RESEARCH PAPER

"A Band-Aid Solution": Policy Maker and Primary Care Provider Perspectives on the Value of Attachment Incentives

« Une solution de fortune » : points de vue des décideurs et des fournisseurs de soins primaires sur la valeur des incitations à l'adhésion

EMILY GARD MARSHALL, PhD
Professor
Primary Care Research Unit
Dalhousie Family Medicine
Dalhousie University
Halifax, NS

RICHARD BUOTE, PhD
Senior Research Associate
Primary Care Research Unit
Dalhousie Family Medicine
Dalhousie University
Halifax, NS

MACKENZIE COOK, BSc
Undergraduate Research in Medicine Student
Primary Care Research Unit
Dalhousie Family Medicine
Dalhousie University
Halifax, NS

MARIA MATHEWS, PhD
Professor
Department of Family Medicine
Schulich School of Medicine and Dentistry
Western University
London, ON

LAUREN MORITZ, MA
Research Associate
Primary Care Research Unit
Dalhousie Family Medicine
Dalhousie University
Halifax, NS

MYLAINE BRETON, MBA, PhD
Associate Professor
Department of Community Health Sciences
Université de Sherbrooke
Longueuil, QC

Abstract

Approximately 15% of Canadians are without a primary care provider ("unattached"). To address "unattachment," several provinces introduced a financial incentive for family physicians who attach new patients. A descriptive qualitative approach was used to explore perspectives of patient access and attachment to primary care. Semi-structured qualitative interviews were conducted with family physicians, nurse practitioners and policy makers

in Nova Scotia. Thematic analysis was performed to identify participant perspectives on the value and efficacy of financial incentives to promote patient attachment. Three themes were identified: (1) positive impacts of the incentive, (2) shortcomings of the incentive and (3) alternative strategies to strengthen primary healthcare. Participants felt that attachment incentives may offer short-term solutions to patient unattachment; however, financial incentives cannot overcome systemic challenges. Participants recommended alternative policy levers to strengthen primary healthcare, including addressing the shortage of primary care providers and developing remuneration and practice models that support sustainable patient attachment.

Résumé

Environ 15 % des Canadiens n'ont pas de fournisseur de soins de santé primaires (« sans adhésion »). Pour lutter contre le « manque d'adhésion », plusieurs provinces ont mis en place un incitatif financier pour les médecins de famille qui accueillent de nouveaux patients. Une approche qualitative descriptive a été utilisée pour explorer les perspectives d'accès et d'adhésion des patients aux soins primaires. Des entrevues qualitatives semi-structurées ont été menées auprès de médecins de famille, d'infirmières praticiennes et de décideurs en Nouvelle-Écosse. Une analyse thématique a été effectuée pour identifier les points de vue des participants sur la valeur et l'efficacité des incitations financières pour promouvoir l'adhésion du patient. Trois thèmes ont été identifiés : (1) les impacts positifs de l'incitatif, (2) les lacunes de l'incitatif et (3) les stratégies pour renforcer les soins de santé primaires. Les participants ont estimé que les incitations à l'adhésion peuvent offrir des solutions à court terme au manque d'adhésion des patients. Cependant, les incitations financières ne peuvent pas surmonter les défis d'ordre systémique. Les participants recommandent des leviers politiques pour renforcer les soins de santé primaires, notamment en s'attaquant à la pénurie de prestataires de soins primaires et en développant des modèles de rémunération et de pratique qui favorisent une adhésion durable de la part des patients.

Introduction

Health system policy makers prioritize the notion of "value" or making the best use of available resources (Lewanczuk et al. 2020; Smith et al. 2020). Canadian provincial and territorial health systems are allocated a substantial but finite amount of resources, and they ration these resources across appropriate investments to address health system priorities (e.g., health outcomes, patient/provider experience, access) (Forest 2020; Lewanczuk et al. 2020). Ideally, the health system contributes to collective or personal well-being by ensuring health improvement priorities, including responsiveness, financial protection, efficiency and equity (Smith et al. 2020). Policy makers can use a variety of policy levers to address these priorities, including considerations of funding allocation, promoting the use of evidence and strengthening primary healthcare (Smith et al. 2020).

Primary care is vital for ensuring population health and reducing health disparities (Starfield et al. 2005). Countries that have made substantial investments in primary care (e.g., the UK, the Netherlands) perform well in terms of access to care and equity, suggesting that strengthening primary care can be an effective and valuable investment (Hutchison 2013; Schneider et al. 2021). According to Commonwealth Fund rankings of Organisation for Economic Co-operation and Development countries, Canada ranks poorly in access to care (ninth among 11 countries; Schneider et al. 2021). Many Canadians struggle to access a regular doctor and are more likely to visit the emergency department, compared to those from peer counties (Schneider et al. 2021). Challenges in accessing a primary care provider may be partially attributable to the fact that approximately 15% of Canadians are unattached, meaning that they do not have a regular primary care provider (Statistics Canada 2020).

Attachment to a primary care provider is a core value of and a substantial challenge faced by health systems across Canada (Marshall et al. 2022). To support the attachment of Canadians to primary care, several provinces have established monetary incentives for family physicians who attach new patients (Breton et al. 2015, 2019). In April 2018, the Government of Nova Scotia and the Nova Scotia medical association (Doctors Nova Scotia) announced the creation of the Patient Attachment Incentive Trust (Government of Nova Scotia 2020; Nova Scotia Medical Services Insurance 2018). The introduction of this Trust coincided with a rise in the number of unattached patients in Nova Scotia. Between 2015 and 2019, Nova Scotia saw an increase from around 11% of the population reporting being unattached to 14%, while other provinces saw a decrease in unattachment (Statistics Canada 2020). For this Trust, $6.4 million was allocated to provide family physicians with a $150 incentive for each patient they enrolled into their practice from the centralized primary care waitlist (known as the "Need a Family Practice Registry" in Nova Scotia) or by any other means, including referrals from retiring physicians or emergency departments (Nova Scotia Medical Services Insurance 2018). The one-time financial incentive was to be billed at the first visit between the patient and family physician and required family physicians to retain the patient for at least one year (Nova Scotia Medical Services Insurance 2018). Patient retention was defined as "keep[ing] the patient in your practice and maintain[ing] an open chart for at least a year" (Nova Scotia Medical Services Insurance 2018: 2). When the incentive rolled out, around 5% of the population (45,500 patients) was publicly reported to be enrolled in the Need a Family Practice Registry (Nova Scotia Health Authority 2018). Between April 2018 and January 2020, 627 physicians claimed the incentive and accepted 61,086 patients into their practice for a total of ~$9.2 million spent via the incentive (Government of Nova Scotia 2020). The incentive ended in March 2020 with approximately 5.1% of the population (47,956 patients) on the registry (Nova Scotia Health Authority 2020; Nova Scotia Medical Services Insurance 2019). The proportion of people on the registry did not change as an almost equivalent number of people enrolled as were taken off.

Health system actors have historically relied on the same policy "levers" (e.g., payment incentives; McKay et al. 2022) despite the range of levers that exist (e.g., education, evidence-based care; McKay et al. 2022; Smith et al. 2020). However, there is evidence to suggest that there are limits to the efficacy of financial incentives to change the behaviours of primary care providers, including the promotion of patient attachment and access to primary care (Glazier et al. 2019; Lapointe-Shaw et al. 2017; Lavergne et al. 2018; Sempowski 2004). Regardless of the limited effectiveness, several Canadian provinces have used financial incentives to encourage patient attachment to primary care (McKay et al. 2022). There are data to suggest that these incentives may only have modest efficacy, and there is a need to understand *why* these incentives are not working as intended to create evidence for novel policy intervention. To do this, our study explores the perspectives of family physicians, nurse practitioners and policy makers on the value of a financial incentive to promote patient attachment to a primary care provider.

Methodology

A qualitative descriptive study design was used to elicit the experiences and perspectives of family physicians, nurse practitioners and policy makers in Nova Scotia related to patient attachment and the administration of, use of, and access to the Need a Family Practice Registry. Semi-structured interviews were conducted as part of the "Problems in Coordinating and Accessing Primary Care for Attached and Unattached Patients Exacerbated during the COVID-19 Pandemic Year (the PUPPY Study)" (Marshall et al. 2021). The interview guides (Appendices 1–3, available at longwoods.com/content/27090) were developed by the multidisciplinary team using findings from a policy scan and analysis and input from members of the study team, which included representatives from various stakeholder groups (e.g., clinicians, policy makers). The interview guides included questions on the use of incentives to encourage patient attachment. Family physician and nurse practitioner participants were asked this question: "What are your thoughts on providers being offered financial incentives to take on new patients from the centralized waitlist?"

Policy maker participants were asked two questions about the use of incentives:

- Before COVID-19, if you thought about attaching patients to primary care providers in this province, what key policies, strategies or incentives would you consider, and how would they impact attachment?
- Before COVID-19, what were the rules, regulation and incentives that posed obstacles for providers in taking on new patients? Which ones made things easier?

If policy makers did not mention the attachment incentive within their response, the interviewer used probes to ask about financial incentives for attachment. All stakeholders were asked questions in which there may have been the opportunity to mention the financial

incentive. For example, interviewees were asked: "What sort of supports or resources would you like to see offered for providers to better execute the effectiveness of the centralized waitlist?"

Purposeful and snowball sampling methods were used to recruit participants. Purposeful sampling ensured that participant characteristics such as role (i.e., family physician, nurse practitioner, policy maker), gender and region (e.g., urban/rural, health zone) were represented. Potential participants were identified by knowledge users on the research team, the research team's network of primary care stakeholders and other participants (i.e., snowball sampling). Invitations were also distributed to potential participants via partner organizations (e.g., physician and nursing professional associations, relevant university departments, primary care clinics) and social media (e.g., Facebook, Twitter). Interested participants were directed to contact the research team by e-mail or phone. Some knowledge user members (n = 4) of the research team also agreed to take part in interviews as participants. Informed consent was obtained from each participant before their participation.

Semi-structured, in-depth interviews took place via Zoom (Zoom Video Communications Inc.) or telephone between October 2020 and July 2021. There were three interviewers for this study; each interviewer was primarily responsible for conducting the interviews with a single stakeholder group. The interviews were overseen by the PhD-trained nominated principal investigator (EGM) of the study. Interviews were digitally recorded and transcribed verbatim; personally identifiable information was removed. The interviewers recorded their initial reflections following the interview within their field notes. The interviewers and members of the research team had ongoing conversations and debriefs to identify early themes from the interviews. Once the interviewers and members of the research team felt that no new themes were being identified, two additional interviews were conducted. When no new themes were identified within those interviews, it was determined that thematic saturation (Guest et al. 2020) had been reached and recruitment concluded.

Data were managed using NVivo software (QSR International Pty Ltd., 2018). Data were coded to identify when participants were responding to the questions about the attachment incentive and to identify interview excerpts mentioning the incentive (e.g., when participants spoke about the incentive in an unrelated question). Two trained qualitative research analysts conducted thematic framework analyses to manage and analyze the data (Gale et al. 2013). The framework method involved creating a matrix of cases (participants) and themes, with in-between cells housing key quotes or summaries of the data. For the purpose of this paper, relevant themes were identified by research analysts, and consensus on the names and descriptions of the themes was reached through a discussion between the analysts and the primary investigator. Themes and subthemes were shared with members of the research team and knowledge user partners to ensure validity. Data were analyzed for variation in perspectives by participant role (i.e., family physician, nurse practitioner or policy maker). Ethics approval was obtained from the Nova Scotia Health Authority Research Ethics Board (File #1022763).

Results

Twenty-one family physicians, seven nurse practitioners and ten policy makers participated in this study (Table 1).

TABLE 1. Participant attributes

Attributes		Family physicians (*n* = 21)	Nurse practitioners (*n* = 7)	Policy makers* (*n* = 10)	Number of participants* (*n* = 37**)
Self-identified gender	Man	9	0	N/A	9
	Woman	12	7	N/A	19
	Other	0	0	N/A	0
Rurality	Rural	8	5	N/A	13
	Urban	13	2	N/A	15

*Due to concerns regarding identification, no demographic information was collected for the policy maker participants.
**One participant had dual roles of family physician and policy maker, and has been counted in both columns.

We identified three overarching themes, each with subthemes, that were salient to participants: (1) positive impacts of the incentive, (2) shortcomings of the incentive and (3) participant recommendations for alternative policy levers to strengthen primary healthcare.

Positive impacts of the incentive

Participants identified several positive impacts of the financial incentive. Participants felt that the incentive was effective at reducing the number of unattached patients, compensated the administrative work involved in accepting a new patient into one's practice and was helpful for data validation of the Registry for primary care attachment.

"FORTUNATELY OR UNFORTUNATELY, MONEY DOES CHANGE PRACTICE"

Family physician and policy maker interviewees perceived an increase in patient attachments that occurred while the incentive was in effect. Participants felt that the incentive could encourage the attachment of patients in need of a provider, such as newborns and those on the Need a Family Practice Registry.

> Adding that little incentive might just make a small difference … maybe they'll take five or ten patients every couple of months for a little bonus. I don't think it's the worst idea … I think it could help a little bit with movement on the [Need a Family Practice Registry]. (Family physician, FFS [fee-for-service])

"IT PAID US FOR THE WORK WE HAVE TO DO"

Family physicians emphasized the value of the incentive in remunerating "some of the time that you would need to take when you do start with a new patient" (family physician, APP [alternative payment plan]). Although the incentive is "not equivalent to … your billable

hours," physician interviewees found the incentive to be helpful as it compensated them for the time it took to complete the necessary tasks when taking on a new patient, such as a lengthy first visit with a complex patient and accessing and reviewing the patient's medical records, which can "take hours and hours."

"IT WAS REALLY HELPFUL FROM A DATA VALIDATION PERSPECTIVE"

Policy maker participants identified the value of the incentive in helping to validate the number of attached patients on the registry. Physicians who attach a new patient would need to submit a billing claim to receive the incentive. The billing claim would be associated with a patient's health card number; thus, administrators "could remove those [patient] names from the [registry]. It was really helpful for us from a data validation perspective" (policy maker). Using the incentive billing also allowed policy makers to "get a count on how many patients had found providers with that incentive" and understand whether patients were being attached from the registry.

Shortcomings of the incentive

Participants identified several shortcomings of the incentive, such as money not being the most important consideration in attaching patients, the potential of the incentive to negatively impact patient care and access, the ethics of the incentive, criticism of the incentive as a political idea and the inability of the incentive to address systemic challenges in primary care.

INCENTIVE MONEY CANNOT OVERCOME SYSTEMIC CHALLENGES

Many participants stated that the incentive could not overcome larger issues in primary care. Participants explained that providers are currently "overburdened" with their current panel size and "it's not really the money that matters so much" (family physician, FFS). Participants explained that they have other obligations, such as "hospital work" and "learners," that limit "the number of patients that we can serve and manage in a timely manner." The providers who did have the capacity for new patients would accept patients regardless of the incentive, and they were "happy to accept the incentive for taking on the patient. But it didn't really make [them] do anything [they] wouldn't have done anyway" (policy maker).

"I DON'T THINK IT EQUATES TO BETTER CARE"

Interviewees expressed concern that funding physicians to take on additional patients may lead to poorer quality of care. As one family physician said "…if you can't get in [to your family doctor] for a number of months … you don't really have a family doctor." Interviewees said that offering a financial incentive to take on additional patients is problematic:

> If I'm compelled to take [on] more patients because I want the money, but the patients that I take on don't have access to quality care, are we really doing a good thing? (Family physician, FFS)

"I THINK IT'S UNETHICAL"

In addition to concerns about impacts on patient care and access, participants were also concerned about "…certain potential abuses…" of the incentive. One nurse practitioner described an experience where changes were made to the practice so that family physicians collected the incentives for patients cared for by nurse practitioners or family practice nurses, which they "did not agree with at all." Participants also expressed concern for other unethical behaviours related to "supplier-induced demand" and the incentive leading to "cherry-picking" of "easier" patients, instead of more complex patients.

"A POLITICAL, TERRIBLE IDEA"

Participants described the attachment incentive as largely "political," perceiving that it was used as a tool to "pacify anger in the patient and physician community." Participants felt that the provincial government wanted to show that patients were becoming attached because it "…looks good on paper if the numbers [of people waiting for a primary care provider] are low." Furthermore, participants felt that the incentive was "dropped too quickly…" without "…looking at what the value of the [incentive] was" and "…how it could be used to… help with attachment [of certain populations]" (family physician, APP). Nurse practitioner participants expressed disagreement with the choice to only offer the incentive to family physicians because nurse practitioners are a group who could also contribute to greater patient access and attachment to primary care.

Participant recommendations for alternative policy levers to strengthen primary healthcare

Participants made several suggestions for improving patient attachment to primary care providers, such as incentivizing "priority" patient populations, addressing the "shortage of primary healthcare providers," addressing the need for different models of practice and remuneration and identifying an appropriate patient panel size.

INCENTIVES FOR "PRIORITY" PATIENT POPULATIONS

Participants expressed support for "incentives for rostering people who are defined to be priority" (family physician, APP). Interviewees identified a need to define "priority" but mentioned that complex patients, such as patients with cancer, and "babies" might fall under the definition of priority. As one participant explained, an incentive for priority patients might be worthwhile because there are "professional or personal disincentives to take on sicker people" (family physician, APP).

ADDRESSING THE "SHORTAGE OF PRIMARY HEALTHCARE PROVIDERS"

As one participant said "…we just need more family physicians" (family physician, APP) and that the attachment incentive did not address the larger issue of a lack of providers to care for unattached patients. Many participants felt that there is a need for more primary care

providers to "share the burden. We don't need to keep dumping it on the existing ones that are burning out" (family physician, APP). Nurse practitioner participants suggested that there is a need to "increase the nurse practitioner population of providers as a way to get people off that list … rather than incentivizing physicians" and that nurse practitioners should be "provided the same opportunities … as physician providers."

THE NEED FOR DIFFERENT MODELS OF PRACTICE AND REMUNERATION

Participants recommended changes to practice models, including collaborative practice teams and sessional fees with no overhead as models, which would encourage family physicians to accept unattached patients into their practice. Sessional fees are "attractive" because there is "no overhead" when paid hourly and providers "don't have to worry about whether [patients are] going to show up or not" (policy maker). Changes to the existing fee structure, such as adding a fee for the first visit with a patient and allowing for differentials in this fee based on patient complexity "would be a better use of funding as opposed to just an incentive to take people off the list" (family physician, APP). From a policy maker perspective, one participant mentioned that collaborative family practice teams offer oversight regarding the number of patients being accepted, allowing for "consequences" if agreements are not followed.

IDENTIFYING AN APPROPRIATE PATIENT PANEL SIZE

A few participants recommended developing a method to measure a family physician's capacity so that the appropriate patient panel size could be identified and supported. As one policy maker described:

> We don't have tools or measures to assess capacity within a primary care provider's office. We've … deferred to [using] 1,350 patients [as the recommended panel size for] family practice, with no measure of health status or demographics or from a determinants of health approach – let alone provider practice styles and preferences and things like that. We have to really develop some practical key metrics. (Policy maker)

Such metrics could help ensure that family physicians are not taking on too many or too few patients but rather are providing care to an appropriate number of complex and non-complex patients, recognizing that not all patients require the same amount of care.

Discussion

Participants described the positives and shortcomings of the attachment incentive and made recommendations for alternative policy levers to strengthen primary healthcare. Among the positives, participants felt that the incentive was somewhat effective at encouraging providers to attach patients and compensated family physicians for the administrative work involved with taking on new patients. However, many participants felt that the incentive did

not change the attachment behaviours of family physicians and did not equitably support attachment. Interviewees identified alternative policy levers to reduce patient unattachment, including incentives for attaching priority populations, addressing the shortage of primary healthcare providers and expanding the types of remuneration and practice models that are available in the Nova Scotia health system.

Equity should be valued within universal healthcare as the application of equity concepts ensures that need determines access to care (Smith et al. 2020). Certain groups of people are underserved by the health system (e.g., patients who require opioids, people with lower incomes and transgender people [Asada and Kephart 2007; Marshall et al. 2017, 2019; Vermeir et al. 2018]) and face more challenges in obtaining attachment to a primary care provider. Prioritizing the attachment of these equity-deserving patients may help to address barriers to primary care access. Jurisdictions across Canada struggle to provide equitable access to care based on patient needs. Provinces such as British Columbia, Ontario and Quebec prioritize patient attachment from centralized waitlists based on the patient's assessed vulnerability or complexity (Breton et al. 2019). Thus, in addition to a targeted incentive, Nova Scotia would benefit from applying an equity lens to prioritize patients' attachment to a primary care provider from the centralized primary care waitlist, thereby ensuring that patients with the most need would have timely access to preventative care, a valuable function of the health system (Smith et al. 2020). Furthermore, payments could be used to appropriately compensate physicians for the time it takes to onboard new patients, considering the additional time required for complex or vulnerable patients. Prioritizing patients most in need may lead to calls for adjusting provider payments based on patient complexity, and provincial decision makers should prepare for such calls from medical associations and patient advocates.

Financial policies, including incentives, are commonly used to encourage change within primary care practices in Canada (McKay et al. 2022). Financial incentives may change the behaviours that are being incentivized and result in small, short-term improvements but may not create long-term changes (Lavergne 2017; Mendelson et al. 2017). For example, a financial incentive might increase patient attachment but might not lead to good access as attachment to a busy, overburdened provider is not likely to result in good access. In addition, incentives aimed at increasing the attachment of patients in greater need have shown that providers will choose to take a smaller amount of money and enroll *a greater number of* patients who require *less* care as opposed to a greater amount of money for enrolling patients who require more care (Breton et al. 2015; Glazier and Redelmeier 2010). If health system decision makers wish to promote greater patient attachment, they must take a systems approach and consider the various factors that contribute to poor access and attachment. Practice and funding models are known to influence providers' willingness to attach patients (Breton et al. 2021). Providers who are employed directly by the health system or who are working in interdisciplinary teams may have an increased willingness to attach new patients. Canadian health systems could invest in strategies that have proven successful in other

countries, such as neighbourhood-based clinics that are designed to meet the needs of their community and have the capacity to provide attachment to the surrounding population (Kiran 2022).

There is a need to understand provider panel size in a more nuanced way. Quantity measures, such as the number of patients enrolled in a practice, do not account for the quality of care patients receive or the care needs of individual patients (Ashcroft 2014), particularly across varying care models (e.g., FFS, collaborative care teams). Doctors Nova Scotia, in cooperation with the provincial government, has begun rolling out an accountability framework that will help to ensure that physicians paid by APP are maintaining an appropriate panel size (Doctors Nova Scotia 2022). This framework accounts for patient age and socio-economic status, is designed to support physician management of their practices and allows provincial stakeholders to better understand primary care capacity in the province. Such metrics of provider capacity are needed to inform policy initiatives directed at improving patient attachment and access to primary care. Without this broader health system planning, a financial incentive for attachment alone is likely insufficient to overcome systemic challenges in supporting appropriate physician compensation and patient access to timely care.

Strengths and limitations

Qualitative interviews with participants from three stakeholder groups – policy makers, family physicians and nurse practitioners – provided rich, in-depth perspectives from various stakeholders in primary care. The end of the incentive coincided with the beginning of the COVID-19 pandemic; therefore, we cannot draw associations between the ending of the incentive and the marked increase in the number of patients on the registry since that time.

Future directions

Patient perspectives on attachment and access to primary care, specifically related to meeting perceived needs, would be a valuable qualitative follow-up. Quantitative analyses could be used to triangulate the perspectives of the participants of our study. Future analysis of administrative data may help indicate whether there were changes in provider behaviours during the period when the incentive was available. In addition, the incentive only required physicians to maintain an open file for the patient for one year following the initial visit. Analysis of billing data may show if patient attachment was maintained once the incentive obligations ended. Furthermore, an analysis of visits to other providers and emergency departments would help show the attachment incentive's financial value.

Conclusion

From 2018 to 2020, Nova Scotia used a financial incentive to encourage the attachment of patients to family physicans. While some participants perceived short-term benefits of

the incentives, generally, the incentive was not perceived as either valuable or effective in addressing the underlying causes of patient unattachment and raised ethical and professional concerns. Participants identified alternative policy levers that may be effective in strengthening primary care in Nova Scotia. Encouraging greater patient attachment to primary care may require addressing systemic problems, including targeted interventions to address challenges related to equitable access and team-based models of primary care. These investments may better support patients accessing the right care from the right provider at the right time, reducing the overall health system burden.

Correspondence may be directed to: Emily Gard Marshall. Emily can be reached by e-mail at emily.marshall@dal.ca.

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