

CANADIAN PRIMARY HEALTHCARE POLICY THE EVOLVING STATUS OF REFORM

JANUARY 2012

ANN L. MABLE JOHN MARRIOTT MARRIOTT MABLE E This synthesis is the first of a series of papers being produced by the Canadian Health Services Research Foundation on the topic of financing models.

ACKNOWLEDGEMENTS

The authors wish to thank those who took time to provide input for this study, whose efforts greatly enriched the report.

The views expressed in the content of this document are those of the key informants or authors, or as summarized from other references, and do not necessarily reflect the views of the Canadian Health Services Research Foundation or its partners.

This document is available at www.chsrf.ca.

This research report is a publication of the Canadian Health Services Research Foundation. Funded through an agreement with the Government of Canada, CHSRF is an independent, not-for-profit corporation with a mandate to promote the use of evidence to strengthen the delivery of services that improve the health of Canadians. The views expressed herein are those of the authors and do not necessarily represent the views of CHSRF or the Government of Canada.

ISBN: 978-1-927024-28-7

Canadian primary healthcare policy—The evolving status of reform $\,^{\circ}$ 2011, Canadian Health Services Research Foundation.

All rights reserved. This publication may be reproduced in whole or in part for non-commercial purposes only and on the condition that the original content of the publication or portion of the publication not be altered in any way without the express written permission of the CHSRF. To seek this permission, please contact info@chsrf.ca.

To credit this publication please use the following credit line: "Reproduced with the permission of the Canadian Health Services Research Foundation, all rights reserved, (modify year according to the publication date)."

CHSRF

1565 Carling Avenue, Suite 700 Ottawa, Ontario K1Z 8R1

E-mail: info@chsrf.ca Telephone: 613-728-2238 Fax: 613-728-3527

TABLE OF CONTENTS

KEY MESSAGES FOR DECISION-MAKERS i
EXECUTIVE SUMMARY ii
CONTEXT
IMPLICATIONS
APPROACH4
RESULTS6
ADDITIONAL RESOURCES FOR DECISION-MAKERS 11
FURTHER RESEARCH
APPENDIX A PRIMARY HEALTHCARE POLICY: F/P/T JURISDICTIONAL SUMMARIES13
FEDERAL GOVERNMENT/CANADA
Alberta16
British Columbia17
Manitoba18
New Brunswick19
Newfoundland and Labrador20
Northwest Territories21
Nova Scotia22
Nunavut24
Ontario26
Prince Edward Island28
Quebec30
Saskatchewan31
Yukon32
DECEDENCES

KEY MESSAGES FOR DECISION-MAKERS

The key findings for decision-makers on the current state of Canadian primary healthcare (PHC) policies, and the perceptions thereof, offer insights for renewed direction and action.

- All jurisdictions have maintained some focus on PHC policy. Although the extent and complexity of PHC application varies, the glass is half-full, not half-empty.
- The combined information that can be found about PHC at the federal, provincial and territorial levels provides a foundation of PHC policy direction that could be built upon for a more cohesive PHC strategy across Canada.
- The many links between current PHC activity and work done under prior national initiatives confirm the continuity and legitimacy of direction that, in turn, strengthen the foundations for current PHC reform.
- The system would benefit from renewal of an overarching framework for PHC reform across Canada to provide guidance and a reference point for aligning with principles and objectives and understanding progress.
- Different PHC delivery models, elements and capacity building—many showing considerable innovation—have emerged in jurisdictions across Canada. Their successes should be showcased and problems addressed from a high level to recognize good work and relieve pressures on the ground.
- Given the diverse activity under way and issues of clarity about and between primary healthcare and primary care, there is a perception by key informants of a lack of coherence in reform across Canada.
- Continued tensions between old and new ways of care delivery are affecting PHC reform progress at all levels and require resolution if reform is to achieve desired goals.
- Despite good work under way, the situation is not well served by the unsatisfactory state of data, lack of interoperable information systems and insufficient available research across the country.

EXECUTIVE SUMMARY

From the late 1990s to the present, major pan-Canadian and provincial/territorial reviews have placed growing focus on primary healthcare (PHC) within the larger scheme of health system integration and reform. The major reform push represented by accords and transition funds is notable for the scale of PHC-related policy support and investment. It accentuates the highly collaborative process by which *Canadian federal, provincial and territorial (F/P/T) governments worked together and agreed* to the underlying PHC intents and parameters to fund, launch and evaluate initiatives.

Even though it has been noted recently that good evidence now exists demonstrating the substantive contributions of primary level healthcare, some literature reflects concern that changes at the system level may not have kept pace with available evidence "despite the investment made ... by Health Canada through the PHCTF." A sense of impatience emerges from current research. International comparisons have been cited to support a contention that Canadian PHC is lagging behind that of other comparable industrialized countries.

This raises a legitimate fundamental question that frames this research: What is the status of current PHC policy and reform across Canada? A full range of detailed answers cannot be taken up within this report, but it is important to begin with a snapshot of the current F/P/T PHC policy landscape. This study was undertaken to allow decision-makers to better understand the current picture, consider the legitimacy of significant recent PHC investments (and any critiques thereof), and be able to applaud, showcase and promote positive change and progress. It also enables scrutiny of what might not be working in Canadian PHC today.

The specific objectives of the study were these:

- to summarize the current status of F/P/T policy intentions, applications and outcomes related to advancing PHC improvement in Canada
- to gather information (through grey and easily accessible health literature, web-based research and key informant interviews) and feedback on the status of PHC reform in Canada from F/P/T government officials, other senior decision-makers and academics, as well as from the perspective of Health Canada

We used a targeted, expeditious process to access, synthesize and summarize readily available information and input. The intent was to access such information and input to produce a high-level snapshot of policy—not an inventory, audit or exhaustive review of all policy intents, applications or results across Canada. Sixty-one key informants were invited to take part in confidential interviews; of this group, 42 (or 69%) responded and were interviewed. They represented all jurisdictions and diverse F/P/T, Aboriginal and other stakeholder perspectives. A draft of the report was shared in a policy dialogue immediately following the November 2010 conference of the Canadian Health Services Research Foundation (CHSRF), called Picking Up the Pace: *How to accelerate change in primary healthcare*, where some attendees took the opportunity to comment on the draft.

Canada comprises distinct healthcare systems in varied F/P/T contexts. As such, PHC progress must be considered separately in each of these contexts to better understand the progress being made on PHC improvement. To this end, Appendix A provides a summary of the state of PHC progress in each jurisdiction.

The results of the study confirm the status of F/P/T PHC policy and activity and summarize the range of experiences found within these jurisdictions, revealing numerous key issues that arise in multiple jurisdictions. These issues include the following.

As related to policy and links with prior national initiatives:

Finding 1 At the federal level, despite external impressions to the contrary, PHC policy support exists in direct and indirect ways, involving explicit PHC elements or indirect facilitation of related activities.

Finding 2 At the provincial and territorial level, many links to earlier national PHC-related initiatives (e.g. the Health Transition Fund and the Primary Health Care Transition Fund) are found in continued and developing models, elements and capacity building.

Finding 3 At the provincial and territorial level, PHC policy-related activity is described in nearly all provincial or territorial health department websites or related documentation, and each jurisdiction does it differently.

As related to progress with emerging models constrained by a lack of coherence and continuing professional tensions:

Finding 4 At the provincial and territorial level, PHC-related vision and reform receives a lot of attention and support, but an apparently disproportionate focus on primary care sometimes creates inconsistency in terms of who needs to be involved and how to engage them.

Finding 5 Progress is happening across a range of PHC reforms, but stakeholders may not know about it or have access to related information.

Finding 6 Interprofessional teamwork is taking hold in many forms and settings, but there are still impediments to collaborative practice as envisioned in PHC reform.

Finding 7 The positive trend of increasing support among physicians and other health professionals for participation in new PHC models is somewhat offset by the reality that many physicians across Canada remain in traditional models and roles.

Finding 8 Meaningful understanding of PHC reform in Canada is limited by the state of PHC-related information and research.

The findings in this study show that policy focus on PHC exists and is building on prior initiatives, and that there are some real changes, large and small, under way. Facilitators, barriers and gaps all hold major implications and opportunities for decision-makers and other stakeholders. In the face of current concerns about progress, if achievement of a PHC-based system is the goal, then decision-makers can use these findings to help renew their approach.

CONTEXT

The promise of primary healthcare (PHC) has a long history in Canada. It dates back to early advocates such as Dr. John Hastings, through organizational models such as community health centres and health services organizations operating often at the fringes of mainstream healthcare. The Group Health Centre in Sault Ste. Marie, Ontario, predated medicare. It demonstrates a model of PHC with a comprehensive range of services that include many of the key elements that other models are still trying to implement today. For some time, such PHC-based models have shown the benefits of committed, community-based, alternatively funded, patient-registered, interdisciplinary and collaborative service delivery. Models include physicians in groups and a range of other providers supported by health information across a continuum of care. But they did not, and do not yet, represent the majority of Canadian PHC.

From the late 1990s to the present, major pan-Canadian and provincial or territorial (P/T) reviews have placed growing focus on PHC within the larger scheme of health system integration and reform. The National Forum on Health recommended priorities including primary care or PHC and integration. This led to the Health Transition Fund (HTF), which enabled pan-Canadian and P/T pilot projects and evaluations to test new models, underlying elements and/or capacity building for PHC. For the purposes of this report, the major defining characteristics of PHC and primary care are based on definitions presented in the Synthesis

Series: Primary Health Care report for the HTF,¹ as follows: Primary health care is typically the first point of entry to the Canadian health system. It is linked to and often provides a referring or coordinating function for other specialized health care sectors as well as community services. Primary care, the medical model of response to illness, is part of the broader concept of primary health care. Primary health care recognizes the broader determinants of health and includes coordinating, integrating, and expanding systems and services to provide more population health, sickness prevention, and health promotion, not necessarily just by doctors. It encourages the best use of all health providers to maximize the potential of all health resources.

PHC was increasingly referred to by governments and other stakeholders as the foundation, and at the core, of health system reform. It recognized a broader scope, including emphasis on determinants of health, coordination and integration of services with focus on population health, sickness prevention and health promotion by the most appropriate health providers working in collaboration. This expanded the traditional focus of primary care on diagnosis, treatment, management and prevention of health problems as well as health promotion, provided principally by solo or groups of family physicians and their related medical or other staff.

During this period, major P/T reviews such as the Clair Commission in Quebec,² the New Vision in New Brunswick³.⁴ and the Fyke report in Saskatchewan⁵ all fine-tuned the focus on community-based PHC teams, networks and improved access. First ministers' health accords spurred momentum and increased federal PHC support and investment, resulting in the Primary Health Care Transition Fund (PHCTF), which provided significant opportunity to explore P/T, multijurisdictional and national PHC-related implementation and reform. The Aboriginal Health Transition Fund (AHTF), although not solely PHC-focused, represents significant additional support for a specific population group, including for PHC. Such initiatives established a strong policy foundation for continuing PHC reform across Canada.

The major reform push represented by accords and transition funds is notable for the scale of PHC-related policy support and investment. It accentuates the highly collaborative process by which Canadian federal, provincial and territorial (F/P/T) governments worked together and agreed to the underlying PHC intents

and parameters upon which initiatives were funded, launched and evaluated. The PHCTF program office was closed and the summative evaluation completed and issued in 2008. Since that time, the Canadian PHC "environment" has appeared to encompass both progress and provocation.

While some literature has noted that good evidence now exists demonstrating the substantive contributions of primary level healthcare, other literature reflects concern that changes at the system level may not have kept pace with available evidence despite the investment made by Health Canada through the PHCTF. A sense of impatience emerges from current research. It calls for better understanding of PHC, a pan-Canadian focus, a sustained transformation toward a high-performing PHC "system," and assertions about the state of *primary care*. International comparisons have been cited to support a contention that Canadian PHC is lagging behind other comparable industrialized countries.^{6, 7, 8, 9, 10} These critiques appear to call into question prior PHC initiatives as well as the current performance and status of PHC.

Although such concerns and comparisons are legitimate, the underlying data referenced are from a time period around or just before the end of the PHCTF. Because of this, the authors caution that it is premature to suggest that such major PHC initiatives have not produced satisfactory results.

All the same, the current contextual dynamics produce a legitimate fundamental question that frames this research: What is the status of current PHC policy and reform across Canada? In other words, is the promise of PHC as it has been envisioned for some time being fulfilled?

If there is ongoing "pan-Canadian" PHC policy focus and activity, then what is it, how is it expressed and how has it been going? A full range of detailed answers cannot be taken up within the scope of this report, but it is important to begin with a snapshot of the current F/P/T PHC policy landscape. This allows decision-makers to better understand the current picture, consider the legitimacy of significant recent PHC investments (and various critiques) and be able to applaud, showcase and promote positive change and progress. It also enables scrutiny of what might not be working in Canadian PHC today, and why not, to determine what else needs to be understood and done to move things forward.

IMPLICATIONS

The findings of this study show that policy focus on PHC exists and is *building* on prior initiatives, and that there are some real changes, large and small, under way. Facilitators, barriers and gaps all hold major implications and opportunities for decision-makers and other stakeholders. In the face of current concerns about progress, if achievement of a PHC-based system is the goal, then decision-makers can use these findings to help renew their approach.

For decision-makers, the presence of readily available basic information on PHC policy and activity on all F/P/T websites demonstrates and legitimizes the considerable continuing focus on PHC across Canada. The links between current activity and prior national initiatives confirm the continuity of reform and the benefits of large-scale collaborative approaches to implement and accelerate PHC reform. Policy-makers, regional health authorities and others responsible for reform can access this information to become more familiar with the larger scheme and use it to drive and reinforce reform strategy. In addition, these findings can give F/P/T policy-makers confidence in pan-Canadian collaborative policy approaches and the potential to fine-tune reform to a higher level based on drivers for performance, accountability and outcomes.

A major implication of this research involves the need for decision-makers to create a more cohesive picture of PHC reform in Canada and a more collegial atmosphere among those involved. The reason for this need is that PHC policy and its reform are being carried out with different areas of focus and levels of progress in essentially isolated settings. The jurisdictions have become solitudes to a great extent, in stark contrast to the days of the PHCTF with its energy and active sharing.

These findings might be used to promote the reintroduction of a PHC-focused F/P/T committee to reassert a central voice or national focus on PHC. Such a committee could use the confirmation of direction, as reflected in the information available across jurisdictions, to renew and reinforce intentions to support and strengthen PHC reform. Decision-makers should consider F/P/T collaboration to establish a PHC policy framework that incorporates definitions, principles, models and applications that could be adapted by P/T governments and the federal government in its areas of responsibility. A simple PHC framework could be reintroduced to unify dialogue, generated from the elements and objectives of the HTF and the PHCTF as related to models, elements and capacity building.

The issues that emerge in this study could be reviewed from an F/P/T level to consider the major jurisdictional level challenges being faced. PHC intents and concerns could be looked at to promote or accelerate the ability to address common issues and opportunities in reform. Study informants also described the benefit of a central facilitator during national initiatives, which would promote informal interaction of networks of colleagues and improve the flow of information across the country. Such a degree of commitment shown by governments would go a long way toward lending support to providers and other stakeholders on the ground. Providers could also use the findings to refresh and accelerate service delivery.

The promising evidence of emerging and developing PHC models, elements and capacity building across the country can be used by P/T stakeholders to build confidence about the direction and momentum of reform. The findings should encourage decision-makers to consider how to build on chronic disease management (CDM) as a mechanism or facilitator of change in advancing PHC reform. "Why?" you may ask. The answer if that CDM is being pursued in all jurisdictions, whether linked directly to PHC or not. And in the context of CDM, there is consistent encouragement to address chronic care needs with interdisciplinary teams.

The implications of the extent of changes made, when compared with objectives, reveal numerous problems requiring attention. The findings of this study reflect tensions between old and new ways of doing things. These tensions are complicated overall by an apparent lack of coherence and understanding of PHC models, which are often made more confusing by differences in the articulation and strategy (often by governments) related to *primary healthcare* and *primary care*. And when interprofessional tensions complicate service delivery or block the progress of reform, the larger health systems are affected. P/T governments, providers and professional associations can use this study's findings to renew their commitment to solve problems, finish the work to be done and do what they can to break up blockages in the system.

The issues related to, for example, whether and how physicians are participating in PHC reform should induce P/T governments and medical associations to use this information to review and improve that area. Informants, including physicians, observed that many jurisdictions have continued to face resistance from health professionals. Even those jurisdictions with somewhat successful agreements in place still face contractual constraints. Successfully resolving negotiations that address and support physician participation in PHC reform in keeping with PHC principles, elements and goals would go a long way toward easing tensions and facilitating reforms.

Findings also reveal the need for P/T governments, health professionals and academic institutions to re-examine the impediments to establishing teams and collaborative practice. The findings, and resources such as the Building a Better Tomorrow modules, may help determine options for reducing barriers and moving forward. Much work has been done and continues to be done in collaborative practice education as well as in producing guidelines and financial incentives and supports. However, more work is needed. Solutions may include alternative remuneration of PHC organizations and physicians, along with new forms of PHC governance and administration to support better partnership and teamwork among providers.

Given the issues raised about the state of data systems and information resources, the research community could use these findings to continue to take the lead in promoting a focused approach to PHC research across Canada. The findings could help researchers to assemble a more complete picture of where things stand and to fill important gaps.

APPROACH

We used a targeted, expeditious process to access, synthesize and summarize readily available information and input. The approach was designed to quickly capture the current status of PHC policy in F/P/T governments and to provide illustrations. We aimed to identify the presence of continuity with prior major initiatives and a sense of "how reform was going," as expressed in major activities, and to identify major facilitators or barriers. Our intent was to access readily available information and input to produce a high-level snapshot of policy—not an inventory, audit or exhaustive review of all policy intents, applications or results across Canada.

We collected primary data to generate four major lines of evidence:

- selected prior literature and key informant input gathered after major national PHC reform initiatives such as the Health Transition Fund (HTF), national health accords and the Primary Health Care Transition Fund (PHCTF), to establish the recent foundations of PHC reform in Canada
- web-based review of F/P/T government websites and available documentation, to identify evidence of current PHC policy and accountability focus
- web-based research conducted to identify easily accessible PHC policy-focused grey and other literature, to reinforce understanding of current Canadian PHC policy status
- \ key informant interviews with senior level F/P/T government decision-makers, other stakeholders and researchers or observers across Canada, to enrich the picture of current PHC policy and reform

Literature search

Key words (see below) were applied to the following categories of searches:

- The priority was on scanning F/P/T health ministry or department websites to identify expressions of active PHC programs or initiatives as a prime indicator of government PHC policy.
- We also conducted scans of professional associations and academic, think tank, research and other institutions—including the Health Council of Canada, the Canadian Institute for Health Information (CIHI), the Canadian Health Services Research Foundation (CHSRF) and the Canadian Institutes of Health Research (CIHR)—to identify any relevant grey and other literature that could relate to current PHC activities, reports or overviews with inference or direct comment on PHC policy.

- We performed general searches, using key words, with Google, Google Scholar and PubMed to identify documents exclusively within or including reference to Canada and/or the P/T jurisdictions, in order to identify relevant literature, studies and journal articles touching upon PHC policy or direct comment on policy.
- Key informants identified additional documents.

Key words included primary health care (or PHC) policy and primary care (or PC) policy, in combinations with reform, interdisciplinary team(s)/collaboration, chronic disease management (or CDM), patient participation, patient satisfaction, models, performance, governance, administration, physicians, family physicians, nurse(s), nurse practitioner(s) and providers.

Key informant input

The authors collaborated with CHSRF to identify a pool of key informants, including F/P/T government and professional association decision-makers, other stakeholders, researchers, academics and observers with expertise in or links to PHC policy. From an initial pool of 120 possible key informants, we invited 61 in order to overcompensate for the short timeframe. Of this group, we were able to schedule 42 key informants (69%) for interviews. They represented all jurisdictions and a range of national, P/T, Aboriginal and other stakeholder perspectives.

We asked key informants about the current status of PHC policy, for illustrations of activities and the links, if any, with the health transition funds, and for their views on how PHC was progressing in the jurisdictions. The interviews were confidential, lasting approximately 20–30 minutes. In addition, the authors participated in CHSRF's *Picking Up the Pace* conference in November 2010, which showcased a number of innovations that reflected F/P/T policy. The innovations discussed at the conference and feedback from the policy dialogue session that followed provided further input to the report.

Analysis

We based current policy status and activity on identifying explicit information on or through government ministry or department of health websites. Evidence or suggestion of an explicit PHC policy or reform was established first by the presence of:

- a PHC-focused departmental, divisional or regional health authority (RHA) area
- specifically articulated policy in indications, instruments or initiatives related to:
 - policies or direction in definitions, mandates, strategic or business plans, legislation or regulation
 - models—organizational, team, virtual or nature of model (interdisciplinary, for example)
 - elements—modes of access, alternative funding, defined services or specific population needs, promotion or prevention, CDM, coordination or integration with other sectors and services, information technology supports, or

capacity building or professional development in PHC—guidelines and tools or educational materials for setup, administration, governance, funding and/or financial management, team building, collaboration, CDM, PHC-supportive e-health and other related resources We found indications of PHC policy and activity, most of which presented the status of initiatives related to major models, elements such as interdisciplinary teams and collaboration and information technology (including telehealth), electronic medical records (EMRs), electric health records (EHRs), capacity building in CDM, and other key PHC priorities. Discussions with key informants confirmed and expanded on this information and elaborated on the status and progress of P/T initiatives. Key informants also provided broader comment on PHC policy progress and issues overall in Canada.

Dissemination

This report draft was circulated for review to an invited group of participants in the policy dialogue during the November 2010 *Picking Up the Pace* conference. We developed the final version considering input from that meeting. Dissemination by CHSRF of the final document may include posting on its website, circulating online and other means.

Limitation

The authors designed the methodology to gather and analyze readily available data in a relatively short timeframe to make the report available for the policy dialogue hosted by CHSRF following its *Picking Up the Pace* conference. This may have limited the range, depth or completeness of the information that was identified and reviewed. Initial concerns that the short timeframe allowed for interviews might limit the availability of senior level informants were offset by a vigorous response.

RESULTS

The major findings about the status of PHC policy and reform across Canada reveal a range of PHC policy and initiatives under way and issues experienced in multiple jurisdictions. Appendix A offers a more detailed summary of the PHC policy and progress in each jurisdiction.

Finding 1

At the federal level, despite external impressions to the contrary, PHC policy support exists in direct and indirect ways, involving explicit PHC elements or indirect facilitation of related activities.

Across Health Canada, much activity is occurring in PHC-related areas. These activities include a major focus on CDM at the Division of Continuing and Chronic Care. Support for evolving nursing roles and interdisciplinary collaborative practice is ongoing at the Office of Nursing Policy. An explicit PHC office at the First Nations and Inuit Health Branch maintains focus on this area for Aboriginal communities and sees them through reforms such as the groundbreaking tripartite agreement with the Government of B.C. to transfer responsibility for health services to the Aboriginal people of that province.

Major PHC initiatives have been supported within the ongoing operation of health systems, including for specific population groups (Canadian Forces, Aboriginal Peoples, Correctional Services of Canada, and others). Health Canada still maintains readily accessible information about the major PHC-related initiatives (transition funds), accords and projects of the last decade and more. These are available for use, and are being used in some circumstances, to frame current and ongoing activity.

Finding 2

At the provincial and territorial level, many links to earlier national PHC-related initiatives (e.g. HTF and PHCTF) are found in continued and developing models, elements and capacity building.

A significant amount of work is taking place across the country and at the federal level that reflects continued and ongoing work on initiatives launched, developed or energized during the major Canadian national, provincial, territorial and multijurisdictional initiatives.

Informants confirmed that prior foundations are evident in current P/T PHC activity. In different ways in different settings, the models and their elements reflect new modes of access, alternative forms of funding, physicians in groups and rostered populations. Collaborative practice, interdisciplinary teams, and activity in prevention or promotion and CDM are applied within defined services for specific population needs. PHC and coordination or integration with other sectors and services is supported by information technology and reinforced through professional and other capacity building (Building a Better Tomorrow educational modules, standards, guidelines, etc.). The ongoing work with Canada Health Infoway is helping to pull the pieces together.

Finding 3

At the provincial and territorial level, PHC policy-related activity is described in nearly all P/T health department websites or related documentation, and each jurisdiction does it differently.

Available information is not necessarily identified as "policy." Instead, it may simply begin with a definition of PHC on the government website. In some cases it takes some work to uncover information related to PHC policy, activity or any form of assessment, even when considerable activity is under way.

When asked about policy intentions, applications and results, some interview respondents were not confident about the state of PHC policy (despite a range of distinct mandates or links to policy instruments that exist on government sites). Much was said about what respondents were doing, plans and activities under way, and how it has been going (facilitators, barriers). Some informants also expressed uncertainty concerning how to refer to PHC policy or reform because of lack of clarity and/or a range of activity related to primary care, as opposed to PHC.

Finding 4

At the provincial and territorial level, PHC-related vision and reform receives a lot of attention and support, but an apparently disproportionate focus on primary care sometimes creates inconsistency in terms of who needs to be involved and how to engage them.

Communication abounds regarding PHC at the P/T level. It appears in statements of government mandates and goals and in business or strategic plans. Related documentation and literature linked to government websites tend to be the same. Strong PHC terms are used to describe what is taking place in service delivery. At the same time, informants shared that it has become unclear as to what is going on in PHC because of the way it is articulated by governments and others in dialogue, information and research.

First, there is inconsistency at times in identifying what PHC is, how it is defined and what it involves. The inconsistency is complicated by considerable mention of primary care, with widespread use and interchanging of the terms primary health care and primary care. This terminology confusion occurs without explanation of which parts of the system or the reform are referred to (whether it is about a fuller scheme of PHC attributes or whether it is about fine-tuning primary care with some other elements attached).

Second, despite governments' widely articulated commitments to patient-focused PHC objectives and benefits, a gap is created by an apparently disproportionate degree of focus on primary care and one provider group (primary care physicians). This situation is reinforced by considerable activity, resources and related information dedicated to primary care practices rather than comprehensive PHC models. Informants indicated that some jurisdictions are pursuing PHC reform but referring to all or some of it as "primary care reform" to avoid resistance to reform. This confuses other stakeholders and may reflect challenges in encouraging physicians to change aspects of their medical practice.

This confusion spurs questions about whether current PHC policy or activity is on track and causes frustration among stakeholders at many levels, leading to tensions at the level of service delivery. Despite many remarks about the confusion of unclear definitions, informants widely affirmed that stakeholders know the difference between PHC and primary care but continue without clarification to avoid political or professional issues.

Finding 5

Progress is happening across a range of PHC reforms, but stakeholders may not know about it or have access to related information.

Progress at many levels is insufficiently documented, reviewed or appreciated at this time. Sometimes those on the ground are too busy doing their jobs to document reforms, are not allowed to participate in them, are limited by funding to do only certain things, or are constrained by resources from sharing what they have done or finding out what others are doing. Some informants admitted outright that they do not know, but want to know, what is happening with PHC across Canada (including within their own jurisdiction), if it has improved or not, or if reforms are resulting in major changes.

For example, in the Northwest Territories, physicians are on enhanced salary remuneration packages, with electronic health record (EHR) support that is accessed by a range of health providers. Many benefits have been identified with this new model. The effort took some time to produce and is the kind of situation that exemplifies PHC reform objectives. It would be useful for other stakeholders to be familiar with it, but given the need for those involved to focus on the implementation over time, the documentation is just under way.

Other PHC reform examples include nurse practitioner-led clinics in Ontario and nurse practitioners in Saskatchewan who are making referrals to specialists. These reforms are of great interest and are drawing increasing attention, but not enough is known about how the reforms operate or impact on care. In addition, in most settings, emergency medical records (EMRs) exist or are under development, but due to professional or legislative constraints, most health providers will not have access to them to enhance service delivery or to assess impacts.

Sometimes the successful activity is not widely enough engaged across the country for people to be familiar with or appreciate it. An example was what one informant called the "tremendous amount of work being done on quality and safety, on measuring quality—we're just getting there—for example, having push-button reminder of Pap smears … but it's not common across the country, still a work in progress."

Some stakeholders think that only province-wide scale is meaningful reform, while others caution that equally legitimate reforms may be incremental in nature and take time to introduce.

Finding 6

Interprofessional teamwork is taking hold in many forms and settings, but there are still impediments to collaborative practice as envisioned in PHC reform.

Where it is working, teamwork shows progress, with better delineation and clarity of roles and responsibilities and interactions occurring in new ways to address a wide range of health and population issues. Much evidence exists of "more and better" interest in and appreciation of the benefits of diverse health professionals working together. Numerous health professionals are emerging more actively in teams or are more accessible as a "right" provider, including more nurse practitioners, family physicians, dietitians, midwives and others, depending on the setting.

While progress is happening in the number of allied health professionals participating, there are still some challenges in sorting out who does what, although informants indicated that it is still early in that process. Most informants commented often that teamwork to date is still too physician-centric and not in sync with patient-focused PHC objectives. Even though teams are a major component and more kinds of health providers are involved, the allied providers do not appear, from literature or informant input, to be at the core of the dialogue or debate on PHC system reforms that affects them.

The numbers and kinds of health professionals that form teams, their co-location (in one setting) and the extent of collaboration vary widely according to setting. Patient focus is prevalent in rhetoric and sometimes evident in voluntary citizen participation in initiatives, but it is not often reflected in more explicit PHC attributes, such as registration or rostering, or specific aims regarding care. The latter would better align resources with patient focus and provide more meaningful data to assess performance.

Informant observations raised concerns that teamwork may be only superficial when the emphasis is still on the medical model of primary care, with a limited number of other health professionals working in narrowly defined supportive roles, rather than working when appropriate to a fuller scope when the patient need would justify it.

For the most part, nurses still tend to work in hospitals, public health or physician offices in relatively traditional roles, often combining administrative or reception duties as well as less critical health service tasks. This situation in turn raises questions about the "cost of PHC reform" if funding has not left a fee-for-service scheme and the use of other health professionals is not sufficient to create desired PHC impacts on the larger health system.

There is still a range of legal, professional and political impediments to full involvement in PHC practice for nurses in a range of settings, emerging nurse practitioners and midwives. For example, an informant commented that midwives would be logical members of teams but that some provinces have set up legislation that blocks them from participating. Further, because midwives are supposed to be able to practise autonomously, the view is that they should not necessarily be forced to work within physician-directed controls, yet nonetheless might be required to do so.

These combined factors contribute to interprofessional tensions and more things to be worked out. Turf issues still exist, with intersecting aims related to scope, the "right" provider and local needs. These issues can limit or impede smooth service delivery along with cost efficiency, professional satisfaction and larger aims of patient focus.

Finding 7

The positive trend of increasing support among physicians and other health professionals for participation in new PHC models is somewhat offset by the reality that many physicians across Canada remain in traditional models and roles.

As reported by informants, a promising prospect in the current environment is that Canada is attracting more family physicians from other countries (like the U.S.) than are leaving. In addition, more students are choosing to go into family medicine. There are increasing indications that family physicians are "happier here" and are experiencing an increasing voice in new strategies and collaborative models of PHC-related reform. Informants in several jurisdictions (see Appendix A) reported that increasing numbers of physicians are involved or have expressed interest in PHC reforms.

At the same time, even where there may appear to be disproportionate attention to primary care as part of reform, most physicians are still paid on a fee-for-service (FFS) basis and are not alternatively funded, practising in groups nor collaborating fully in teams. This situation also raises longstanding concerns about costs and other issues associated with FFS and solo practice.

There is still resistance by some physicians and medical associations to participating in new PHC-related models. This resistance occurs because some physicians still do not want to make changes, despite the positive reports of their colleagues and other stakeholders about the benefits and potential to meet important lifestyle and other personal and professional objectives. This is seen by most stakeholders, including some physicians, as counterproductive to reform.

Most of the facilitators of reform identified by informants had to do with steps taken to encourage physicians, often monetarily, into new ways of doing things. Despite the encouragement, Canada's "primary healthcare system" has been criticized in the literature for lagging behind other comparable countries for a range of reasons. If true, this does not contribute to a positive sense of progress. This situation is frustrating to other stakeholders in particular because of the system resources that have been directed without a distinct or accountable link to PHC reform aims.

Many, if not most, informants (including physicians) pointed to problems in government negotiations with medical associations. They identified a range of related issues, from broad areas of distrust and lack of information sharing among negotiating partners, to concerns about blocking and delays that hold back PHC progress and larger system reform. Such concerns offset the stature and limit the potential of the important role in reform played by family physicians and may serve to distract from PHC progress rather than improve or accelerate it.

Finding 8

Meaningful understanding of PHC reform in Canada is limited by the state of PHC-related information and research.

Several issues were identified related to PHC information availability, accessibility, sharing and quality. These issues affect many areas, including service delivery, performance evaluation and recognition of what is working and what is not. Some informants hoped that there were studies to demonstrate improvements and changes to verify their hard work, while others asserted that stakeholders cannot easily find information that reports on or assesses PHC reform.

Search efforts confirm that, while there is information on Canadian PHC objectives, there is significantly less available information about Canadian PHC outcomes-related activity, performance or accountability (related to organizations, practices, providers, teams and support resources), Inconsistency across information systems

also impedes cross-Canada data collection, review, comparison and sharing. This has long been cited as a problem, with concerns about cost expended in systems that cannot interrelate. Key informants expressed hope that initiatives across the country such as the Canada Health Infostructure Partnership Program (CHIPP) or the Canada Health Infoway program would help resolve this.

Inconsistent and/or undisciplined use of language or terminology related to PHC and primary care contributes to a lack of clarity about the scope of healthcare elements under consideration. Problems include differing definitions and indiscriminate use of terms by stakeholders and in documentation and the literature. Other notions have also been introduced and articulated within P/T reforms (for example, "medical home" as introduced from the U.S.) that seem to be geared to adding other providers to physician practices, as compared with collaborative PHC models and interdisciplinary services delivered by teams of health professional peers.

Despite its importance in performance and progress assessment and reporting, evaluation in PHC is also problematic for different reasons. Some new models are just getting started and may not yet have been evaluated. The considerable body of evaluation work done during the PHCTF may now require updating that has not been done. A common challenge is not having resources or time to do evaluations. There are also concerns about evaluations being conducted too early, with projects still under way, to best capture meaningful data on progress (a concern about evaluation that also existed during the time of the PHCTF).

Where they exist in some settings, evaluations have been generated by governments (including examples at both P/T and federal levels) but not released or shared with other stakeholders who should know about progress or challenges. The research community is also greatly concerned about the absence of a focused body of PHC research to confirm the status of reform. In addition, there are indications of researcher isolation and the lack of a comprehensive view of research or system studies that are available or still ongoing. Questions have arisen about capturing a full range of participants in the extended research community, including those doing work at the clinical level in academic health science centres and other locations, to expand the knowledge base about PHC reform.

ADDITIONAL RESOURCES FOR DECISION-MAKERS

From the many links and resources noted in the reference list for this study, the following examples were selected as being particularly valuable for decision-makers. They relate to policy formulation and the business of implementing new models of PHC. The authors also recommend that readers review the jurisdictional summaries and links to information on models and approaches (Appendix A and References).

Nova Scotia Department of Health and Wellness—Building a Better Tomorrow Together (downloadable educational modules): http://www.gov.ns.ca/health/primaryhealthcare/bbtt.asp

Ontario Ministry of Health and Long-Term Care (MoHLTC)—Family Health Teams (downloadable pdf guides): http://www.health.gov.on.ca/transformation/fht/fht_guides.html

Ontario MoHLTC—Nurse Practitioner-Led Clinics (downloadable pdf guides for clinic development): http://www.health.gov.on.ca/transformation/np_clinics/np_infokit.html

Quality Improvement and Innovation Partnership (QIIP) Ontario (access to tools and resources): http://www.giip.ca/tools_and_resources.php

Quebec system information—Rapport d'appréciation de la performance du système de santé et de services sociaux 2009 : État de situation portant sur le système de santé et de services sociaux et sur sa première ligne de soins : http://www.csbe.gouv.qc.ca/fileadmin/www/RapportAppreciation/csbe-EtatSituation-t1-042009.pdf

The Health and Welfare Commissioner of Quebec—2009 Appraisal Report on the Performance of Québec's Health and Social Services System—Building on Primary Healthcare Renewal: Recommendations, Issues and Implications: http://csbe.gouv.qc.ca/fileadmin/www/RapportAppreciation/version_anlaise_Volume_4/CSBE_AppraisalReportBuildingPrimaryCare.pdf

Canadian Institute for Health Information (CIHI)—Analysis in Brief: Experiences With Primary Health Care in Canada: http://secure.cihi.ca/cihiweb/products/cse_phc_aib_en.pdf

Canadian Institutes of Health Research (CIHR)—CIHR Primary Healthcare Summit report: Patient-Oriented Primary Healthcare—Scaling Up Innovation: http://www.f2fe.com/cihr/2010/postevent/CIHR%20PHC%20Summit%20Report_For%20Distribution.pdf

FURTHER RESEARCH

The richness of accessible information on PHC policies, approaches, models, programs and strategies as found in this time-limited survey suggests significant opportunities for research. Much more may be understood about PHC reform in Canada with more time and by more detailed extraction of what is already available. This should be strengthened by informant input on key areas of interest or concern to flesh out these data for better understanding of the situation on the ground. Based on the results of this study, several suggestions for further research follow below, though these do not represent all possibilities.

Policy

A more detailed comparative review of PHC policy as it exists across jurisdictions would help align key aspects related to models, elements and capacity building. With the input of related key informants, such a review would create a more comprehensive and organized picture of policy, approaches, key distinctions and, especially, common ground. This would improve understanding and contribute to a more unified or pan-Canadian view of where things stand, as well as the possibility of a national framework.

PHC or primary care

It would be beneficial to clarify this fundamental question. Given cost and other issues identified, it would be useful to look at PHC- and primary care-focused reforms. This would help to more clearly delineate distinctions and compare influences and impacts. It would also help to generate more and better information on what else is happening across the full spectrum of care, in addition to primary care-related activities. The intent of focusing on broader PHC reform by a range of health professionals was to change the traditional paradigm of primary care response to illness. While some may be frustrated by differentiation of PHC from primary care, others consider the distinctions critical in guiding PHC reform. More clarity might help to change perspectives or attitudes of providers and decision-makers to promote the broader policy direction and behaviour in models.

Progress

Where it is possible to do so, major systemic changes or more incremental adjustments that may be under way as a result of PHC reform should be identified so that decision-makers can better understand where Canada stands. Successful models and activities could be studied within a framework of assessing models, elements and capacity-building activities to better understand and communicate their comparative strengths. New work could build on examples like the innovations that were presented at CHSRF's *Picking Up the Pace* conference, to generate more information on what works, what doesn't and why.

Potential

Other examples of progress-building activities include key PHC elements that would benefit from focused review. One such example is a comparative review of interprofessional teams, including their development, governance, implementation, administration, and the larger models and approaches taken in Canadian and other jurisdictions, to improve understanding of their status, strengths and impacts.

Gaps

Studies and reviews should be designed to fill the information or data gaps identified in this study that limit progress. A need was expressed for more explicit performance and accountability standards for physicians and PHC models. To begin, it would be beneficial to examine what is in place and how it is working. Many informants and some literature also pointed to the need to better understand the impact of various PHC models and approaches on other sectors in the health system and on the community. Many aspects could be examined, such as the impact on hospitalization, economic savings, or other benefits of particular models or elements.

Similarly, many informants indicated a lack of public information on government oversight and evaluation. Stakeholders within and outside of jurisdictions would benefit from a better understanding of what is being done, what the government expectations are for new models or approaches, what information governments are collecting and how they assess it, and whether this information is publicly available.

It would be useful to have a better understanding of the perspective of family physicians as related to PHC reform. Some of the challenges referred to by informants may be better understood and better strategies developed to positively engage the community and reduce delays in PHC and system reform as a result of such an improved understanding.

Finally, decision-makers might benefit from a more extensive survey and focused organization of currently available resource information on F/P/T PHC reform. Building on what was identified in this study and organizing and tailoring such information to their needs would enable decision-makers to readily access relevant information. This approach might be enhanced by a review and the addition of links to current facilities for knowledge exchange.

APPENDIX A—PRIMARY HEALTHCARE POLICY: F/P/T JURISDICTIONAL SUMMARIES

The first line of evidence of an active primary healthcare (PHC) policy is to determine whether a jurisdiction presents and maintains information on PHC on the health department or ministry website. One page presenting a definition, with nothing else on the site, does not suffice. The initial PHC information must link to PHC initiatives, models, applications, guides on development and implementation, and other information available to the public and to providers. Additional support information beyond this would include service plans, strategic plans or other reports that clearly present the government's policy intent to maintain, strengthen or introduce new initiatives related to PHC.

Some jurisdictions may not start with a central PHC page, but may jump right to presentations of a PHC model or models. Many jurisdictions place greater emphasis on and pay more attention to the current preferred PHC model or approach. Information is more difficult to find on prior PHC models that are still being maintained or modestly grown.

Information on initiatives related to such areas as interdisciplinary teams, collaboration or chronic disease management (CDM), including descriptions and guides for implementation and practice, may be presented in conjunction with preferred PHC models or presented on their own without mention of a PHC model. In the latter context, a PHC policy is inferred.

Key informants helped to confirm and provide comment on the progress of PHC policy, direction and implementation in each jurisdiction.

The following are summary snapshot reports for each jurisdiction reviewed.

FEDERAL GOVERNMENT/CANADA

PHC policy and applications in the federal government have to be examined in terms of this level of government's responsibilities in the areas of helping Canadians maintain their health: namely, setting and administering national principles through the Canada Health Act and financial and other contributions to the provincial and territorial healthcare systems. In addition, the federal government is responsible for delivering healthcare services to First Nations and Inuit, members of the armed forces, and inmates in federal correctional facilities.

In relation to PHC policy and reform, federal government leadership—in partnership with provincial, territorial and Aboriginal leaders—has made significant contributions to PHC policy and initiatives, with all partners agreeing to the underlying principles of PHC. The Health Transition Fund (HTF) contributed \$150 million to support a variety of initiatives in all jurisdictions from 1997 to 2001.¹¹ The HTF produced 10 synthesis reports, ¹² including one focused on PHC.¹³ Many of the HTF initiatives were considered pilot projects to gain experience and knowledge. The Primary Health Care Transition Fund (PHCTF) contributed \$800 million to support various initiatives from 2000 to 2007.¹⁴ Much of the focus of the initiatives was on team development; collaboration; CDM; information technology (IT) development, including telehealth, health lines, electronic medical records (EMRs), electronic health records (EHRs) and computerized decision support for PHC; enhancing access hours up to 24/7; and patient registration and participation.

The end of the PHCTF resulted in the end of a PHC organization as such within Health Canada. In addition, the end of the PHCTF saw the end of the federal, provincial and territorial (F/P/T) committee for PHC—eliminating not only the connection but also the opportunity for ongoing dialogue on this subject. For now, as a number of informants expressed it, the federal government maintains a continuous and long view while standing ready to support credible initiatives of national importance where and when there is stakeholder support for such initiatives. And as presented below, the federal government continues to initiate or fund initiatives that are significant to PHC reform and, in this context, demonstrates a de facto policy of support.

A residual connection to PHC monitoring and informal engagement remains within the Division of Chronic and Continuing Care at Health Canada. In addition, the department's Office of Nursing Policy continues to be supportive of nursing in several areas, including facilitating interprofessional collaboration, the role of nurses and nurse practitioners in leadership, and responding to patient needs as PHC practitioners. The Office continues to work with colleagues at the provincial and territorial levels to determine where it can provide support in these areas of PHC reform.

The First Nations and Inuit Health Branch (FNIHB) of Health Canada contains the Primary Health Care and Public Health Directorate, which, in turn, includes the Division of Primary Health Care. The Division is:

... responsible for several aspects of primary healthcare, program delivery and program support. The Division also supports the enhancement of services through the use of information and communications technology. Working closely with First Nations and Inuit communities, national health organizations and FNIHB regions, the Division strives to improve primary healthcare service and health outcomes. 15

The Aboriginal Health Transition Fund (AHTF) was the result of a first ministers and national Aboriginal leaders' meeting to address disparities in the health status of Aboriginal Peoples. The AHTF was a \$200 million investment that ran from 2004 to 2010. While not specifically targeting PHC, numerous initiatives included developing or strengthening PHC centres or focused on specific areas related to activity considered to be within PHC. These included health teams for PHC and for specific populations such as people with mental health conditions.¹⁶

The Canadian Armed Forces conducted a review of PHC a number of years ago. The current Primary Care Renewal Initiative clinic model promotes continuity of care, long-term wellness and interdisciplinary approaches to patient care. All Canadian Forces personnel are rostered to a Care Delivery Unit through a formalized rostering process. The basic building block of this approach is the Care Delivery Unit, an interdisciplinary team of civilian and military primary care providers who work in a collaborative practice. Core team members include a civilian physician, a civilian nurse practitioner, a civilian nurse coordinator, military medical technicians and civilian administrative support. The team works collaboratively with patients to assess their needs and helps coordinate the care necessary to support recovery and complete wellness as required. Additional in-house providers include physiotherapists, pharmacists and mental health professionals who provide care in collaboration with the primary care team or through direct interventions. The unit is supported by an integrated medical record accessible to team members.¹⁷

The first ministers' health accords (2003 and 2004) reinforced PHC reform by establishing PHC goals. One goal was established as a high priority for all jurisdictions: to achieve timely access to family and community care through PHC reform. An explicit commitment for all jurisdictions was to have 50% of all Canadians having 24/7 access to PHC through multidisciplinary teams by 2010. The first ministers had agreed to establish a best-practice network to share information and find solutions to barriers to PHC reform in areas such as scope of practice. Study informants indicated that this latter promise has not yet been met.

Health Canada provides complete or partial funding to a number of national organizations with mandates that include technical support, monitoring and research related to PHC. These include Canada Health Infoway, the Health Council of Canada and the Canadian Institute for Health Information (CIHI). The federal government also funds the Canadian Institutes of Health Research (CIHR). Health Canada also participates in contributions to, or contracts with, the Canadian Health Services Research Foundation (CHSRF) in support of initiatives or research.

Canada Health Infoway was created by first ministers in 2001 as the main mechanism to meet their agreement to accelerate health records, e-prescribing and telehealth development, with particular focus on rural and remote areas. Canada Health Infoway is a non-profit organization to foster and accelerate the adoption of EHR systems. Infoway is funded by Health Canada but works with all provinces and territories to implement private, secure EHR systems, enabling best practices in one area to be shared with others. The EHR funding grant for 2001–2010 was \$2.1 billion. A recent grant of \$500 million is earmarked for EMR implementation for primary and ambulatory care settings with potential to integrate clinical solutions across the spectrum of care. This represents significant Health Canada support for an important aspect of PHC policy and reform.

The Health Council of Canada was also created by the first ministers in 2003 to:...publicly report through federal/provincial/territorial Ministers of Health and will include representatives of both orders of government, experts and the public. To fulfill its mandate, the Council will draw upon consultations and relevant reports, including governments' reports, the work of the Federal/Provincial/Territorial Advisory Committee on Governance and Accountability and the Canadian Institute for Health Information (CIHI). Health Ministers will establish the Council within three months. Quebec's Council on Health and Welfare, with a new mandate, will collaborate with the Health Council.¹⁹

The Health Council of Canada is funded primarily by Health Canada. The Council has developed resources and initiatives related to PHC, including a conference on PHC reform, teams in action, effective CDM and an update on PHC reform.²⁰

CIHI is a non-profit organization funded by Health Canada as well as the provincial and territorial health ministries and individual care institutions. It maintains an organizational section and focus on PHC. CIHI has analyzed the PHC experience in Canada²¹ as one product of its PHC information program.²²

CIHR has also pledged to tackle PHC.²³ CIHR is the major federal agency responsible for funding health research in Canada. The organization recently supported a summit on PHC.²⁴

CHSRF is a non-profit organization committed to bringing "researchers and decision-makers together to create and apply knowledge to improve health services for Canadians." CHSRF was established with endowed funds from the federal government and its agencies and receives additional funding from contributing agencies, associations and governments as partners in research and initiatives. The organization has supported PHC over time.^{25, 26} It is now participating in efforts to rejuvenate PHC policy, reform and research. Its November 2010 conference, *Picking Up the Pace*, was one part of that initiative.

Alberta

Alberta Health and Wellness maintains information on PHC on its website with links to more detailed information. The site also provides links to information on their Primary Care Network (PCN) model and the Primary Care Initiative (PCI), which is responsible for PCN development.²⁷

Current Alberta PHC policy shows linkages to both the HTF and the PHCTF. The HTF supported the establishment and reinforcement of health centres and multidisciplinary primary care teams to serve rural areas. Further, Alberta examined integrating the services of specialists in areas such as mental health at PHC sites. Later, with the PHCTF, Alberta established health lines and CDM in concert with British Columbia, Saskatchewan and Manitoba. With the establishment of regional health authorities (RHAs), Alberta began developing primary care physician collaborations and shared-care approaches with interdisciplinary teams of physicians, nurses and others, with alternate payment plans such as geographic base capitation.

PCNs were established at this time. A PCN is a network of family physicians and other providers, such as nurses, dietitians and pharmacists, working together to provide services, but not necessarily in the same place. Alberta continues to strengthen and refine the model with plans to expand physician participation in the future. The PCI was established by Alberta Health and Wellness, Alberta Health Services and the Alberta Medical Association to support PCN development. The PCI provides access to information on what a PCN is²⁸ and on developing²⁹ and operating a PCN;³⁰ a guide for other healthcare providers;³¹ and access to a variety of resources to support the development of health records, health resources, team development and other information.³² According to the PCI site, there are currently 35 PCNs in the province, with eight more in the planning process.³³ PCNs have a joint governance of physicians and Alberta Health and Wellness, with the latter assisting with population health needs assessment.

According to study informants, there is a strong commitment to PHC that recognizes primary care within a PHC system. PCNs are seen as a successful model that needs to be strengthened and taken to the next level. In the absence of explicit patient registration or rostering, Alberta Health and Wellness is working to further refine a system to better identify patient populations who relate to given PCNs and to link this information in order to improve the capacity to evaluate performance. Currently, other health professionals may be on a physician site, or they may be located elsewhere in the community for patients to access. It is possible for a patient to see other health providers directly, as long as they are linked in turn to a physician who is part of the PCN.

Alberta Health Services is the new single health authority. Its business plan calls for strengthening of PHC within the "Building a Primary Care Foundation," as a transformational improvement program.³⁴ Alberta Health Services' strategic directions include a commitment to improving access by strengthening primary care. The plan states that it will "enable physician-led and interprofessional-based care in which teams of care providers are working to full scope" and "strengthen processes to attach patients to primary care teams" (p. 10).³⁵

Finally, the recently announced recommendations for a new Alberta Health Act maintain a strong commitment to PHC development. One recommendation is to incorporate a health charter that should "specifically commit that all Albertans have access to primary care services through primary care teams" (p. 5). Further, the document acknowledges some weaknesses in current legislation and practices that "do not recognize or support today's team-based approach to care delivery" (p. 10). This is underpinned by an Albertan perspective that team-based primary care "has improved their ability to access care from a range of health professionals" (p. 10).³⁶ Later in the recommendations document (p. 26), priorities for action expressed by Albertans include a direction to pursue policy opportunities in primary care and team-based care to include, but not be restricted to, expanded care teams.³⁷

Some informants pointed to various potential challenges, including implementing collaborative teams, making a virtual model work given that many PCN providers are not co-located, and dealing with the significant number of physicians who remain paid on a fee-for-service (FFS) basis.

Key informants also highlighted what is working. For example, they acknowledged that support from physicians for PHC reform and for the PCN model is growing and, with this, so is the possibility of patients' accessing other health professionals. Informants mentioned the positive support for PCNs by Alberta Health Services, both in terms of co-governance and taking responsibility to conduct population health needs assessments.

British Columbia

The Ministry of Health maintains a PHC website with links to resources for patients and providers, divisions of family practice, the General Practice Services Committee (GPSC) and the Primary Health Care Charter. 38

The Primary Health Care Charter, which was developed with PHCTF support, presents principles and methods to support and guide PHC development. It asserts that patients and their families will be partners in the system and that family physicians, as a cornerstone of PHC, are part of a broader network and team including nurse practitioners, public health staff, community nurses, midwives, pharmacists, mental health professionals, clinical counsellors, physiotherapists, chiropractors, home and community care workers, dietitians, specialists and many others. Further, the Charter states that "patients should receive accessible, appropriate, efficient, effective, safe, quality care at the right time, in the right setting by the right professional." ³⁹

British Columbia's participation in the HTF and the PHCTF also resulted in the development of health lines and a range of models such as community health centres (CHCs) and PHC organizations (PHCOs). PHCOs are interdisciplinary models with virtual rostering and capitation-based funding⁴⁰ as well as approaches to CDM. Informants indicated that these models, which are still active, continue to present benefits and lessons to guide the current direction in primary care. However, informants also indicated a sense that past efforts did not engage a large enough number of primary care physicians. This view had significant influence on the development of the current B.C. PHC policy direction that follows.

The GPSC is a joint committee of the B.C. Ministry of Health and the B.C. Medical Association. It was activated in 2003 to support general practice physicians in developing and implementing programs to improve healthcare for patients and job satisfaction for physicians.^{41, 42} The GPSC develops funding incentive programs and practice support with evidence-based strategies and tools, including training modules. This policy direction moves away from a focus on new models of PHC to provide a range of supports to the existing structures of general practitioners and encourage a change in how they practise medicine.⁴³ One national informant described the B.C. approach as having an emphasis on quality and collaboratives, but not on changing structures or models.

The Divisions of Family Practice program was established in 2008 as a joint program of the B.C. Medical Association and the Ministry of Health Services. It represents the major policy direction for primary care policy in British Columbia. Approved divisions of family practice bring groups of physicians together to support family practice and discuss gaps in care. Divisions are required to work in partnership with local health authorities. They co-chair collaborative services committees to develop solutions to their local or regional community's needs. ⁴⁴ As of 2009, 10 divisions had been established, with 10 more planned for 2010. ⁴⁵ Informants stated that all B.C. residents should be attached to a family physician by 2015.

The major policy change in CDM is a move from a single disease model (like diabetes) to a general chronic disease model within integrated health networks (IHNs); for example, through having a chronic disease nurse rather than a diabetes nurse.⁴⁶ IHNs have been described as a mechanism to support links between community organizations and PHC and to realign health authority and specialist services with PHC.⁴⁷ The number and types of other providers, such as nurses, nurse practitioners, social workers and pharmacists, are established based on requirements to meet patient needs or fill gaps in care.

Informants have indicated that current privacy rules are too restrictive and hamper the legitimate sharing of information among physicians, other providers and health authorities. The system is now exploring ways to overcome this limitation in order to share records, but there is still a long way to go.

Informants pointed to the benefits of their current process of building significant trust in the family physician community, which in turn builds good faith to move forward. This relationship has led to greater flexibility in identifying and addressing barriers as the process moves forward. The focus on patient needs and outcomes has also been demonstrated as positive. Another facilitator to support development was GPSC support to pay and train family physicians. Finally, the establishment of patient voices' networks provides important reaction and input from citizens.

Manitoba

Manitoba Health has maintained a PHC website with links to access information on advanced access initiatives, Physician Integrated Networks, Collaborative Practice and other PHC reform initiatives.⁴⁸

A number of PHC models began within the HTF and PHCTF initiatives, including community health centres and other primary care facilities that are still active.

The current focus is on the Physician Integrated Network (PIN) initiative. The initiative is directed to facilitate improvements in the delivery of primary care by FFS physicians.⁴⁹ Three demonstration sites were started in 2008, and one of the sites moved to a full PIN site in 2009. Plans called for recruiting another 65 FFS family physicians in 2009.⁵⁰ The PIN initiative has explored the encouragement of interdisciplinary teams⁵¹ and different approaches to remuneration, such as blended funding and quality-based funding combined with FFS.^{52, 53}

An evaluation of PIN Phase 1 concluded that, while the work life of participating physicians had not improved, other areas of assessment of the PIN did show improvement, including quality of care and improved access. Quality was enhanced, particularly for those with chronic diseases. Quality improvement was also seen as a result of the use of EMRs, testing reminders and other allied primary care providers. The presence of other providers on the team was determined as a major reason for improved access.⁵⁴ Depending on service requirements, teams may include family physicians, nurses, social workers, psychologists, dietitians and others. Some challenges remain with PINs. Manitoba has a large number of solo and small practice primary care physicians, which requires an approach that is more responsive to them. Currently, the level of physician engagement is hampered by the fact that five or more physicians are currently required to initiate a PIN.

CareLink is another initiative. Launched in 2008, it currently has two programs: the Chronic Disease Self-Management program, which links patients with chronic disease nurses on health lines to support self-care, and the After-Hours Access to Primary Care program, which links patients to a triage nurse after hours and, if necessary, to a network of physicians who provide after-hours care. ⁵⁵ Potential expansion of health lines may lead to online self-management centres with a nurse and dietitian on staff, who maintain clients with the possibility of virtual assessments and follow-up.

Informants indicated that future policy direction will embrace PHC along the lines of integrated networks, including aspects of the "medical home" concept. Such a direction would allow for more virtual pairing of physician practices and further engagement of other health providers to form teams with extended hours of operation. The intent is to build the approach around service standards and greater guarantees for citizens, including the ability to access teams by choice, not by chance. Future policy is expected to focus on greater integration, for instance through e-health records with greater linkages for PHC. There are indications that many providers are supportive of a new direction. The expertise of RHAs will be used to bring all parties together.

Challenges identified by informants included some resistance from physicians and allied health professionals. There is also confusion over PHC versus primary care. The direction is seen as going with PHC, although it will likely be referred to often in terms of primary care—but with the right pieces and connections in place.

Informants identified several enablers, including a stronger appreciation of the role of PHC and growing comfort with different funding models and incentives.

New Brunswick

New Brunswick had just changed governments at the time of this review. The campaign platform of the victorious conservative party prior to the election stated that "all New Brunswickers are entitled to primary care and access to a family doctor" (currently 92% have access). Further, the party promised to "expand the Collaborative Practice Clinic model" and "explore the use of Family Health Teams to bring together doctors, nurses, pharmacists and other professionals to expand access …" (p. 11). Much of the PHC policy presented below was part of their previous time in government, so it may be safe to assume it will continue.

The New Brunswick Department of Health maintains information on PHC on its website.⁵⁸ Informants confirmed that the initial four key elements of PHC⁵⁹ (teams, access, information and healthy living) are still being used to guide discussion for further development.⁶⁰

New Brunswick continues to support initiatives begun during the PHCTF, such as the network of nine CHCs offering primary care, health promotion, disease prevention, health education and CDM using interprofessional collaboration.⁶¹ In addition, there are 19 primary care practices with physicians and nurses and five collaborative practices with physicians and nurse practitioners.⁶² The PHCTF also supported the establishment of the Building a Better Tomorrow initiative (BBTI) program⁶³ for education on PHC and building teams. Many health providers and others from the Atlantic regions have gone through the teaching modules, which are still being used in the education of staff at a new "medical home" pilot in the Miramachi.

The Primary Health Care Advisory Committee, which was begun under the previous government, has just completed a discussion paper on improving PHC. The committee framed its discussion within the initial four pillars guiding PHC reform in New Brunswick, as noted above. The committee made a number of recommendations. It endorsed the notion of access to innovative models that will ensure that all citizens will have access to family physicians supported by an interdisciplinary PHC team. To support the provision and use of better information, the committee supported improved IT, including more adoption of EMRs with linkages to EHRs. The "One Patient One Record" initiative is being developed now. The committee also proposed the development and adoption of software with a dashboard of indicators to enhance understanding of the types and frequency of delivery of services by individual providers and teams, as well as IT for prescription information. The committee also proposed exploration of alternative pay and remuneration models and funding models.⁶⁴

According to informants, there have been some challenges. Better use could be made of the BBTI PHC educational system. One of the challenges for FFS physicians and some other providers is potential loss of income to attend or participate due to the need to replace lost FFS revenue. Also, CDM does not have the spread or uptake in PHC settings that it should.

Informants indicated that the good news is that more physicians are asking about PHC approaches. As well, in PHCOs, there is a sense that more physicians are saying that they appreciate that the traditional model of primary care is unsustainable and does not provide the potential of proposed interdisciplinary or collaborative models. Informants indicated that rural physicians want to discuss how to move forward while keeping in mind the particular role that rural hospitals play in concert with primary care in their communities. New Brunswick was pointed to as a jurisdiction that has retained a high level of hospital privileges for family physicians. This was seen positively as maintaining vertical integration of PHC with acute care and hospitals. Overall, informants felt that there is strong interest among physicians and other providers to keep PHC reform going.

Newfoundland and Labrador

The Newfoundland and Labrador Department of Health and Community Services does not present a policy or central direction for PHC. Much of the drive to support PHC and related initiatives is expressed at the level of regional authorities. PHC teams are currently providing an array of services. Teams include physicians, nurses, community health staff, social workers and a coordinator. Other team members are added as needed, potentially including occupational therapists, pharmacists, physiotherapists and psychologists. The province plans to set up 30 team areas that would cover the whole population.⁶⁵

Newfoundland and Labrador developed three PHC CHC sites with support from the HTF, including one site that incorporated alternative funding. The PHCTF supported continued development of the three CHCs, including exploration of networks and collaboration with multidisciplinary healthcare teams, nurse

practitioners and alternative funding. Newfoundland also partnered with other Atlantic provinces in the development of self-care/telecare and the Building a Better Tomorrow PHC education initiative with multiple education modules for PHC and elements like team development and collaboration.

The 2008–2011 strategic plan of the Newfoundland and Labrador Department of Health and Community Services has established a goal to increase capacity in CDM.⁶⁶ Diabetes collaboratives now include physicians or physicians' groups. According to informants, these efforts require more interdisciplinary teams that include nurses, nurse practitioners and others as they move forward.

A major challenge is working out arrangements to replace the lost FFS funding of physicians when they are required to spend time away from patients to work on PHC development programs.

On the positive side, informants reported an increased willingness on the part of physicians and other providers to collaborate and work together. And good work is continuing with small groups of physicians in the area of broader PHC development. Memorial University is helping to lay the groundwork for future PHC development with its program of interprofessional education to support collaborative practice. This program was developed with the support of the Faculty of Medicine and the Schools of Social Work, Nursing and Pharmacy.⁶⁷

Northwest Territories

While "primary healthcare" may not be explicitly mentioned on the NWT Health and Social Services website entry, the department's stated overarching mission to "... promote, protect and provide for the health and well-being of the people of the NWT" evokes its PHC-oriented approach. This is reinforced by key aims for promoting healthy choices, protecting public health, preventing illness and disease, and protecting children and people at risk from abuse. These aims are echoed in the department's activity and the 2009/10 Annual Business Plan⁶⁹ and demonstrated in its annual reports. PHC-related activity is driven by eight Health and Social Services Authorities responsible for the planning, management, and administration and delivery of health and social services programs and services. To

In general, community health programs include daily drop-in clinics, public health clinics, home care, school health programs and educational programs. Visiting physicians and specialists routinely visit communities. Social service programs include early intervention and support to families and children, child protection services, adoptions, family violence prevention, and mental health, addictions and corrections programs.⁷¹

In the Northwest Territories, PHC and other services are delivered through the Integrated Services Delivery Model (ISDM), a client-focused, team-based approach to providing health and social services, highlighting a focus on illness and injury prevention and health promotion. The ISDM comprises three key elements to better integrate health and social programs and services: using a primary community care approach; ensuring that all caregivers and their organizations are connected and work together; and resolving to strengthen six core services.⁷²

As the basis of the ISDM, the Primary Community Care (PCC) model was developed during the PHCTF to build on existing services, along with formation of two interdisciplinary health organizations and a range of programs. The PCC model targets service and system integration from primary community care to secondary and tertiary levels of service. PCC characteristics and principles are geared to strengthen collaborative, client-centred and comprehensive PHC wellness and social services.^{73, 74, 75} There is growing focus on CDM.

In most of the Northwest Territories outside major centres, the primary caregivers are nurse practitioners or advanced-practice nurses, ^{76, 77, 78} who practise with long-distance support from physicians who are all on salary. Most medical services, including obstetrics and hospital services, are provided by family practitioners. Other team members include mental health workers and community social workers. Specialist physicians provide consultation services and direct care for high-risk or intensive cases only.⁷⁹

PCC teams provide services at the community level, where providers may or may not be co-located. They are supported by regional support teams that operate from regional centres and provide mobile services to communities. Regional teams can provide referral to territorial support teams/services or to outside services as required. Informal interprofessional teams of two to six members deliver health programs in smaller communities.

CHCs in all but eight communities provide 24/7 access to basic care. Access is enhanced by "Tele-Care," health lines for nursing input, information and triage that were developed during the PHCTF to "support the PHC system by improving access to health information and services." With development support from Canada Health Infoway, NWT's WestNet supports provision of a range of clinical and social services, while a telespeech pathology initiative will bring telehealth functionality to all NWT communities. 81

Despite systemic challenges presented by health personnel shortages and the discontinuity of short-term, transient locums or visiting personnel, citizens recently reported considerable satisfaction with their healthcare. ⁸² Informants attributed much of this progress with reforms to nurse leaders, medical directors and political support. In sync with this, the 2009–2012 NWT Health and Social Services strategic plan, *A Foundation for Change*, provides a vision of partnership in a seamless and efficient system, building on the departmental mission with a plan that "continues to evolve how we support our staff in providing these vital services."

Informants indicated that PHC reform takes time—"much like moving the Titanic"—and that the RHAs can sometimes function like "stovepipes." One challenge is overcoming the historic focus on acute care and hospitals to draw more attention to the PHC side. The next challenge has been overcoming initial resistance from physicians, other health providers and communities. Informants pointed to another issue—the lack of health human resources—which is particularly hard on small communities that lose provider continuity and have inadequate bandwidth for IT development.

On the positive side, support for adopting teamwork and collaboration has grown and is mostly working well, with physicians and other health providers now seeing it more as part of the solution. In addition, it was reported that having all physicians on salary has been very helpful, while the building of an accountability structure for salaried physicians to ensure appropriate access for patients and productivity has been well received.

Nova Scotia

The Nova Scotia Department of Health and Wellnessⁱ maintains information on PHC on its website. PHC is defined as:

...the first and continuing point of contact for Nova Scotians with the healthcare system. It focuses on promoting health, preventing illness, managing chronic diseases and treating people when they are sick. Primary Health Care also helps ensure continuity of care across the system.

i This new department was created in January 2011, merging the former N.S. Department of Health with the Department of Health Promotion and Protection.

Partnering, patient involvement and improvement of access are major aims identified, along with other PHC attributes, as the system's foundation.⁸⁴

Nova Scotia builds on work supported through the HTF and the PHCTF to pilot PHC models with interdisciplinary teams. The PHCTF also supported Nova Scotia's partnership with other Atlantic provinces to establish self-care, telecare and the innovative Building a Better Tomorrow initiative (BBTI), with educational modules for establishing PHC and teams that were attended by many throughout the area. 85 Nova Scotia also used PHCTF support to hire PHC directors at the district level to oversee PHC.

A PHC section exists within the Department to provide support, materials and information. ⁸⁶ Nine district health authorities (DHAs) across Nova Scotia and the IWK Health Centre in Halifax ^{87, 88} are principally responsible for the delivery of services, including PHC. The Department retains responsibility for physician services, pharmaceutical programs and emergency health services. Informants indicated that DHAs establish most of the "on-the-ground" PHC policies and coordination, as they are responsible for hospitals, community health services, mental health services and public health programs. Performance, outcomes and accountability targets, including those related to PHC access, are outlined in the *Nova Scotia Department of Health 2010-11 Statement of Mandate*. ⁸⁹

Reform in Nova Scotia has focused on developing collaborative PHC teams and alternative funding approaches, culturally sensitive guidelines and policies, and efforts in support of EHR development. *The Registered Nurses Act* and regulations (2002) enables nurse practitioners to work with physicians in collaborative practices across the province. There have been significant investments in the Nova Scotia Nursing Strategy (Phase 1: 2001–2006⁹⁰; Phase 2: April 2007⁹¹), as developed jointly by the Department of Health and the Provincial Nursing Network to enhance nursing practice within a collaborative environment.

Collaborative teams vary across settings and may include a physician, nurse practitioner, midwife, pharmacist, dietitian, social worker, community mental health worker, physiotherapist or occupational therapist, according to local needs. 92 93 Midwifery is being introduced using model sites in three DHAs to represent urban, rural/remote and regional populations. Midwives are paid by the DHAs. 94 Team development is supported by the BBTI through online access to diverse educational materials covering community partnerships, conflict resolution, decision-making and leadership, enhancing collaboration, generations and learning styles at work, interpersonal and communication skills, program and planning, roles and responsibilities, team functioning, and understanding PHC. 95

The Primary Health Care Information Management Program supports PHC providers through an EMR system to support access to patient information, population-based approaches to delivery, CDM and health promotion as well as team-based care. ⁹⁶ Nova Scotia HealthLink 811 provides 24/7 access to a registered nurse who provides advice and information and may, in turn, advise seeing a doctor or going to the emergency room. ⁹⁷

The Nova Scotia Department of Health, Primary Health Care and the Department of Family Medicine at Dalhousie University have been supporting primary care research and evaluation in recent years. An evaluation system/framework for PHC and an evaluation reference manual were developed to assist DHAs and other stakeholders in conducting primary care research and evaluation. An October 2008 meeting of provincial stakeholders promoted sharing of information and lessons learned in primary care research and linkages within a larger PHC environment.⁹⁸

The *Nova Scotia Department of Health 2009-10 Business Plan* sets out a strategic priority to "develop a comprehensive primary health care system for all." The plan calls for strengthening HealthLink 811, expanding the use of EMRs by physicians from 40% to 77% by 2012, strengthening CDM, establishing strategies and more support for collaborative teams, and assessing the three model sites using midwives, for future application elsewhere.⁹⁹

Informants indicated that progress in PHC development has been mixed. Data to confirm and evaluate progress are inadequate. The Department is primarily responsible for production of much of the PHC information for the province and for overall funding of districts. PHC principles are still guiding overall direction. One barrier is the fiscal unknown related to what the cost will be to make the full transition to integrated PHC. There is no requirement for districts to spend a specified amount on PHC. Districts are leading most of the policy and activity on the ground. While guidelines and material provided have proven useful, there is still a tug between the emphasis on primary care versus that on PHC. As independent business owners, many physicians are reluctant to support PHC development, but there are increasing signs that there is more appreciation that the old models are not sustainable. Many more physicians and other providers are moving PHC forward, including through the establishment of interdisciplinary teams and collaborative approaches. One example was cited where a nurse practitioner is visiting six physicians' nursing home patients, charting the information and reporting back to the physicians. The family practice nurse initiative to add nurses to solo physician practices is being well received. CDM is going well, with 80% of activity connected to PHC settings.

Nunavut

The mission and mandate of the Government of Nunavut Department of Health and Social Services distinctly reflect a PHC-focused health system. The Department offers a range of programs and services in primary and acute care (both inpatient and ambulatory), child protection, family services, mental health, health promotion and protection, and injury prevention. Departmental goals include a focus on the health of families and communities, health promotion and protection, and service delivery that integrates and coordinates health and social services with accountability and responsiveness to the people of Nunavut.¹⁰⁰

Nunavut Tunngavik's 2008 Report on the Health System, which reviewed the state of Inuit health and healthcare, indicated the following: The primary health care approach places the community, rather than the nurse, doctor, and other health workers, at the centre and does not exclude traditional healing methods ... It is a basic principle of the primary health care approach that individuals and communities should have the right and responsibility to be active partners in making decisions about their health care and the health of their communities. (p. 33)¹⁰¹

PHC is also influenced and guided by the goals and plans for health protection and prevention of disease and injury set out in the Department's first public health strategy for Nunavut, *Developing Healthy Communities* 2008–2013.¹⁰²

Nunavut presents an especially complex environment for PHC. It offers services in four languages to the youngest population in Canada distributed across three time zones, to 25 communities accessible only by sea or air, in the youngest (established on April 1, 1999) and the largest jurisdiction in Canada. 103, 104, 105

At the same time, Nunavut is experienced in PHC, delivering services in communities through health centres using a multidisciplinary team PHC approach that includes community health nurses, nurse practitioners, community health representatives, visiting physicians and interpreters. In some communities,

teams also include social workers, midwives, physiotherapists, occupational therapists, speech pathologists, visiting consultants, mental health workers, laboratory technicians and others. Medivac teams are also important interfaces between primary health and other services.

Nurses are the primary providers in Nunavut, at the core of the interdisciplinary team approach. As the first point of contact, they provide primary and emergency services, refer to physicians and prescribe certain medications, while operating under a registered nurse Scope of Practice, ¹⁰⁶ PHC nurse practitioner Practice Guidelines ¹⁰⁷ and/or nurse practitioner Prescriptive Authority Guidelines. ¹⁰⁸ To overcome recruitment and retention challenges, health professionals such as advanced-practice nurse practitioners are offered a mix of salary and bonus to encourage longer-term practice. ¹⁰⁹ Recent input indicated that a proposal for licensed practical nurses was before the legislature with anticipated completion by November 2010. Licensed practical nurses are anticipated to fill gaps in such settings as CHCs, home care, hospitals and long-term care.

PHC reform in Nunavut has included building the capacity of health centres, multidisciplinary teams and coordination with other health services as well as enhanced health promotion initiatives for mental health, better health practices for newborns and early childhood development, prevention of injury and abuse, and PHC outreach to communities for citizen engagement and education to promote greater self-reliance in care.¹¹⁰

Services are both face-to-face and virtual. All communities have PHC centres consisting of at least two community health nurses, a social worker, community health representatives, clerk interpreters and an X-ray technician. The nurse in charge provides both clinical and administrative leadership for the team.¹¹¹ There are also two interdisciplinary PHC organizations and teams established during the PHCTF: the Family Practice Clinic serving the city of Iqaluit, which has two physician positions, three nurse practitioners, one licensed practical nurse and two interpreters; and the Regional Rehabilitation Clinic serving the Qikiqtani (Baffin) Region of 12 communities, with two physiotherapists, one occupational therapist, one territorial rehabilitation coordinator and support staff.¹¹²

Given the geographic area, Telehealth has provided patients with virtual access to team members. Health lines developed during the PHCTF, and still in use today, support PHC by improving access to health information and services. Funding from the Canada Health Infostructure Partnership Program (CHIPP) and the PHCTF helped to expand Telehealth in Nunavut beyond the original five sites to reach 25 communities. In 2006, the program demonstrated savings of \$1.6 million associated with reduced medical evacuations and reduced need to place patients at risk during travel. The Ikajuruti Inungnik Ungasiktumi (IIU) Network Telehealth Project is unique in involving clinical referral patterns that extend to several Canadian jurisdictions, including Alberta, Manitoba, Ontario and the Northwest Territories. A Winnipeg-based Northern Medical Unit hires physicians to be on call for phone or email consultation. 113, 114, 115, 116

Informants commented that there has been some resistance by some nurses to adding midwives. Other issues reported include the lack of understanding of health risks by the population and continuing challenges attracting adequate numbers of health providers.

On the positive side, the nursing first-point-of-contact model works very well and has strong community support. Clear statements of direction, coupled with gentle persuasion and engagement with nurses, physicians and others, appear to work well. The working relationship with physicians is good, and they are active in supporting PHC reform.

Ontario

Our search for the key words "primary health care" on the Ministry of Health and Long-Term Care (MoHLTC) website opened up a site for family health teams. There was no presentation of a consolidated PHC vision or policy site.

Ontario has a long history of PHC model development with interdisciplinary teams of providers predating national initiatives, including CHCs, health service organizations (rostered populations, capitation funding and incentive payment for achieving less hospitalization than area primary care practices) that are now called family health organization (FHOs), and Sault Ste. Marie's Group Health Centre, with its inclusion of specialist physicians along with family physicians in the medical partnership.

The HTF supported the development of primary care networks of physicians with enrolled patients and remuneration through either reformed FFS funding or global capitation.

The PHCTF supported telehealth, health line establishment, educational support for providers on collaboration and teams, and the development of additional models of PHC. Family health networks (FHNs) have five or more physicians, nurse practitioners, nurses and other providers. They are funded using capitation to determine a cap on FFS funding, and they feature EHRs and rostered populations. Family health groups (FHGs) have three or more physicians and enrolled populations and maintain FFS funding. All these models are still in place, including family health teams (FHTs) which were also developed at this time (see below).

As is clear from the above paragraphs, abbreviations and models abound. Information on policy related to FHNs, FHGs and FHOs is difficult to locate on the Ministry website, other than contact information within the Ministry. An additional model is presented here, the Comprehensive Care Model (CCM), which is for solo practitioner physicians, but with enrolled patients. Enrolment or rostering the population to primary care physicians and organizations represents a major thrust of Ontario policy. The de-emphasis on public information on the status and policy for all these models could be attributed to the emphasis on FHTs as the paramount PHC model for Ontario.

Family health teams include family physicians, nurse practitioners, registered nurses, social workers, dietitians and other health professionals. Patients are rostered, and compensation is through forms of blended funding (e.g. capitation or salary) plus other incentive payments.^{119, 120} The Ministry also provides compensation support for other health professionals.¹²¹ Ministry road maps and guides for FHT development are provided for interested physicians and others. The guides cover the implementation process, governance and accountability, health promotion and disease prevention, community partnerships, interdisciplinary/team development, roles and compensation, physician compensation, planning, technology, and integration of French-language services where appropriate.¹²² New applications are being phased in over time.¹²³ According to informants, demand from physicians to join or implement an FHT is high. In 2009, the government announced the creation of 150 new FHTs.¹²⁴ Information is also provided for the public to better understand what FHTs are and what they offer.¹²⁵ FHTs may include physicians, nurses or nurse practitioners, midwives, dietitians, pharmacists, chiropodists, podiatrists, mental health or addiction professionals, physiotherapists, occupational therapists, or chiropractors.¹²⁶

CHCs¹²⁷ are non-profit organizations with community boards. In addition to teams of providers, they also offer an array of additional community services and linkages to community programs depending on the needs of their populations. The government has announced adding 49 new CHCs in 2009.¹²⁸

Ontario has also created nurse practitioner-led clinics that include a collaborating physician and other health providers.¹²⁹ Ministry guides are provided to support implementation, interprofessional compensation, business and operational planning, and information technology.¹³⁰ Ontario announced the creation of 25 new clinics in 2009. The total population served by these clinics now numbers 50,000.¹³¹

Ontario provided additional support for implementing interprofessional care through a working group—the Interprofessional Care Strategic Implementation Committee, organized within Health Force Ontario, a provincial initiative aimed at healthcare professionals. The committee developed a number of resources¹³² and released a final report on implementing interprofessional care when its mandate ended in 2009.¹³³

Ontario established the Quality Improvement & Innovation Partnership (QIIP) as a provincially funded organization to advance the development of high-performing PHC in Ontario. ¹³⁴ QIIP conducts workshops and other meetings, facilitates innovative methods of exchanging information, supports networking, and provides tools and resources. ¹³⁵

Numerous informants put forward both challenges and successes in Ontario's PHC approach, which are described below.

Some informants pointed to the absence of a clearly articulated overarching direction for PHC that places patients at the centre and is coupled with principles to guide that direction. Rather, Ontario's direction could be described as a "selection of models" approach with extra emphasis and focus on preferred models.

Views on the development of teams were mixed. One informant indicated that it can take up to two years for teams to work out roles and relationships. Some physicians and others in new FHTs were not committed to teams and working with others, but they went along with their colleagues. This left some FHT patients at a disadvantage in receiving access to other providers. Over time, these physicians appeared to be more accepting of teams. Nurse practitioners are also more accepting, but there are some who are reluctant to collaborate with physicians. On the positive side, informants stated that there are now more positive developments with FHTs, as more physicians and other providers indicate that they want to move in this direction. And there is growing demand from both physicians and their patients for more access to other health providers.

IT development is still a challenge. All FHTs are required to use electronic records and supports, but many challenges remain and expected benefits have not been widespread. Nevertheless, there were reports of positive electronic applications supportive of quality, like receiving hospital diagnostic and other reports such as discharge information, as well as use of reminders to notify patients that it is time for procedures such as Pap smears.

Government oversight and evaluation of FHTs and other models using available data appeared to be lacking. Some informants felt that this was due, in part, to the emphasis on implementing FHTs and other models.

Two challenges relate to family physician coverage of hospitals in small towns and rural areas. Generous funding to work in hospitals had previously pulled many primary care physicians away from their practices. But now, generous funding for PHC work in the office has appeared to remove incentives to work in hospitals. Some northern contracts with physicians have balanced this situation, but additional evaluation is needed. A negative consequence of the trend to stay in the PHC office is a sense that family physicians may be more isolated in the system. Some family physicians elect to work as hospitalists or only in long-term care. The promise of improved PHC integration has worked well in linking primary care

providers and systems, and linking these with community health. However, more integration or linking PHC with specialists and hospitals has not worked well. One exception is the Group Health Centre in Sault Ste. Marie, where, as noted previously, specialists are part of the physician practice organization.

Some informants mentioned a need for more patient education, given the continuing high use of walk-in clinics and emergency rooms for primary care.

Informants also highlighted several positive developments. Patient enrolment, or rostering, is an area of success, given that more than 70% of the population is now rostered. There has also been a significant move away from FFS payment, with the majority of family physicians now being on some form of alternate payment plan. The number of medical students electing to specialize in family medicine is up, and many communities no longer have shortages of family physicians. Recognition of the importance of nurse practitioners, nurses, dietitians, pharmacists, social workers, physiotherapists and others is growing. In addition, there are more success stories that can be shared to support others' improvement. For example, the Group Health Centre reduced the number of patients re-hospitalized for heart failure by 43% and achieved a 25–33% reduction in diabetes-related complications. 136

Informants remarked that the next steps for Ontario should be to refine policy and programs to improve patient outcomes; establish performance measures; encourage a greater focus on EHRs and systems; establish more evidence-based outcomes in areas such as diabetes and cardiac care; and achieve targets for screening measures such as Pap smears.

Prince Edward Island

The Prince Edward Island (P.E.I.) health system has been going through significant transition to a "One Island Health System," with PHC as an important focus of system redesign since the PHCTF.¹³⁷ High-level province-wide health system reviews and stakeholder engagement from 2006 to 2008 recommended transformation of P.E.I. healthcare delivery to "... change its focus from acute (hospital-based) care to primary healthcare renewal."^{138, 139}

Government legislation in November 2009 and the *Health Services Act*¹⁴⁰ proclaimed April 1, 2010, created Health PEI, an island-wide Crown Corporation (Health Authority) to which the responsibility for operation and delivery of all P.E.I. health services was transferred on July 6, 2010. This organization includes more than 4,100 nurses, physicians and other health personnel. ^{141, 142}Cabinet and departmental shifts announced in January 2010 confirmed the Department of Health and Wellness's responsibility for policy development and administration of publicly funded health services in P.E.I., ¹⁴³ based on an explicit commitment to "work together in an environment of trust as team members and partners in care." ¹⁴⁴ Currently available PHC information reflects the transition under way.

The Department of Health and Wellness contains the Division of Primary Care, which encompasses responsibility for family/community health centres, community mental health, addictions, public health, chronic disease prevention/health promotion, and diabetes programs. ¹⁴⁵ On the Health PEI site, these areas have been folded into a new division, Community Hospitals and Primary Health Care, presenting the latest activity on primary care networks. Health centres and chronic disease prevention and management are under the primary care network management structure. ¹⁴⁶

Building on processes and initiatives over the previous five years, the *PEI Health System Strategic Plan* 2009–2012 guides health system decision-making and activities toward strategies for change that focus on community-based PHC, home-based hospital care services, focused integration of acute and related

facility-based care, and system enablers. The strategic plan becomes the basis for public reporting and accountability on performance and results. ¹⁴⁷ *The Health PEI Business Plan: April 1, 2010–March 31, 2011* serves as an agreement between the Minister of Health and Wellness and Health PEI, keeping a focus on the strategic plan's objectives. ¹⁴⁸

The Department of Health and Wellness incorporated the 2008 system review recommendations into the Integrated Health System Project, with PHC initiatives as a cornerstone of reform.^{149, 150} Underpinned by a PHC vision statement, three major PHC projects are under way: the new Primary Health Care Network model, the Mental Health Services Strategy, and the Integrated Chronic Disease Prevention and Management project. The design of the new PHC Network model is reflected in the new Health PEI organizational design.¹⁵¹

The new model puts patients and families at the centre of care "with a role to play," refocusing the emphasis of care on PHC "and services that can appropriately and safely be provided locally." Five PHC networks are now being developed, located to ensure similar population sizes and equitable access to services (the aim is to have PHC services within a 30-kilometre radius). Each network will include a network manager and a part-time medical director who will work in collaboration with family physicians, nurses and other health professionals, and administrative staff across the network. Consistent administrative structure, core groups of providers and principles such as collaboration will provide a unified approach. Moving to one leadership promotes common goals and standards.

Each network comprises a number of health centres, five of which were developed during the PHCTF ¹⁵³ and two of which are being developed in rural areas. Teams in health centres provide provincial services that include care for a full range of acute and chronic illnesses with emphasis on diagnosis and treatment, health promotion through education, illness prevention and CDM, primary mental health, public health, and targeted screening programs.^{154, 155, 156}

Approximately 33% of family physicians work in teams and on salary plus incentives. Overall, 60% of physicians are on forms of alternate payment (remuneration is set out in a master agreement between the Medical Society and government). Various types of teams provide health services in PEI and at times work together. They include those in health centres, primary health home care teams, integrated palliative care teams, public health teams, and community mental health and addiction teams. Is Informants mentioned current plans and resourcing to build capacity in current collaborative practice within health centres, networks and outreach. This may involve additional training using the BBTI Collaborative Practice Training modules developed during the PHCTF that were used to train family health centre personnel. There are plans to increase the number of nurse practitioners to at least one for each network. Other efforts include reaching out to other physician practices (both FFS and salaried) outside of health centres to collaborate in pilots such as for CDM.

Informants highlighted the use of facilitators to promote and spur reforms, currently in a team/network developer role to assist with network implementation and clarification of roles and responsibilities. To support and strengthen health system renewal and ongoing care, effort has been under way to develop a provincial interoperable EHR. During the PHCTF, the five family health centres were linked to the provincial health information system, with practice management software installed at all centres. Although there is currently no EMR for PHC, the vision is to complete development in stages (perhaps with Canada Health Infoway funding) and ensure that the existing acute-care Clinical Information System can ultimately connect physicians' offices and island hospitals. 160

Another major facilitator of reform was government commitment to fund and engage in significant focus on PHC renewal. A particular challenge identified by informants is the high expectation in terms of what PHC can do, with key performance indicators set and a lot to implement at the same time. One informant commented: "There is a lot going on and it's exciting!"

Quebec

Quebec's health and social system has gone through changes over time that have both incorporated and formed the foundations for PHC reform. The earliest efforts on PHC from the 1970s focused on the Centres locaux de services communautaires (CLSCs) as the first point of contact in the system. CLSCs are a form of CHCs with interdisciplinary teams of health and social service providers that provide primary care services, social services, health promotion and disease prevention, rehabilitation, and public health services. They have not always had a physician, but many did. Primary care was otherwise provided by FFS physicians, who resisted this direction.¹⁶¹

The HTF supported examination of numerous foundational efforts in PHC reform, including examination of capitation funding, CDM and telehealth applications to support nurse-led services in isolated communities, as well as refinements to CLSCs. The 2000 Clair Commission's recommendations for change to the health and social system included reforming PHC primarily through the establishment of family medicine groups (FMGs). These were formed in 2002 with support from the PHCTF.¹⁶²

Additional health system reform had regional authorities or social service agencies take responsibility for establishing local health and social services networks. In turn, the networks assumed responsibility for bringing together all parties, including physicians. Created within the networks were health and social services centres (CSSSs), produced by a merger of one or more CLSCs, residential and long-term care services organizations (CHSLDs), and hospital centres (CHs). 163, 164, 165, 166

FMGs consist of six to12 family physicians who work in groups, with extended working hours. The population served is registered with one of the FMG physicians. ¹⁶⁷ In addition to family physicians, there are nurses on site. The FMG is also required to develop service agreements with the CSSS to arrange access to other nurses and health providers at or from the CLSCs and potentially other local institutions as required. ^{168, 169, 170} The objectives for this model are to "(1) provide all residents of Quebec with access to a family doctor; (2) increase the accessibility of services and enhance the quality of care; (3) improve management, the continuity of care and the monitoring of registered patients; (4) augment complementarity with other health care entities; and (5) promote and enhance the role of the family doctor."¹⁷¹ The Health and Welfare Commissioner has reviewed PHC and produced an overview of the system¹⁷² in addition to a final appraisal to be presented later.

PHC is a mix of what are thought of as the public social model, expressed initially in the CLSC, and the private delivery model, expressed in the FMG. The current emphasis is on expanding and strengthening FMGs while continuing to refine and strengthen the CLSCs and other PHC elements. Informants indicated that one of the early challenges to bringing these two parts together has changed from the early days of emphasis on CLSCs, when many physicians resisted a move to what was seen as socialized medicine. Now, CLSC supporters are reluctant to move closer to the FMG and other private delivery, which is perceived as moving to the "medicalization" of allied health professionals. Physicians are remunerated through FFS plus additional funding for vulnerable patients and after-hours care provision. The administrative physician also receives administrative funding.

Informants recounted several challenges, including the slow process of encouraging physicians and others to move from working independently to working with others collaboratively. This concern also included observations that, to some extent, the local health networks and FMGs are not able to better address the needs of the elderly, given the continuing dominance of hospitals. Other areas of concern were the lack of progress on interdisciplinary team building and the use of nurses only for triage. Informants acknowledged that nurses, psychologists, pharmacists and others do not need to be hired by FMGs. They felt, however, that there should be more emphasis on including more allied health professionals in these settings, through service agreements that emphasize true partnerships and collaboration. Informants indicated that some progress is being made at a few sites, with nurses having enhanced follow-up with patients and, at some sites, being delegated to write prescriptions for some things like birth control.

Another concern was the high rate of hospital work by family physicians coupled with insufficient followup of non-complicated issues that are now being picked up by physician specialists. And in spite of efforts on reform, there are still a significant number of people in Quebec without a family physician.

Some of these concerns were echoed in the appraisal of PHC by the Health and Welfare Commissioner. The final report points to various concerns and presents recommendations for government to address, some of which are described below.¹⁷³

To overcome the significant number of physicians still in solo practices, the Commissioner recommended more encouragement of medical group practice and the expansion of FMGs to 300, to cover 75% of the population.

The use of electronic records has not kept pace with reform targets. Use of EMRs by physicians is very low. Quebec has a shareable EHR that allows for the tracking of laboratory tests, diagnostic radiology and pharmaceutical profiles. Linking this with the EMR for practice information was recommended for support by appropriate financial and other supports, including guidelines.

At this time, one in three physicians works alone, and only one-quarter work in collaboration with professionals from other disciplines. The Commissioner recommended increasing interdisciplinarity in PHC group practices to include nurses, nurse auxiliaries, psychologists, dietitians, social workers and others who could maintain their employment through the CSSS but work with or at the FMG.

Other recommendations included strengthening capacity to support self-care, encouraging and improving patient registration with FMGs, and introducing mechanisms for clinical performance, appraisal and ongoing medical improvement. Finally, the Commissioner recommended the realignment of physician remuneration to encourage movement toward a mixed or blended form that would include portions of salary, capitation and FFS, along with incentives to encourage registration of patients.

Saskatchewan

Saskatchewan has maintained information on primary health on its website.¹⁷⁴ The development of health lines and of multidisciplinary teams and networks began under the HTF and continued with PHCTF support. To facilitate this early development, Saskatchewan funded directors of PHC in all the RHAs, and they remain in place today.

PHC policy is guided by a set of defined characteristics including access, public participation, health promotion/disease prevention, CDM collaboration, use of technology, inter-sectoral co-operation, patient-centred care, community development, best use of health resources, and integrated and coordinated services. The PHC plan is for an integrated system of health services within RHA-managed networks

and teams of healthcare providers available to all.¹⁷⁶ Different forms of network teams will exist. Program teams will focus on specific populations for mental health, CDM or others. Central teams for PHC will have a minimum of three physicians and a primary care nurse practitioner to serve a population of 5,000. Urban central teams may be larger. Co-location of team members is considered desirable, but not required. Satellite teams would have a primary care nurse and a visiting primary care physician, as well as other visiting staff provided through linkages with a central team.¹⁷⁷

Informants indicated that the process of development has continued, with Saskatchewan Health providing funding and other guidelines, and the RHAs implementing and managing the process within their regions. The Patient First consultation, concluded in 2009, calls for a health system that makes patients and family-centred care the foundation and principal aim of Saskatchewan Health. Recommendations call for improvements to primary care, particularly for rural and remote areas, and for province-wide disease management connected to interdisciplinary teams.¹⁷⁸

Challenges at the provincial level include physician engagement, leadership and accountability. Informants indicated that discussions with family physicians on compensation are not as productive as moving the discussions to focus on what services are required and what the outcomes should be. Another challenge to development and distribution was community competition to attract physicians. Recent meetings that have included mayors have proved beneficial in getting this out in the open and introducing more options for community sharing of providers. IT applications are moving forward, with eight teams now using IT solutions. However, informants pointed to the need for more HER use to support PHC work. Recent referrals by nurse practitioners to specialist physicians have produced mixed reactions, with some of the referrals being accepted and others not.

Although some informants reported that RHAs are still facing a continuing struggle in trying to make collaboration and teams work, they also indicated that good progress has been made toward interdisciplinary and shared care. Some rigidity of provincial parameters was acknowledged as a challenge at both the provincial and RHA levels. Some other challenges identified were timely access to services, inadequate physician participation in program development, and some shortages in mental health professionals, rehabilitation therapists and pharmacist resources. In addition, bringing on board other providers such as physiotherapists, where required, has sometimes been hampered by the fact that much of the funding for team development was restricted to nurse practitioners. However, nurse practitioners have been very well received wherever they have been placed.

Yukon

PHC services continue to be provided primarily through nursing stations and health centres in Yukon, with community nurses providing most of the first point of contact.^{179, 180} Primary care physicians are predominantly paid by FFS.

There is no overarching PHC policy in Yukon at this time. Rather, the policy direction has been to establish initiatives related to PHC, with key elements including collaboration among providers to achieve teamwork. The initial PHC work launched under the PHCTF focused on CDM collaboratives. The Diabetes Collaborative, for instance, with teams of physicians, nurses, physiotherapists, pharmacists and nutritionists, has grown and matured over time with continued government support. From an initial small number, currently more than 80% of Yukon physicians are participating in the Diabetes Collaborative.

Partnerships with other jurisdictions have been part of PHC-related initiative development in Yukon. The Diabetes Collaborative toolkit and flow sheet was developed initially in partnership with British Columbia. Another recent example is Yukon's partnership with Alberta to implement the Weight Wise program involving a physician, nurse, dietitians and a kinesiologist. It provides access within the territory to education modules for patients and, if necessary, a referral for gastric by-pass surgery. According to informants, the program has improved access for the public, eliminated a two-year waiting time for surgery and reduced costs.

Most physicians have EHRs with linkages to laboratory results. E-health continues to expand, providing access for 95% of Yukoners to telehealth, videoconferencing, telehomecare and teleradiology. Plans exist to develop more integration with British Columbia.¹⁸²

Yukon has passed legislation for the licensing of nurse practitioners. Discussions are now under way with government staff, nurses, physicians and others to discuss the best use of nurse practitioners in the health system.¹⁸³

Yukon has conducted a health care review, releasing a final report in 2008. ¹⁸⁴ There was strong support for the concept of collaborative or interdisciplinary team models. Yukon has used a collaborative approach to managing diabetes for years. The report also discussed the potential to apply this model to primary care settings to "help avoid inappropriate emergency room visits, improve patient access, and reduce physician workloads." The report recommended that "the government should proactively encourage the expansion of a collaborative (or team-based multidisciplinary) PHC delivery model where it can be demonstrated that the model will work with chronic care patients and/or in clinical models, in an effort to ensure better and accelerated access to primary care in a more appropriate and more cost-effective manner"(p. 45).

The subsequent consultation with the public presented strong support for collaborative care models for PHC and for the inclusion of midwifery. The 2009–2014 strategic plan promises to review the recommendations of the health care review for implementation. In addition, the plan makes several commitments to information technology, including plans to establish a comprehensive medical record available to all physicians and allied health professionals for patient care. Further, the plan calls for improvements to the telehealth system, health line access to a specially trained nurse on a 24/7 basis for Yukoners through a partnership with British Columbia, and continued enhancement of CDM programs. 186

Informants mentioned a few issues that slowed progress, such as initial physician resistance. There was also some initial conflict between physicians and nurse practitioners. There is still a challenge funding FFS physicians to participate in PHC education and meetings when away from their patients. However, informants pointed to growing positive support from physicians. A key facilitator here was working with physician leaders.

REFERENCES

- Mable, A. L., &t Marriott, J. (for Health Canada). (2002). Sharing the Learning: The Health Transition Fund. Synthesis Series: Primary Health Care. Ottawa: Health Canada. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-htf-fass-prim/2002-htf-fass-prim-eng.pdf
- 2 Commission d'étude sur les services de santé et les services sociaux. (2000). Emerging Solutions.
- 3 New Vision New Brunswick.
- 4 Legislative Assembly of New Brunswick. (2000 November). Speech From the Throne, 2000. Retrieved from: http://www.gnb.ca/legis/business/pastsessions/54/54-3/thronespeech00-e.asp
- 5 Fyke, K. J. (2001). Caring for Medicare—Sustaining a Quality System. Saskatchewan Commission on Medicare.
- McMurchy, D. (2010). What Are the Critical Attributes and Benefits of a High-Quality Primary Healthcare System? Ottawa: Canadian Health Services Research Foundation. Retrieved from: http://www.chsrf.ca/Libraries/Primary_Healthcare/11498_PHC_McMurchy_ENG_FINAL.sflb.ashx
- Russell, G., Johnston, S., Thille, P., Geneau, R., Conklin, J., Hogg, W., & Ikezawa, Y. (2010). A Structure for Co-ordinating Canadian Primary Healthcare Research. Ottawa: Canadian Health Services Research Foundation. Retrieved from: http://www.chsrf.ca/Libraries/Primary_Healthcare/11498_PHC_russell_ENG_FINAL.sflb.ashx
- Katz, A., Glazier, R. H., & Vijayaraghavan, J. (2010). The Health and Economic Consequences of Achieving a High-Quality Primary Healthcare System in Canada—"Applying What Works in Canada: Closing the Gap." Ottawa: Canadian Health Services Research Foundation. Retrieved from: http://www.chsrf.ca/Libraries/Primary_Healthcare/11498_PHC_Katz_ENG_FINAL.sflb.ashx
- 9 Barclay, K., & Fletcher, L. (2010). CHSRF knowledge transfer: Policy priorities for primary healthcare improvement: A national conversation. Healthcare Quarterly, 13(2), 12–13
- Schoen, C., Osborn R., Doty M. M., Squires D., Peugh, J., & Applebaum, S. (2009, November 5). Perspectives on care, costs, and experiences. Health Affairs, w1171–1183.
- Health Canada. (2007). Health Care System: Health Transition Fund. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/infostructure/finance/htf-fass/index-eng.php
- Health Canada. (2007). Health Care System: Health Transition Fund Publications: Synthesis Reports, Spring 2002. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/infostructure/finance/htf-fass/pubs-eng.php
- 13 Mable, A. L., & Marriott, J. (for Health Canada). (2002). Op. cit.
- Health Canada. (2007). Health Care System: Public Health Care Transition Fund. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index-eng.php
- Health Canada. (2007). About Health Canada: Primary Health Care Division: Retrieved from: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/phcphd-dsspsp/phcd-dssp-eng.php
- Health Canada. (2007). First Nations, Inuit and Aboriginal Health: Aboriginal Health Transition Fund. Retrieved from: http://www.hc-sc.gc.ca/fniah-spnia/services/acces/ahtf-eng.php

- National Defence and the Canadian Forces. (2008). Primary Care Renewal Initiative: An Innovative Model for Care. Retrieved from: http://www.forces.gc.ca/health-sante/proj/RX2000/pcri-irsp-eng.asp
- 18 Canada Health Infoway. (2011). About Canada Health Infoway. Retrieved from: http://www.infoway-inforoute.ca/lang-en/about-infoway
- Health Canada. (2006). Health Care System: 2003 First Ministers' Accord on Health Care Renewal. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php
- Health Council of Canada. (2009a). Online Library: Publications: Primary Health Care. Retrieved from: http://healthcouncilcanada.ca/en/index.php?page=shop.browse&category_id=20&toption=com_virtuemart&Itemid=170
- Canadian Institute for Health Information (CIHI). (2009). Analysis in Brief: Experiences With Primary Health Care in Canada. Ottawa: CIHI. Retrieved from: http://secure.cihi.ca/cihiweb/products/cse_phc_aib_en.pdf
- Canadian Institute for Health Information (CIHI). Primary health care information. Retrieved from: http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=indicators_phc_e
- CIHR pledges to tackle primary health care [News]. (2010, March 9). CMAJ, 182(4), E188–189. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2831697/pdf/182e188.pdf
- Canadian Institutes of Health Research (CIHR). (2010). CIHR Primary Healthcare Summit: Patient-Oriented Primary Healthcare—Scaling Up Innovation. Ottawa: CIHR. Retrieved from: http://www.f2fe.com/cihr/2010/postevent/CIHR%20PHC%20Summit%20Report_For%20Distribution.pdf
- Canadian Health Services Research Foundation (CHSRF). (n.d.). Programs: Primary Healthcare. Retrieved from: http://www.chsrf.ca/Programs/PrimaryHealthcare.aspx
- Canadian Health Services Research Foundation (CHSRF). (n.d.). Primary Healthcare: Improving Primary Healthcare in Canada. Retrieved from: http://www.chsrf.ca/Programs/PrimaryHealthcare/ImprovingPrimaryHealthcareInCanada.aspx
- Alberta Health and Wellness. (n.d.). Primary Health Care. Retrieved from: http://www.health.alberta.ca/initiatives/primary-health-care.html
- Primary Care Initiative (Alberta). (2011a). Primary Care Initiative: About PCNs. Retrieved from: http://www.albertapci.ca/AboutPCNs/Pages/default.aspx
- 29 Primary Care Initiative (Alberta). (2011b). Primary Care Initiative: Developing a PCN. Retrieved from: http://www.albertapci.ca/DevelopingPCN/Pages/default.aspx
- Primary Care Initiative (Alberta). (2011c). Primary Care Initiative: Operating a PCN. Retrieved from: http://www.albertapci.ca/OperatingPCN/Pages/default.aspx
- Primary Care Initiative (Alberta). (2011d). Operating a PCN: Guide for other Health Care Providers. Retrieved from: http://www.albertapci.ca/OperatingPCN/Pages/GuideforOtherHealthCareProviders.aspx
- 32 Primary Care Initiative (Alberta). (2011d). Op. cit.
- Primary Care Initiative (Alberta). (2011e). PCN Features: Primary Care Networks Use Teamwork to Deliver Seamless Care to Albertans (article courtesy of Alberta Health Services). Retrieved from: http://www.albertapci.ca/NewsEvents/PCNFeatures/Pages/Primarycarenetworksuseteamwork.aspx

- Alberta Health Services. (2010). 2010/11 Operating Budget and Business Plan. Retrieved from: http://www.albertahealthservices.ca/Publications/pub-2010-06-29-budget-businessplan.pdf
- Alberta Health Services. Strategic Directions 2009–2012: Defining Our Focus/Measuring Our Progress. Retrieved from: http://www.albertahealthservices.ca/files/org-strategic-direction.pdf
- Horne, F. (Legislative Assembly Alberta). (2010). Putting People First, Part One: Recommendations for an Alberta Health Act. Retrieved from: http://www.health.alberta.ca/documents/Alberta-Health-Act-Report-2010.pdf
- 37 Horne, F. (Legislative Assembly Alberta). (2010). Op cit.
- British Columbia Ministry of Health. (n.d.) Primary health care. Retrieved from: http://www.primaryhealthcarebc.ca/phc
- British Columbia Ministry of Health. (2007). Primary Health Care Charter: A Collaborative Approach. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2007/phc_charter.pdf
- British Columbia Ministry of Health. (n.d.). Primary Health Care Practices: Primary Health Care Organizations / Community Health Centres. Retrieved from: http://www.health.gov.bc.ca/pcb/phc_infosites.html
- General Practice Services Committee (GPSC). (2009). Fact Sheets. Retrieved from: http://www.gpscbc.ca/media/fact-sheets
- General Practice Services Committee (GPSC). (2009). Backgrounders. Retrieved from: http://www.gpscbc.ca/media/backgrounders
- Hollander, M. (for the British Columbia Ministry of Health Services and the General Practice Services Committee). (2009). Evaluation of the Full Service Family Practice Incentive Program and the Practice Support Program: Final Synthesis Report. Retrieved from: http://www.gpscbc.ca/system/files/GPSC_Synthesis_Report_2009-06-28.pdf
- Divisions of Family Practice (a GPSC initiative). (n.d.). Welcome to the Divisions of Family Practice. Retrieved from: http://www.divisionsbc.ca/provincial/home
- Health Council of Canada. (2009b). Teams in Action: British Columbia. Integrated Health Networks:

 A New Way to Care for Chronic Conditions. Retrieved from: http://www.healthcouncilcanada.ca/docs/rpts/2009/TIA_BC.pdf
- 46 Health Council of Canada. (2009b). Op cit.
- Divisions of Family Practice (a GPSC initiative). (n.d.). Divisions of Family Practice Glossary. Retrieved from: http://www.divisionsbc.ca/glossary
- 48 Manitoba Health. Primary Health Care Initiatives. Retrieved from: http://www.gov.mb.ca/health/phc/init/index.html
- 49 Manitoba Health. (n.d.). Physician Integrated Network (PIN). Retrieved from: http://www.gov.mb.ca/health/phc/pin/index.html
- Manitoba Health. (n.d.). Physician Integrated Network (PIN): Participating Sites. Retrieved from: http://www.gov.mb.ca/health/phc/pin/sites.html

- Manitoba Health. (n.d.). Physician Integrated Network (PIN): Interdisciplinary Teams. Retrieved from: http://www.gov.mb.ca/health/phc/pin/teams.html
- Manitoba Health. (n.d.). Physician Integrated Network (PIN): Funding and Remuneration. Retrieved from: http://www.gov.mb.ca/health/phc/pin/fund.html
- Manitoba Health. (n.d.). Physician Integrated Network (PIN): What Is Quality Based Incentive Funding? Retrieved from: http://www.gov.mb.ca/health/phc/pin/qbif.html
- PRA Inc. (for Manitoba Health and Healthy Living). (2009). Evaluation of the Physician Integrated Network (PIN): Phase 1—Summary Report. Retrieved from: http://www.gov.mb.ca/health/phc/pin/docs/phase1evaluationreport.pdf
- Manitoba Health. Primary Health Care Carelink. Retrieved from: http://www.gov.mb.ca/health/phc/carelink.html
- Horizon Health Network (N.B.). (2010). Strategic Plan 2010–2013. Retrieved from: http://www.rhab-rrsb.ca/pdfs/strategicplan_2010.pdf
- Progressive Conservative Party of New Brunswick. (2010). Putting New Brunswick First...for a Change [Party platform]. Retrieved from: http://www.pcnb.ca/files/PCNB_ForAChangeBooklet_ENfin UPDATE.pdf
- New Brunswick Department of Health. (n.d.). Primary Health Care: What Is Primary Health Care? Retrieved from: http://www.gnb.ca/0053/phc/index-e.asp
- New Brunswick Department of Health. (n.d.). Primary Health Care: Four Key Elements [also links to CHC services and CDM]. Retrieved from: http://www.gnb.ca/0053/phc/what_is_phc-e.asp
- New Brunswick Department of Health. (2008). Transforming New Brunswick's Health-Care System: The Provincial Health Plan 2008–2012. Retrieved from: http://www.gnb.ca/cnb/promos/php/PHP-e.pdf
- New Brunswick Department of Health. (n.d.) Primary Health Care: Interprofessional Collaboration. Retrieved from: http://www.gnb.ca/0053/phc/interprofessionnal-e.asp
- Primary Health Care Advisory Committee (PHCAC). (2010). Improving Access and Delivery of Primary Health Services in New Brunswick [Discussion paper]. PHCAC.
- New Brunswick Department of Health. (n.d.). Primary Health Care: Building a Better Tomorrow Initiative. Retrieved from: http://www.gnb.ca/0053/phc/better_tomorrow-e.asp
- 64 Primary Health Care Advisory Committee (PHCAC). (2010). Op. cit.
- Health Council of Canada. (2009c). Teams in Action: Primary Health Care Teams for Canadians—A Newfoundland and Labrador Perspective [Summary]. Retrieved from: http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_Newfoundland_Summary.pdf
- Newfoundland and Labrador Department of Health and Community Services. (2008). Strategic Plan 2008–2011. Retrieved from: http://www.health.gov.nl.ca/health/publications/plan2008_11.pdf
- 67 Memorial University of Newfoundland. (2010). Collaborating for Education and Practice:
 An Interprofessional Education Strategy for Newfoundland and Labrador. Retrieved from: http://www.med.mun.ca/CCHPE/Activities/Programs/Interprofessional-Education-for-Collaborative-Pati.aspx
- N.W.T. Department of Health and Social Services. (n.d.). [English website home page]. Retrieved from: http://www.hlthss.gov.nt.ca/english/default.htm

- N.W.T. Department of Health and Social Services. (2009). 2009/10 Annual Business Plan. Retrieved from: http://www.executive.gov.nt.ca/documents/HSS-2009-10.pdf
- N.W.T. Health and Social Services. (2009). Northwest Territories Health and Social Services System: Annual Report: 2007/2008. Retrieved from: http://www.hlthss.gov.nt.ca/pdf/reports/health_care_system/2009/english/hss_annual_report_2007_2008.pdf
- N.W.T. Health and Social Services. (2011). HSS Authorities.

 Retrieved from: http://www.hlthss.gov.nt.ca/english/our_system/authorities/default.htm
- N.W.T. Health and Social Services. (2011). Integrated Services Delivery Model. Retrieved from: http://www.hlthss.gov.nt.ca/english/services/integrated_services_delivery_model/default.htm
- N.W.T. Health and Social Services. (2011). Primary Community Care. Retrieved from: http://www.hlthss.gov.nt.ca/english/services/integrated_services_delivery_model/primary_community_care.htm
- Health Canada. (2011a). Health Care System: Primary Health Transition Fund: NorthwestTerritories. Retrieved from: http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/WebProject/0006?0penDocument&lang=eng&
- N.W.T. Health and Social Services. (2002). NWT Primary Community Care Framework. Retrieved from: http://www.hlthss.gov.nt.ca/pdf/reports/primary_community_care/2002/english/nwt_primary_community_care framework.pdf
- Registered Nurses Association of the Northwest Territories and Nunavut. (2010). Scope of Practice for Registered Nurses. Retrieved from: http://www.rnantnu.ca/Portals/0/Scope%20of%20Practice_Booklet_LR.pdf
- 77 Registered Nurses Association of the Northwest Territories and Nunavut. (2005). Practice Guidelines for Primary Health Care Nurse Practitioners. Retrieved from: http://www.rnantnu.ca/Portals/0/Documents/npguidelines2005.pdf
- Registered Nurses Association of the Northwest Territories and Nunavut. (2007). Prescriptive Authority Guidelines for NWT Primary Health Care Nurse Practitioners, Prescriptive Schedules A, B, C. Retrieved from: http://www.rnantnu.ca/Portals/0/Documents/Registration%202007/NP%20 Application/07_04_Prescriptive_Authority_Guideline_March_30_Signed.pdf
- Health Council of Canada. (2009c). Teams in Action: Primary Health Care Teams for Canadians—A Northwest Territories Perspective (Summary). Retrieved from: http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_NorthwestTerritorries_Summary.pdf
- Health Canada. (2011b). Health Care System: Primary Health Transition Fund: Health Lines. Retrieved from: http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/WebProject/0015?OpenDocument&lang=eng&t
- Canadian Society of Telehealth. (2007). Telehealth—What the Future Holds. Retrieved from: www.coachorg.com/opendoc.asp?docID=1568
- N.W.T. Health and Social Services. (2009). Community Health Services Satisfaction Report. Retrieved from: http://www.hlthss.gov.nt.ca/pdf/reports/health_care_system/2009/english/community_health_services_satisfaction_report.pdf
- N.W.T. Health and Social Services. (2009). A Foundation for Change Building a Health Future for the NWT 2009–2012. Retrieved from: http://www.hlthss.gov.nt.ca/pdf/reports/health_care_system/2009/english/a_foundation_for_change.pdf

- Nova Scotia Department of Health and Wellness. (2011). Primary Health Care. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/
- Health Canada. (2011c). Primary Health Transition Fund: Building a Better Tomorrow: Engaging Current Providers in a Renewed PHC System for Atlantic Canada (and Multi-Jurisdictional Envelope). Retrieved from: http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/WebProject/0014?OpenDocument & Clang=eng&
- Nova Scotia Department of Health and Wellness. Organizational Chart. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/
- Nova Scotia Department of Health and Wellness. (2011). District Health Authorities. Retrieved from: http://www.gov.ns.ca/health/about/DhA.asp
- Health Team Nova Scotia. (2010). IWK Health Centre. Retrieved from: http://www.healthteamnovascotia.ca/dha/iwk.html
- Nova Scotia Department of Health. (2010). Nova Scotia Department of Health 2010-11 Statement of Mandate. Retrieved from: http://www.gov.ns.ca/health/reports/pubs/DOH_Statement_of_Mandate_2010_2011.pdf
- Nova Scotia Department of Health. (n.d.). Nova Scotia's Nursing Strategy: Summary Report, 2001–2006. Retrieved from: http://www.healthteamnovascotia.ca/files/Nursing_Strategy_Summary_2001_2006.pdf
- Nova Scotia Department of Health. (2007). Nova Scotia's Nursing Strategy: Ensuring a Healthy, Vibrant Nursing Community. Retrieved from: http://www.healthteamnovascotia.ca/files/Nurses%20 Advisory%20Brochure_lowres.pdf
- Nova Scotia Department of Health and Wellness. (2011). Primary Health Care: Collaborative Teams. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/collaborative_teams.asp
- 93 Health Council of Canada. (2009d). Teams in Action: Primary Health Care Teams for Canadians—A Nova Scotia Perspective (Summary). Retrieved from: http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_NovaScotia_Summary.pdf
- Nova Scotia Department of Health and Wellness. (2011). Primary Health Care: Midwifery. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/midwifery.asp
- Nova Scotia Department of Health and Wellness. (2011). Primary Health Care: Building a Better Tomorrow Together. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/bbtt.asp
- Nova Scotia Department of Health and Wellness. (2011). Primary Health Care: Primary Health Care Information Management and Electronic Medical Records. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/PHIM.asp
- Nova Scotia Department of Health and Wellness. (2011). Primary Health Care: Healthlink 811. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/811.asp
- Research Power Inc. (for Nova Scotia Department of Health). (2008). Primary Care Research and Evaluation Meeting: October 21 and 22, Meeting Report. Retrieved from: http://www.gov.ns.ca/health/primaryhealthcare/documents/Primary_Care_%20Research_Evaluation_report_2008.pdf
- Nova Scotia Department of Health. (n.d.). Nova Scotia Department of Health 2009-10 Business Plan. Retrieved from: http://www.gov.ns.ca/health/reports/pubs/DOH Business Plan 2009-10.pdf

- Nunavut Department of Health and Social Services. (n.d.). Developing Healthy Communities: A Public Health Strategy for Nunavut, 2008–2013. Retrieved from: http://www.gov.nu.ca/health/ http://www.hss.gov.nu.ca/PDF/Public%20Health%20Strategy%20-%20English%20final.pdf
- Nunavut Department of Health and Social Services. (2008). Department of Health and Social Services 2008-2009 Business Plan. Retrieved from: http://www.tunngavik.com/documents/publications/2007-2008%20Annual%20Report%20on%20the%20State%20of%20Inuit%20 Culture%20and%20Society%20%28English%29.pdf
- 102 Nunavut Department of Health and Social Services. (n.d.). Op. cit.
- SAFRAN (Santé en français au Nunavut) [Health in French in Nunavut]. (n.d.).Accueil [Welcome] (Example of French language support). Retrieved from: http://www.franconunavut.ca/safran/accueil.html
- Hubert, D. (for SAFRAN, Santé en français au Nunavut). (n.d.). Quelques leçons sur l'accessibilité aux soins de santé [Some Lessons Learned About Healthcare Access]. Retrieved from: http://www.franco-nunavut.ca/safran/publications-du-safran/nunavoix-no4.html
- Government of Nunavut. (2010). Tunngasugatti: Welcome to the Government of Nunavut. Retrieved from: http://www.gov.nu.ca/english/
- 106 Registered Nurses Association of the Northwest Territories and Nunavut. (2010). Op. cit.
- 107 Registered Nurses Association of the Northwest Territories and Nunavut. (2005). Op. cit.
- 108 Registered Nurses Association of the Northwest Territories and Nunavut. (2007). Op. cit.
- Government of Nunavut. (n.d.). Government of Nunavut Employment Opportunity: Primary Health Care Nurse Practitioner. Retrieved from: http://www.gov.nu.ca/hr/site/jobs/job%20ads/iqaluit/pen/PrimaryHealthCareNursePractitioneropen.pdf
- Government of Nunavut. 2009 Social Services Review. Retrieved from: http://www.socialservicesreview.gov.nu.ca/apps/authoring/dspPage.aspx?page=home
- Health Council of Canada. (2009e). Teams in Action: Primary Health Care Teams for Canadians—A
 Nunavut Perspective (Summary). Retrieved from: http://www.healthcouncilcanada.ca/docs/rpts/2009/
 TeamsInAction_Nunavut_Summary.pdf
- Health Canada. (2011d). Health Care System: Primary Health Transition Fund: Nunavut.

 Retrieved from: http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/WebFactSheet/0008?OpenDocum ent&lang=eng&
- Health Canada. (2005). Canada Health Infostructure Partnerships Program (CHIPP): Project: Nunavut Telehealth Project [Project description]. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/pubs/chipp-ppics/2003-iiu/synopsis/index-eng.php
- Health Canada, Health and the Information Highway Division. (2003). Canada Health Infostructure Partnerships Program (CHIPP): IIU Network Nunavut Telehealth Project [Full report]. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/pubs/chipp-ppics/2003-iiu/index-eng.php
- 115 Canadian Society of Telehealth. (2007). Op. cit.
- 116 Health Canada. (2011b). Op. cit.

- Health Force Ontario. (2010). MOHLTC Primary Health Care Contacts: June 1, 2010. Retrieved from: http://www.healthforceontario.ca/upload/en/work/mohltc%20primary%20health%20care%20 contacts%20june10.pdf
- Health Force Ontario. (2010). Family Practice Models. Retrieved from: http://www.healthforceontario.ca/Work/OutsideOntario/PhysiciansOutsideOntario/PractisingInOntario/family_practice_models.aspx
- Ontario Ministry of Health and Long-Term Care. (2011). Family Health Teams. Retrieved from: http://www.health.gov.on.ca/transformation/fht/fht_mn.html
- Ontario Ministry of Health and Long-Term Care. (2009). Guide to Physician Compensation, Version 3.0. Retrieved from: http://www.health.gov.on.ca/transformation/fht/guides/fht_compensation.pdf
- Ontario Ministry of Health and Long-Term Care. (2010). Guide to Interdisciplinary Provider Compensation, Version 3.2. Retrieved from: http://www.health.gov.on.ca/transformation/fht/guides/fht_inter_provider.pdf
- Ontario Ministry of Health and Long-Term Care. (2011). Family Health Teams: Information for Family Health Teams [FHT guides in PDF]. Retrieved from: http://www.health.gov.on.ca/transformation/fht/fht_guides.html
- Ontario Ministry of Health and Long-Term Care. Family Health Teams Application Process. Retrieved from: http://www.health.gov.on.ca/transformation/fht/infokit/fht_infokit_mn.html
- Government of Ontario. (2009). Progress Report 2009. Retrieved from: http://www.ontario.ca/ontprodconsume/groups/content/@onca/@initiatives/@progress/documents/document/ont06_024570.pdf
- Ontario Ministry of Health and Long-Term Care. (2011). Q&A: Understanding Family Health Teams. Retrieved from: http://www.health.gov.on.ca/transformation/fht/fht_understanding.html
- Ontario Ministry of Health and Long-Term Care. (2005). Guide to Interdisciplinary Team Roles and Responsibilities. Retrieved from: http://www.health.gov.on.ca/transformation/fht/guides/fht_inter_team.pdf
- Ontario Ministry of Health and Long-Term Care. (2011). Community Health Centres. Retrieved from: http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html
- 128 Government of Ontario. (2009). Op. cit.
- Ontario Ministry of Health and Long-Term Care. (2011). Nurse Practitioner-Led Clinics. Retrieved from: http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html
- Ontario Ministry of Health and Long-Term Care. (2011). Nurse Practitioner-Led Clinics: Information for Nurse Practitioner-Led Clinics. Retrieved from: http://www.health.gov.on.ca/transformation/np_clinics/np_infokit.html
- 131 Government of Ontario. (2009). Op. cit.
- Health Force Ontario. (2011). Resources: IPCSIC Reports. Retrieved from: http://www.healthforceontario.ca/WhatIsHFO/AboutInterprofessionalCare/ProjectResources.aspx
- Implementing Interprofessional Care in Ontario: Final Report of the Interprofessional Care Strategic Implementation Committee. (2010). Health Force Ontario. Retrieved from: http://www.healthforceontario.ca/upload/en/whatishfo/ipcproject/hfo%20ipcsic%20final%20reportengfinal.pdf

- Quality Improvement and Innovation Partnership (QIIP). (2010). About Us: Who We Are. Retrieved from: http://www.qiip.ca/about_us.php
- Quality Improvement and Innovation Partnership (QIIP). (2010). Tools and resources. Retrieved from: http://www.qiip.ca/tools_and_resources.php
- Ontario Ministry of Health and Long-Term Care. (2010). Excellent Care for All: Strengthening the Focus on Quality, Value and Evidence-Based Care in Ontario [Presentation]. Retrieved from: http://www.health.gov.on.ca/en/legislation/excellent_care/excellent_presentation_20100503.pdf
- Health Canada. (2011e). Health Care System: Primary Health Transition Fund: Prince Edward Island. Retrieved from: http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/WebFactSheet/0010?OpenDocument&lang=eng&t
- 138 Corpus Sanchez International Consultancy (for P.E.I. Department of Health). (2008). An Integrated Health System Review in PEI. A Call to Action: A Plan for Change—Executive Summary. Retrieved from: http://www.gov.pe.ca/photos/original/doh_CSI_exsum.pdf
- 139 Corpus Sanchez International Consultancy (for P.E.I. Department of Health). (2008). An Integrated Health System Review in PEI. A Call to Action: A Plan for Change. Retrieved from: http://www.gov.pe.ca/photos/original/doh_csi_report.pdf
- P.E.I. Department of Justice and Public Safety, Legislative Counsel Office. (2010). Health Services Act [Office consolidation of Act for information and reference purposes only]. Retrieved from: http://www.gov.pe.ca/law/statutes/pdf/H-01-6.pdf
- Health PEI. (2010). One Island Future: One Island Health System [Health PEI website home page]. Retrieved from: http://www.oneislandhealthsystem.ca/
- Health PEI. (2011). Health PEI: Who We Are. Retrieved from: http://www.oneislandhealthsystem.ca/index.php3?number=1034144&lang=E
- Policy Monitor Canada. (2010, January 13). PEI Cabinet Shuffle. Retrieved from: http://policymonitor.ca/government/legislative/pei-cabinet-shuffle/?doing_wp_cron
- P.E.I. Department of Health and Wellness. (2011). [Department's website home page]. Retrieved from: http://www.gov.pe.ca/health/dg.inc.php3
- PEI Department of Health and Wellness. (2010). Primary Care Division [Division's home page]. Retrieved from: http://www.gov.pe.ca/health/pc-info/dg.inc.php3
- Health PEI. (2011). Health PEI—Executive Leadership Team [Organization chart]. Retrieved from: http://www.gov.pe.ca/photos/original/hpei_func_orgch.pdf
- Health PEI. (2010). PEI Health System Strategic Plan 2009–2012. Retrieved from: http://www.oneislandhealthsystem.ca/photos/original/hpei_stratpla12.pdf
- Health PEI. (2010). Health PEI Business Plan: April 1, 2010–March 31, 2011.

 Retrieved from: http://www.oneislandhealthsystem.ca/photos/original/hpei_busplan11.pdf
- 149 Health PEI. (n.d.). Primary health care—A time of growth. Healthy Strides: Progress Bulletin on the Primary Health Care Project, Issue 1. Retrieved from: http://www.gov.pe.ca/photos/original/doh_ pmo_phc_nl.pdf

- P.E.I. Department of Health. (2009 November). One Island Health System: Integrated Health System Project Update, 1(3). Retrieved from: http://www.gov.pe.ca/photos/sites/peihealthsystems/file/Vol_%201%20Issue%203(1).pdf
- P.E.I. Department of Health. (2009 July). Collaborating on PEI's new model of care. One Island Health System: Integrated Health System Project Update, 1(2), 1. Retrieved from: http://www.gov.pe.ca/photos/sites/peihealthsystems/file/Vol1%20Issue%202_%20Integrated%20Health%20System%20 Project%20Update_%20Newsletter_Jul09.pdf
- P.E.I. Department of Health. (2009). A New Model of Care for PEI: Building a Plan to Improve Care Delivery Across the Continum. Retrieved from: http://www.gov.pe.ca/photos/sites/peihealthsystems/file/A%20New%20Model%20of%20Care%20for%20PEI%281%29.pdf
- 153 Health Canada. (2011e). Op. cit.
- Health PEI. (2011). Health Centres. Retrieved from: http://www.oneislandhealthsystem.ca/index. php3?number=1020492&lang=E
- Government of Prince Edward Island. (2011). Build PEI: Investing in Our Future: New O'Leary Health Centre. Retrieved from: http://www.buildpei.ca/index.php?number=1028885&lang=E
- Health PEI. (2011). Four Neighborhoods Health Centre. Retrieved from: http://www.oneislandhealthsystem.ca/index.php3?number=1020494&tlang=E
- 157 Master Agreement Between the Medical Society of Prince Edward Island and the Government of Prince Edward Island, April 1,2007–March 31, 2010. (n.d.). Retrieved from: http://www.gov.pe.ca/photos/original/doh_masteragree.pdf
- Health Council of Canada. (2009f). Teams in Action: Prince Edward Island. Team Care for the End of Life. Retrieved from: http://www.healthcouncilcanada.ca/docs/rpts/2009/TIA_PEI.pdf
- Health Council of Canada. (2009g). Teams in Action: Primary Health Care Teams for Canadians—A Prince Edward Island Perspective [Summary]. Retrieved from: http://www.healthcouncilcanada.ca/ docs/rpts/2009/TeamsInAction_PEI_Summary.pdf
- Powers, P. (2010). Health PEI's vision: Completing the Island's e-health bridge to healthcare delivery integration. ElectronicHealthcare, 9(2), e24–e32. Retrieved from: http://www.longwoods.com/content/21924
- Pomey, M.-P., Martin, E., Forest, P.-G. (2009). Quebec's family medicine groups: Innovation and compromise in the reform of front-line care. Canadian Political Science Review, 3(4), 31–46. Retrieved from: http://www.queensu.ca/iigr/Res/crossprov/Pomey--QuebecsFamilyMedicineGroups.pdf
- Health Canada. (2011f). Health Care System: Primary Health Transition Fund: Quebec. Retrieved from: http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/WebFactSheet/0011?OpenDocument&lang=eng&t
- Gouvernement du Québec, Ministère de la Santé et des Services sociaux. (2008). In Brief: The Québec Health and Social Services System. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2007/07-731-01A.pdf
- Santé et Services sociaux Québec. (2011). Local Services Networks and Health and Social Services Centres. Retrieved from: http://www.msss.gouv.qc.ca/en/reseau/lsn.php
- Santé et Services sociaux Québec. (2011). Responsibility for Governance. Retrieved from: http://www.msss.gouv.qc.ca/sujets/organisation/ssss_enbref/index.php?aid=17

- Santé et Services sociaux Québec. (2011). Establishments Formed Into Networks.

 Retrieved from: http://www.msss.gouv.qc.ca/sujets/organisation/ssss_enbref/index.php?aid=18
- Santé et Services sociaux Québec. (2011). Family Medicine Group: Registration.

 Retrieved from: http://www.msss.gouv.qc.ca/sujets/organisation/gmf/index.php?inscription-en
- Santé et Services sociaux Québec. (2011). The Family Medicine Group: An Asset for the Patient and for the Patient's Doctor [Brochure]. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2007/07-920-04A.pdf
- Santé et Services sociaux Québec. (2011). Family Medicine Groups? Retrieved from: http://www.msss. gouv.qc.ca/sujets/organisation/gmf/index.php?accueil-en
- Hamilton, J. (2002, September 3). Quebec looks to rejig family practice [News]. CMAJ, 167(5), 532. Retrieved from: http://www.cmaj.ca/cgi/reprint/167/5/532.pdf
- 171 Pomey, M.-P., Martin, E., Forest, P.-G. (2009 December). Op. cit.
- 172 Le Commissaire à la santé et au bien-être (Québec). (n.d.). Rapport d'appreciation de la performance du système de santé et de services sociaux 2009 : État de situation portant sur le système de santé et de services sociaux et sur sa première ligne de soins. Retrieved from: http://www.csbe.gouv.qc.ca/fileadmin/www/RapportAppreciation/csbe-EtatSituation-t1-042009.pdf
- Health and Welfare Commissioner (Quebec). (n.d.). 2009 Appraisal Report on the Performance of Quebec's Health and Social Services System: Building on the Primary Healthcare Renewal. Rethinking How Things Are Done in Order to Better Respond to the Population's Needs: Summary. Retrieved from: http://www.csbe.gouv.qc.ca/fileadmin/www/RapportAppreciation/csbe_RethinkingHowThingsSummary.pdf
- 174 Saskatchewan Health. (2007). Primary Health: Primary Health Care. Retrieved from: http://www.health.gov.sk.ca/primary-health
- Saskatchewan Health. (2007). Primary Health Care in Saskatchewan.

 Retrieved from: http://www.health.gov.sk.ca/primary-health-care-in-saskatchewan
- 176 Saskatchewan Health. (2007). Saskatchewan's Action Plan for Primary Health Care. Retrieved from: http://www.health.gov.sk.ca/action-plan-for-primary-health
- 177 Saskatchewan Health. (2007). Primary Health Care Networks and Teams.

 Retrieved from: http://www.health.gov.sk.ca/primary-health-care-networks-and-teams
- 178 Dagnone, T. (2009). For Patients' Sake: Patient First Review Commissioner's Report to the Saskatchewan Minister of Health. Retrieved from: http://www.health.gov.sk.ca/patient-firstcommissioners-report
- Yukon Health and Social Services. (2011). Health Services. Retrieved from: http://www.hss.gov.yk.ca/healthservices.php
- Yukon Health and Social Services. (2011). Community Health Centres.

 Retrieved from: http://www.hss.gov.yk.ca/healthcentres.php?WT.mc_id=10004b
- Yukon Government. (2010 September 22). Yukon brings Alberta program north [News release #10-184]. Retrieved from: http://www.gov.yk.ca/news/2010/files/10-184.pdf

- ukon Health and Social Services. (2009 November 2). Yukon at the forefront of e-health expansion [News release #09-256]. Retrieved from: http://www.hss.gov.yk.ca/news/09-256.php
- Yukon Health and Social Services. (2010). Licensing of Nurse Practitioners in Yukon. Retrieved from: http://www.hss.gov.yk.ca/nurse_practitioners_licensing.php
- Yukon Health Care Review Committee. (2008). The Yukon Health Care Review: Final Report. Retrieved from: www.hss.gov.yk.ca/pdf/yukon_health_care_review.pdf
- Yukon Health Care Review Committee. (2009). The Yukon Health Care Review: "Taking the Pulse." What We Heard: A Public Dialogue on the Yukon Health Care Review—Final Report. Retrieved from: http://www.hss.gov.yk.ca/pdf/yukon_health_care_review_final_report.pdf
- 186 Yukon Health and Social Services. (2009). Strategic Plan 2009–2014.