

Barriers and Facilitators for Primary Care Reform in Canada: Results from a Deliberative Synthesis across Five Provinces

Obstacles et appuis à la réforme des soins de santé primaires au Canada : résultats d'une synthèse délibérative réunissant cinq provinces



JEAN-FRÉDÉRIC LEVESQUE, MD, PHD

*Centre for Primary Health Care and Equity, University of New South Wales
Bureau of Health Information
Sydney, Australia*

JEANNIE L. HAGGERTY, PHD

*Department of Family Medicine, McGill University
Montréal, QC*

WILLIAM HOGG, MSC, MCLS, MD

*Department of Family Medicine, University of Ottawa
Ottawa, ON*

FREDERICK BURGE, MD, MSC

*Department of Family Medicine, Dalhousie University
Halifax, NS*

SABRINA T. WONG, RN, PHD

*School of Nursing Culture, Gender and Health Research Unit
Centre for Health Services and Policy Research, University of British Columbia
Vancouver, BC*

ALAN KATZ, MBCHB, MSC

*Family Medicine and Community Health Sciences, Faculty of Medicine
University of Manitoba
Winnipeg, MB*

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DOMINIQUE GRIMARD, MSC

*Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal and Institut national de santé publique du Québec
Montréal, QC*

JAN-WILLEM WEENINK, MSC

*Scientific Institute for Quality of Healthcare (IQ Healthcare)
Radboud University Medical Center, The Netherlands*

RAYNALD PINEAULT, MD, PHD

*Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal and Institut national de santé publique du Québec
Montréal, QC*

Abstract

Introduction: Since 2000, primary care (PC) reforms have been implemented in various Canadian provinces. Emerging organizational models and policies are at various levels of implementation across jurisdictions. Few cross-provincial analyses of these reforms have been realized. The aim of this study is to identify the factors that have facilitated or hindered implementation of reforms in Canadian provinces between 2000 and 2010.

Methods: A literature and policy scan identified evaluation studies across Canadian jurisdictions. Experts from British Columbia, Manitoba, Nova Scotia, Ontario and Quebec were asked to review the scope of published evaluations and draft provincial case descriptions. A one-day deliberative forum was held, bringing together researchers ($n = 40$) and decision-makers ($n = 20$) from all the participating provinces.

Results: Despite a relative lack of published evaluations, our results suggest that PC reform has varied with regard to the scope and the policy levers used to implement change. Some provinces implemented specific PC models, while other provinces designed overarching policies aiming at changing professional behaviour and practice. The main perceived barriers to reform were the lack of financial investment, resistance from professional associations, too overtly prescriptive approaches lacking adaptability and an overly centralized governance model. The main perceived facilitators were a strong financial commitment using various allocation and payment approaches, the cooperation of professional associations and an incremental emergent change philosophy based on a strong decentralization of decisions allowing adaptation to local circumstances. So far the most beneficial results of the reforms seem to be an increase in patients' affiliation with a usual source of care, improved experience of care by patients and a higher workforce satisfaction.

Conclusion: PC reforms currently under consideration in other jurisdictions could learn from the factors identified as promoting or hindering change in the provinces that have been most proactive.

Résumé

Introduction : Depuis 2000, des réformes des soins de santé primaires (SSP) ont lieu dans plusieurs provinces canadiennes. Les nouvelles politiques et les nouveaux modèles organisationnels en sont à divers stades de mise en œuvre. Il y a eu peu d'analyses panprovinciales de ces réformes. L'objectif de cette étude est de déterminer les facteurs qui ont permis de faciliter ou ont fait obstacle à la mise en œuvre des réformes dans les provinces canadiennes, entre 2000 et 2010.

Méthodes : Un examen de la littérature et des politiques a permis de repérer des études d'évaluation dans les provinces canadiennes. Nous avons demandé à des experts de la Colombie-Britannique, du Manitoba, de la Nouvelle-Écosse, de l'Ontario et du Québec d'examiner l'étendue des évaluations publiées et des descriptions de cas. Un forum délibératif d'un jour a été organisé pour réunir les chercheurs (n=40) et les décideurs (n=20) de toutes les provinces participantes.

Résultats : Malgré le manque relatif d'évaluations publiées, nos résultats font voir que la réforme des SSP varie selon l'envergure et les appuis politiques employés pour mettre en œuvre les changements. Certaines provinces ont mis en place des modèles spécifiques de SSP, tandis que d'autres ont mis au point des politiques générales visant un changement de comportements et de la pratique professionnelle. Les principaux obstacles perçus sont le manque d'investissements financiers, la résistance de la part d'associations professionnelles, des méthodes trop prescriptives faisant peu de place à l'adaptabilité et un modèle de gouvernance trop centralisé. Les principaux appuis perçus étaient un fort engagement financier employant plusieurs types d'allocations et de paiements, la coopération des associations professionnelles et l'émergence progressive d'un changement de philosophie fondé sur une forte décentralisation des décisions, ce qui permet une adaptation aux circonstances locales. À ce point, les résultats les plus avantageux des réformes semblent être un accroissement de la fidélité des patients à un point de services habituel, une amélioration de l'expérience des soins par les patients et une plus grande satisfaction de la main-d'œuvre.

Conclusion : Les réformes des SSP actuellement envisagées par d'autres provinces peuvent tirer leçon des facteurs qui favorisent ou font obstacles dans les provinces qui ont été les plus proactives.



Introduction

Since 2000, transformation in primary care (PC) delivery has been occurring in varying degrees across Canada. A change in the policy environment was driven by a better fiscal climate after years of cutbacks, increased federal transfers including the Health Transition Fund and the Primary Health Care Transition Fund, recommendations from major commissions, such as the Romanow Commission in 2002, and a shortage of family physicians

throughout Canada (Hutchison 2008; Wilson et al. 2004). In addition, this renewal occurred at a time when the performance of Canadian PC is increasingly recognized as lagging behind other developed countries (CSBE 2009; Lamarche 2008). The state of Canada's PC sector is worrisome, as its performance is worse than most other wealthy and industrialized countries, as described by recent commonwealth fund and OECD surveys (CSBE 2009; Hutchison 2008). To a certain extent, this has been the outcome of years of budgetary cutbacks and a lack of appreciation of family medicine as a discipline. Both of these factors have contributed to the imbalance in the health system towards secondary and specialist care (Katz 2008; Lamarche 2008).

Other major reasons for lagging performance are problems in the organization of PC. These organizational gaps include: the fragmentation of care and inefficient use of providers due to lack of coordination, limited management and follow-up of vulnerable groups; access problems; the low priority given to health promotion and disease prevention; and problems related to the quality, collection and sharing of patient information (CSBE 2009). To address some of these organizational gaps, a consensus has emerged on the necessity to offer PC services on a 24/7 basis through interdisciplinary teams who are supported with information technology and electronic medical records, who undertake health promotion and prevention activities, and who share links with other healthcare providers and local governing bodies (Breton et al. 2009; The College of Family Physicians of Canada 2011; CSBE 2009; Health Affairs 2010).

Across Canada, new models and innovations of care delivery have been introduced to improve the performance of PC (Muldoon et al. 2006a; Pineault et al. 2010; Russell et al. 2009; Watson et al. 2009; Wong et al. 2010). The implementation of collaborative and interdisciplinary models and quality improvement innovations are among the main transformations (Hutchison 2008). New organizational models are more predominant in Quebec, Ontario and Alberta, while the focus in British Columbia, Manitoba and Saskatchewan has been more on quality improvement initiatives within the traditional models of delivery (Hutchison et al. 2011). Other provinces have adopted these components in a more incremental fashion rather than relying on an explicit overarching policy. Another critical area of change has been the adoption of health information systems in PC centres (Hutchison 2008). On the whole, these changes have been implemented on a voluntary basis. They have been incentive-based and occurred by including organized medicine in the process while preserving the autonomy of physicians (Hutchison 2008). Provincial levers for change are limited and mostly related to finances, as these changes are negotiated with organized medicine rather than imposed (Green et al. 2009; Hutchison et al. 2011; Strumpf et al. 2012). Many new models, such as Family Medicine Groups in Quebec, are, however, criticized as limited and lacking the characteristics of high-performing models by remaining physician-centred with limited inter-disciplinarity (Hutchison 2008; Lamarche 2008; Pomey et al. 2009; Russell et al. 2010).

As PC reform has not progressed at the same speed in different provinces, this appears to be an opportune time to explore some questions about these reforms. What factors have

contributed to or have impeded changes occurring in PC models of delivery and quality innovations in the different provinces of Canada? The aim of this study is to identify the factors that have facilitated or hindered implementation of PC reforms in Canadian provinces over the period 2000–2010. The goal of this analysis is to be alert to recurring obstacles as well as levers for change as reforms in Canada continue.

Methods

This synthesis was completed through a two-stage process. The first stage involved the development of case descriptions of PC reforms that had been completed or that were underway in Nova Scotia, Quebec, Ontario, Manitoba and British Columbia between 2000 and 2010. Case descriptions were generated from a review of existing grey and published literature. There has been elaborate discussion about what the concept of PC encompasses (Muldoon et al. 2006b). In this study, we define PC as practices where general practitioners, or in some instances other healthcare professionals taking a similar role, provide medical care to patients. These provinces were selected on the basis of the existence of published evaluations related to PC reform. Whilst other provinces had also engaged in PC reforms, as was the case in Newfoundland, evaluations had not been published at the time of the study. Each of these five provinces was considered the unit of analysis and a case.

The initial case descriptions were developed by synthesizing the information gathered through the grey literature search (scanning provincial level organizations' websites, Google and Google Scholar searches, and PubMed search for published evaluations of PC reforms in Canadian provinces). Consultations with selected experts from each province served to adjust the case descriptions, generate hypotheses with regards to potential barriers and facilitators, and document impacts of emerging models of PC. This consultation was done electronically in iterative waves, asking each of the selected experts to revise and suggest adjustments to the draft case description, and identify additional documents to integrate in the analysis.

An analytic grid was developed to guide the retrieval of relevant information from identified documentation and to permit comparisons across case descriptions. The grid was structured around a previously published conceptualization of PC policies to support the classification of extracted information according to how it related to: (1) the vision, aims and objectives of the reforms; (2) the structural implications; (3) the resources implications; (4) the service provision models impacted or promoted by the reform; and (5) the important elements related to the context (Lamarche et al. 2003; Levesque et al. 2012).

The second stage involved a deliberative process that was held during a *Synthesis and Exchange Forum on the Impact of Primary Care Organizational Models and Contexts*, which took place on November 3rd, 2010. This forum brought together researchers ($n = 40$) and decision-makers ($n = 20$) from different Canadian provinces to discuss factors influencing the reform processes and the impact of reforms initiated over the preceeding decade. The participants were selected through a snowball process, following a purposive selection of recognized leaders in PC research, to ensure sufficient knowledge and experience from each of the

studied provinces, and included researchers in PC and decision-makers from provincial and regional levels. Guiding questions to be addressed during the Forum were submitted to the provincial experts and decision-makers with the case descriptions as preparatory material (see Appendix). These questions elicited complementary information about the case descriptions, factors associated with changes in PC, impacts of primary healthcare and the main findings from each province's experience. At the Forum, various experts and decision-makers from provincial governments or professional associations were invited to discuss these themes and share their own professional experience. Following these presentations, small groups of 8–12 participants discussed two questions:

1. Which factors would you say are the most important either in supporting or hindering changes in PC organizations or implementing reforms? In your opinion, how do you see these factors evolving in the future?
2. What are the most significant impacts of recent PC reforms and introduction of new organizational models? In your opinion, how do you see these impacts evolving in the future?

An open discussion with all participants took these same questions further and attempted to clarify the most important factors and impacts. Drawing upon the wealth of information obtained from the reading materials, case studies and group discussion, participants were asked to identify the most important factors and impacts based on their own research and/or experiences. All discussions were recorded, transcribed and synthesized into a report along with the final revision of the case descriptions and the literature review (Levesque et al. 2012).

The final analysis of barriers and facilitators was performed using a framework adapted from institutional theory, which views organizational change as resulting from three types of environmental influences, namely, coercive (laws, regulations, policies), normative (professional influences and culture) and mimetic (presence of champions and successful leaders) influences, as well as receptivity to change within the practices (perceptions and attitudes) (DiMaggio and Powell 1991; Meyer and Rowan 1991; Scott et al. 2000). We adapted the framework for this study (Levesque et al. 2010). This framework proved to be useful in providing a classification system to critically appraise the factors that have been identified to be crucial in facilitating or impeding primary healthcare reforms in the studied provinces.

Results and Discussion

PC reforms have varied from province to province. Levers used to involve and motivate primary healthcare professionals have varied. Recourses to a more prescriptive and coercive approach (e.g., laws, regulation, financial incentives) or a more emergent and championing approach vary and often mix together in different balances in different provinces. In addition, various barriers and facilitators for reform have been identified in different provinces. However, some common findings emerge. The main barriers to reform were insufficient financial investment in the

reforms, resistance from professional associations, excessively prescriptive approaches lacking adaptability and an overly centralized governance model. In contrast, the main facilitators were a strong financial commitment using various allocation and payment approaches, the cooperation of professional associations through the process of reform, an incremental emergent change philosophy based on a strong decentralization of decisions and adaptation to local circumstances. There were many examples, though, that a lever for change in one context was perceived as a barrier in another context, especially in terms of funding and involvement of professional associations. The full description of the case and literature synthesis as well as detailed findings from the deliberative forum can be found in the full report of this study (Levesque et al. 2012).

Coercive Influences

A STRONG ROLE FOR GOVERNMENTS AND LEGISLATION TO SUPPORT CHANGE

Though the policy environment has historically been neutral towards PC, it is clear that as of 2010, the socio-political context had changed throughout the country. For a long period, PC was left out of explicit policies aimed at reorganizing the healthcare delivery system. In contrast, hospitals and long-term care facilities have been part of reforms of provinces' public delivery systems. Participants at the Forum suggested that PC practices were often perceived as being part of the "private" sector, despite the vast majority of its services being reimbursed through provincial health plans. The recent shift has seen a driving force for reform coming mainly from governments, with the climate among providers ranging from neutral to favourable. Major commissions at the provincial and federal levels have been identified as important influences in initiating a long overdue process of reforms. The federal government has been perceived as having played an important role. Without the massive federal transfers committed for PC reform across the country, many initiatives or new models would certainly not have been implemented or sustained. The federal transfers thus provided the impetus needed for the expansion of programs and models.

Relevant new legislation has expanded the role of non-medical health professionals in PC. This has supported the development of interdisciplinary teams and collaborative practice. In particular, laws redefining the roles and scope of other health professionals, most notably registered nurses and nurse practitioners, have supported their introduction into PC. Legislation has been identified as a major factor benefitting the reform process in various provinces. Quebec has introduced delegations of medical acts and has revised its professional code. The *Health Professions Act* in British Columbia and the *Registered Nurses Act* in Nova Scotia are other examples (Levesque et al. 2007; Pottie et al. 2008; Wong 2009). In some instances, legislation has also been enabled by collaboration between registered nurses and physicians' organizations. However, insufficient attention to appropriate remuneration and certification has slowed the development and implementation of interdisciplinary teams.

A DUAL INFLUENCE OF FUNDING MECHANISMS ON REFORMS

Both too much and too little funding have been identified as critical. The federal health transfers gave a kick-start to many of the first reforms of primary healthcare across the country and enabled many initiatives to start. The emphasis has been on providing incentives for physicians to move into new organizational models of care or for physicians in group practice to transform the way care is delivered in their clinics. It takes large financial resources to incentivize providers and to facilitate changes. The case of Ontario is a good example of this, with all changes in organizational models voluntary and grounded on financial incentives. Alberta has also benefitted from an increased availability of financial resources at the time of the reform, greatly facilitating its implementation. As reforms move forward and the resources required to transform practices increase, will governments have the capacity to sustain this process in the future, especially in a climate of financial restraint and recession?

Remuneration can also become a hindering factor to PC reforms. To begin with, physicians on the basis of potential loss of income, in particular to capitation, often resist changing the remuneration method. An exception is Ontario, where the introduction of blended models such as Family Health Teams (FHTs) and Family Health Groups was associated with an increased remuneration for physicians and has proven to be successful (The Conference Board of Canada 2014; Green et al. 2009; Hutchison et al. 2011). In addition, participants have pointed out how an exclusively fee-for-services (FFS) remuneration system is often incompatible with the development of multidisciplinary teams in PC. Other professionals might not be able to work to the full scope of their practice if the physician does not delegate some tasks to them, given that physicians might otherwise lose income because most of these services are then not billable. This is especially important where FFS is the main remuneration model, and seeing the patient is required for the general practitioner.

In addition, there are challenges related to responsibility for the salaries of registered nurses and other allied health professionals. The introduction of registered nurses is seen as being promoted by governments without the essential funding, and practices cannot be responsible for the funding of other professionals from physician FFS billings. Thus, it is essential that some of these new reform funds be directed to other professionals to integrate them in the PC system. Furthermore, participants have acknowledged the need to provide incentives to registered nurses and allied health professionals, to attract and retain them in PC. The incentives should not be offered exclusively to physicians.

Normative influences

AN EMERGING COLLABORATION BETWEEN GOVERNMENTS AND PROFESSIONAL ASSOCIATIONS

A clash of agendas has been observed between provincial governments and professional medical organizations aiming to preserve the professional autonomy of their members. An example is the opposition from medical associations, such as was the case in British Columbia, to the

implementation of primary healthcare organizations. In contrast, what is observed now is a greater openness to reform by professionals. Although reforms are now accepted and seen as necessary, only a few instances of active lobbying from within the profession for new organizational models have been observed.

In many instances, the biggest change in 2000–2010 has been the increased collaboration between physicians and governments. Physicians, many of whom can be considered “small business owners” delivering essential services, and the government, as the largest payer of these services, recognized an increasing need to strengthen the delivery and organization of PC. Various collaborative committees have been created to negotiate and implement initiatives and new models, thereby ending a long period during which PC physicians were essentially operating with high autonomy but at the margin of health system oversight. In certain provinces, such as British Columbia, these committees involving the representatives of physicians and government have become powerful players. However, most of these approaches also remain essentially physician-centred and, to a great extent, they leave other health professionals out of the decision-making. It has also been observed that the number of requirements imposed on physicians by some of these committees might also ultimately threaten their success at stimulating change in the medical profession.

Another aspect of this collaboration has been seen at the level of governance at the regional or district level. To implement reform, health authorities and ministries have had to build governance structures that include PC physician leadership into the governance of the health system. An example is the case of Nova Scotia where a co-leadership model was implemented in the Capital District Health Authority with a health authority District Department of Family Practice and a PC office. Other examples include the Regional Departments of General Medicine in Quebec and the Divisions of Family Practice in British Columbia (Hutchison et al. 2011; Strumpf et al. 2012).

In some provinces, the provincial chapters of The College of Family Physicians of Canada, as well as the chairs of the university departments of family medicine, have taken an active supportive role. However, some universities’ lack of support or involvement has been identified as a factor explaining the slow uptake of reforms.

Mimetic influences

THE IMPORTANCE OF INNOVATORS AND CHAMPIONS

The role of family physicians in many contexts is undergoing profound changes from being the main provider in traditional models to very often a leadership role of a multidisciplinary team (Beaulieu et al. 2006; Martin-Misener et al. 2004; McKendry et al. 2006; Watson and Wong 2005). Having been practically ignored by health reforms for many years, PC physicians are now expected to transform their practices, be agents of change and to actively participate in the reform process. A number of continuing education programs have helped support this, such as Building a Better Tomorrow Together in Nova Scotia. Physicians are

now asked to take on new leadership roles not only in their practice but also in governance of regional systems of care. Physicians have contributed to change norms and values, to institute a new climate for change and changed attitudes among professionals. New committees composed of physicians and with some degree of decision-making power have also helped change norms and values. These structures may have helped to reduce resistance of physicians towards reforms by giving the profession's voice more merit. However, in every province, the presence of champions among primary healthcare providers has been crucial. They have often acted as role models for other physicians to generate the necessary climate for new models or initiatives to grow.

Receptivity to change

A FELT URGENCY FOR CHANGE

A strong desire for change by physicians delivering PC has been observed in many provinces. Physicians are seeing their workloads increase because of the shortage of human resources relative to the increased complexity of clinical presentations. Many are now more receptive to change. The fact that PC is overwhelmed is acknowledged and represents a strong argument for change. Notwithstanding this receptivity, PC reforms are often perceived as having been made possible because they were essentially based on the voluntary participation of physicians in policy-driven models or quality improvement initiatives. Slow and incremental transformation within physicians' offices has taken place in many provinces, as few providers can (or want to) manage large-scale transformations in their practices. In some provinces, such an incremental approach reflects government fiscal prudence in managing change, as large-scale changes are seen as much more expensive to implement.

Few changes have been imposed on providers and it is more a discourse about incentives or a demonstration of effectiveness that has been seen in many provinces. In fact, most reforms have been based on financial incentives to providers. A lot of money has been injected to mobilize professionals. Quality-based incentive funding or increased remuneration was made available to physicians to attract them to new models. Examples are the Physician Integrated Network in Manitoba and FHTs in Ontario.

A LACK OF INVOLVEMENT OF COMMUNITIES AND PATIENTS

The forum's participants also suggested that little attention so far has been given to the public's voice. In many contexts, there is a perceived failure to sell PC reform to the public and to outline ongoing progressions to transform PC. Community engagement in the reform process and the implementation of new models of care were also identified as critical factors (Muldoon et al. 2010). The Community Health Teams in Nova Scotia, which were constructed using population-based planning and community-engagement strategies, are an example of where this has been done. For some participants, communities clearly have to be involved in the decision-making process. Efforts should be undertaken to inform the public as to what has

been done so far to get input into what needs to be done to transform PC. Governments have to ensure better communication with the public regarding the progress of reforms and to consider the pressure that the democratic point of view can put on the system. An uninformed public can lead to unrealistic public expectations that, coupled with the power of the media, could push governments to move in the wrong direction. However, there was disagreement among participants as to the degree of public input that was necessary and desirable. Some felt that the public is only concerned about having access to a physician and services that are attainable while maintaining relational continuity of providers.

During the forum, participants also put great emphasis on the importance of system integration. The health system in Canadian provinces is fragmented, and PC in particular has been functioning almost in parallel to the rest of the system (Haggerty et al. 2008). Many private clinics have been left out of the reform process. The fragmented system affects not only the capacity of family physicians to ensure continuity of care and establish links with other lines of service, but the collaboration between PC clinics is even more difficult and horizontal integration is almost nonexistent. Practices have to be linked to the rest of the system with greater collaboration. Participants stated that when governments undertake local networks or integration of services, PC is often left out, as was the situation in Ontario. Thus, there is both a need to put emphasis on modernizing and upgrading existing practices and a need to create systems of care where PC providers are integrated with each other and with the rest of the system. This is part of reform in the different provinces, such as Quebec and British Colombia, where structures have been established to integrate the system, but there remains a lack of investment in a system of PC or the integration of PC to the rest of the system.

Conclusion

In this paper, we have presented the results of a deliberative synthesis about the main barriers and facilitators of implementation of PC reforms. This synthesis pertained to five Canadian provinces at various levels of reform implementation and using different modalities to implement change. Our synthesis suggests a strong receptivity to change in clinical settings and a strong role for government and legislative tools to implement change in a context of increased acceptance of reforms from professional organizations. This study also highlights the importance of collaborative designs of reforms involving the policy and professional organizations for a successful implementation. Funding remains a crucial issue. A good balance between enough funds to support the implementation, and not relying too much on purely financial incentives, has to be found.

Many provinces have opted for quality-based incentive funding and pay-for-performance instead of large-scale redesign. Some provinces are more advanced in redesigning PC through the introduction of new models. In many instances, the need to approach reforms in a slow and incremental fashion was chosen in order to mobilize providers. Enthusiasm for new organizational models is present if funding is made available to support providers in transforming their practices. PC reforms are made on a voluntary basis but often they succeed only

with significant incentives. In some instances, governments have started to give themselves a framework and a vision for primary healthcare reform. Examples are British Columbia's Primary Care Charter and Manitoba's Primary Health Care Policy Framework. Perhaps what was needed for many provinces was to first create the necessary conditions for the eventual success for PC reform. In provinces where PC reforms are based on incentives, there is the question of whether these will remain either effective or sustainable and what subsequent policy levers, prescriptive or model-based approaches to reforms, will be used. In particular, future studies should assess the extent with which, as reforms mature and are sustained or dwindle, certain levers play a more crucial role or are more difficult to sustain. This study, looking at various provinces and the implementation of their PC reforms, highlighted that financial incentives and more coercive policies have played an important role at the induction of reforms. Levers related to more normative and mimetic levers and the use of sustain facilitation might prove important for the long-term sustainability of these reforms in the future.

In most of the provinces, the implementation of the reforms has continued since 2010, and there is a renewed interest in furthering PC reform with organizational models that support integration of PC within the broader health and social care systems. Such recent reforms could benefit from understanding the levers that are associated with change in how PC has been delivered in various provinces since 2000. Despite the current study presenting data from 2010, the insights remain relevant to reconsider progress made since and potential adjustment to reform effort in the future.

Correspondence may be directed to: Jean-Frédéric Levesque; e-mail: jeanfrederic.levesque@health.nsw.gov.au.

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