out its day to day operations; and (b) for the purpose of acquiring real property for the use of the authority, or for the purpose of erecting, repairing, adding to, furnishing or equipping a building for the use of the authority. <p>(4) An authority may enter into agreements with other organizations respecting the provision of health and community services by or through or in cooperation with those organizations.</p>
<p>Northwest Territories</p>	<p><i>Hospital Insurance and Health and Social Services Administration</i></p>	<p>5.1.</p> <p>(1) The Territorial authority shall, subject to this Act and regulations, orders, directives and other instruments made under this Act,</p> <ul style="list-style-type: none"> (a) deliver, provide for the delivery of, or coordinate the delivery of <ul style="list-style-type: none"> (i) types of health services and social services approved under paragraph 2.1(1)(c), and

	<p>Act, 1988, R.S.N.W.T., c. T-3.</p>	<p>(ii) health and wellness promotional activities;(b) manage, control and operate each facility, health service and social service for which the Territorial authority is responsible; (c) manage the financial, human and other resources necessary to perform its duties; and (d) perform any other activities assigned to the Territorial authority by the Minister.</p> <p>(2) Subject to this Act, the <i>Financial Administration Act</i> and regulations, orders, directives and other instruments made under these Acts, the Territorial authority may exercise any powers that are necessary and incidental to its duties under subsection (1).</p> <p>(3) For greater certainty, powers, duties and functions in respect of the management, control or operation of social services facilities established or provided for under an enactment, and social services established or provided for under an enactment, may be delegated or assigned to the Territorial authority. S.N.W.T. 2015,c.14,s.2.</p>
<p>Nova Scotia</p>	<p><i>Health Authorities Act, 2014, S.N.S., c. 32</i></p>	<p>19 (1) A health authority shall (a) subject to any determination by the Minister under clause 9(a), determine priorities in the provision of health services by the health authority and allocate resources accordingly; (b) recommend to the Minister which health services should be made available by the health authority; (c) consult with the Minister and implement the provincial health plan; (d) prepare and submit to the Minister a health-services business plan for each fiscal year; (e) implement the health-services business plan for the health authority; (f) assist the Minister in the development of and implementation of health policies and standards, health-information systems, human-resource plans for the health system and other Provincial health-system initiatives; (g) meet any standards established by the Minister respecting the quality of health services provided by the health authority; (h) comply with any directions, policies or guidelines issued or established by the Minister in respect of the health services provided by the health authority and the administration of such health services; (i) provide to the Minister such information, including personal information and personal health information, as is required by the Minister for the purposes of monitoring and evaluating the quality, efficiency, accessibility and comprehensiveness of health services, and health-system planning;</p>

		<p>(j) report on health-system performance as required by the Minister; (k) develop and implement health-system improvement plans as required by the Minister; (l) operate in accordance with any accountability framework established by the Minister; (m) assess the health needs of the residents of the Province and create community profiles according to the requirements established by the Minister; (n) provide to the Minister any other reports as required by the Minister; and (o) carry out such additional responsibilities as the Minister may assign or as are prescribed by the regulations.</p>
<p>Ontario</p>	<p><i>Local Health System Integration Act, S.O. 2006, c.4.</i></p>	<p><i>Objects</i> <i>5 The objects of a local health integration network are to plan, fund and integrate the local health system to achieve the purpose of this Act, including,</i></p> <ul style="list-style-type: none"> (a) to promote the integration of the local health system to provide appropriate, co-ordinated, effective and efficient health services; (b) to identify and plan for the health service needs of the local health system, including needs regarding physician resources, in accordance with provincial plans and priorities and to make recommendations to the Minister about that system, including capital funding needs for it; (c) to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation; (d) to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services that they receive; (e) to evaluate, monitor and report on and be accountable to the Minister for the performance of the local health system and its health services, including access to services and the utilization, co-ordination, integration and cost-effectiveness of services; (e.1) to promote health equity, including equitable health outcomes, to reduce or eliminate health disparities and inequities, to recognize the impact of social determinants of health, and to respect the diversity of communities and the requirements of the <i>French Language Services Act</i> in the planning, design, delivery and evaluation of services; (e.2) to participate in the development and implementation of health promotion strategies in cooperation with primary health care services, public health services and community-based services to support population health improvement and outcomes;

		<ul style="list-style-type: none"> (f) to participate and co-operate in the development by the Minister of the provincial strategic plan and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services; (g) to develop strategies and to co-operate with health service providers, including academic health science centres, other local health integration networks, providers of provincial services and others to improve the integration of the provincial and local health systems and the co-ordination of health services; (h) to undertake and participate in joint strategies with other local health integration networks to improve patient care and access to high quality health services and to enhance continuity of health care across local health systems and across the province; (i) to disseminate information on best practices and to promote knowledge transfer among local health integration networks and health service providers; (j) to bring economic efficiencies to the delivery of health services and to make the health system more sustainable; (k) to allocate and provide funding to health service providers, in accordance with provincial priorities, so that they can provide health services and equipment; (l) to enter into agreements to establish performance standards and to ensure the achievement of performance standards by health service providers that receive funding from the network; (m) to ensure the effective and efficient management of the human, material and financial resources of the network and to account to the Minister for the use of the resources; (m.1) to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons; (m.2) to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the <i>Home Care and Community Services Act, 1994</i>; (m.3) to provide information to the public about, and make referrals to, health and social services; (m.4) to fund non-health services that are related to health services that are funded by the Minister or a local health integration network; and (n) to carry out the other objects that the Minister specifies by regulation made under this Act. 2006, c. 4, s. 5; 2016, c. 30, s. 4.
<p>Prince Edward Island</p>	<p><i>Health Services Act, 2015, c. H-1.6</i></p>	<p>12. Functions (1) Health PEI shall (a) provide, or provide for the delivery of, health services in accordance with the provincial health</p>

		<p>plan; (b) operate and manage health facilities in accordance with the provincial health plan; (c) manage the financial, personnel and other resources necessary to provide the health services and operate the health facilities required by the provincial health plan; and (d) perform such other functions as the Minister may direct.</p> <p>Duties (2) Health PEI is accountable to the Minister in respect of the performance of its functions under this Act and shall</p> <p>(a) meet any standards established by the Minister respecting the quality of health services provided by Health PEI; (b) comply with any directions, policies and guidelines issued or established by the Minister with respect to the health services provided by Health PEI; (c) operate in accordance with any accountability framework established by the Minister; (d) operate in accordance with its approved business plan and approved strategic plan; and (e) operate within its approved budget. 2009,c.7,s.12.</p>
<p>Quebec</p>	<p><i>Act Respecting Health and Social Services, 1991, c. S-4.2</i></p>	<p>CHAPTER I.1 LOCAL HEALTH AND SOCIAL SERVICES NETWORK AND LOCAL AUTHORITY 2005, c. 32, s. 48.</p> <p>99.2. For the purposes of this Act, “local health and social services network” means a network set up in accordance with an order of the Government made under the Act respecting local health and social services network development agencies (chapter A-8.1) and a new network set up in accordance with an order made under section 347. 2005, c. 32, s. 48.</p> <p>99.3. The purpose of establishing a local health and social services network is to foster a greater sense of responsibility among all the health and social service providers in the network to ensure that the people in the network’s territory have continuous access to a broad range of general, specialized and superspecialized health services and social services. 2005, c. 32, s. 48.</p> <p>99.4. The services offered by the health and social service providers in a local health and social services network are coordinated by a local authority, which is a multivocational institution operating a local community service centre, a residential and long-term care centre and, where applicable, a general and specialized hospital centre. Only a local authority within the meaning of the first paragraph may use the words “health and social services centre” in its name. 2005, c. 32, s. 48.</p>

	<p>99.5. The local authority is responsible for defining a clinical and organizational project in which the following elements are identified for the territory of the local health and social services network:</p> <ol style="list-style-type: none"> (1) the social and health needs and the distinctive characteristics of the population based on an understanding of the state of health and well-being of that population; (2) the objectives to be pursued to improve the health and well-being of the population; (3) the supply of services required given the needs and the particular characteristics of the population; and (4) the organizational structures and the contributions expected of the different partners in the network. <p>The clinical and organizational project must be consistent with ministerial and regional orientations and recognized standards of accessibility, integration, quality, effectiveness and efficiency, and take into account the resources available.</p> <p>For the purpose of defining its clinical and organizational project, a local authority must mobilize and ensure the participation, in the territory of its local network, of the institutions offering specialized and superspecialized services, of the various groups of professionals, of the community organizations, of the social economy enterprises, of the private resources and of the key players in the other sectors of activity that have an impact on health services and social services. 2005, c. 32, s. 48.</p> <p>99.6. With a view to improving the health and well-being of the people in its territory, a local authority must offer</p> <ol style="list-style-type: none"> (1) general services, including prevention, assessment, diagnostic, treatment, rehabilitation, support and lodging services; and (2) certain specialized and superspecialized services, when available. 2005, c. 32, s. 48. <p>99.7. In order to coordinate the services required in the territory of the local health and social services network, the local authority must</p> <ol style="list-style-type: none"> (1) define and establish mechanisms for the reception, referral and follow-up of users of health and social services; (2) introduce mechanisms or enter into agreements with different partners or producers of services, including institutions offering specialized and superspecialized services, physicians in the territory, community organizations, social economy enterprises and private resources; (3) take in charge, accompany and support persons, especially those with particular and more complex needs, in order to provide, within the local health and social services network, the continuity of service required by their state of health; and, (4) together with the agency, the regional department of general medicine and the regional panel of heads
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		<p>of departments of specialized medicine, create conditions that foster accessibility, continuity and networking of general medical services, focusing in particular on accessibility</p> <ul style="list-style-type: none">(a) to technical/diagnostic facilities for all physicians;(b) to clinical information, including the results of diagnostic tests such as laboratory tests and medical imaging, drug profiles and record summaries; and(c) to specialists by family physicians, when appropriate, with a view to the hierarchization of services. 2005, c. 32, s. 48. <p>99.8. A local authority must use different methods of informing and consulting the public in order to involve people in the organization of services and ascertain their level of satisfaction with the results obtained. It must report on the application of this section in a separate section of the annual management report.</p> <p>2005, c. 32, s. 48; 2011, c. 15, s. 3.</p>
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<p>Saskatchewan</p>	<p><i>The Provincial Health Authority Act, 2007, c. P-30.3</i></p>	<p>Responsibility of provincial health authority for health services</p> <p>4-1(1) The provincial health authority is responsible for the planning, organization, delivery and evaluation of the health services that it provides.</p> <p>(2) In carrying out its responsibilities pursuant to subsection (1), the provincial health authority shall:</p> <ul style="list-style-type: none"> (a) assess the health needs of the residents of Saskatchewan; (b) in accordance with section 7-1, prepare and regularly update an operational plan for the provision of health services; (c) provide the health services that the minister, pursuant to clause 7-3(b), has determined that it is to provide; (d) coordinate the health services it provides with those provided by other providers of health services; (e) evaluate the health services that it provides; (f) promote and encourage health and wellness; (g) assist the minister in the development of and implementation of health policies and standards, health-information systems, human-resource plans for the health care system and other provincial health-system initiatives; (h) meet any standards established by the minister respecting the quality of health services that it is to provide; (i) comply with any directions, policies or guidelines issued or established by the minister with respect to the health services it is to provide and the administration of those health services; (j) implement any health services plans and any other plans required by the minister; (k) provide any reports that the minister may require; and (l) undertake any other activities that the minister may direct. <p>(3) of carrying out its responsibilities, the provincial health authority shall establish integrated service areas within the Saskatchewan to permit the efficient, effective and timely delivery and management of health services.</p> <p>(4) Integrated service areas must be consistent with and reflect any organizational structure that may be determined pursuant to section 2-4.</p> <p>(5) Subject to the approval of the Lieutenant Governor in Council, the provincial health authority may alter the number of or modify the integrated service areas.</p>
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