RESEARCH PAPER

Have Primary Care Renewal Initiatives in Canada Increased Comprehensive Care for Patients with Complex Care Needs? Yes and No

Les initiatives de renouvellement des soins primaires au Canada ont-elles favorisé les soins complets pour les patients ayant des besoins complexes? Oui et non

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Abstract

The First Ministers Health Accords of 2001 through 2003 (Health Canada 2006) launched the renewal of primary care toward more comprehensive care delivery models. We scanned government websites in the 10 Canadian provinces to assess how comprehensive and integrated renewal models were for health and social services in 2018. More comprehensive primary care delivery models were the norm in five out of 10 provinces. The policy approaches were: (1) expanding traditional family practice; (2) creating primary care networks; and (3) increasing the number of community health centres, which provide the broadest range of health and social care. Integration initiatives were limited to medical services. Additional financial and policy investments will be required to meet the comprehensive needs of patients with complex health and social needs at a system level.

Résumé

Les accords des premiers ministres sur le renouvellement des soins de santé, entre 2001 et 2003 (Health Canada 2006), ont axé le renouvellement des soins primaires vers des modèles de prestation de soins plus complets. Nous avons examiné les sites Web gouvernementaux des 10 provinces canadiennes afin d'évaluer dans quelle mesure les modèles de renouvellement de la santé et des services sociaux étaient globaux et intégrés en 2018. Des modèles de prestation de soins primaires plus globaux étaient la norme dans cinq provinces sur 10. Les approches stratégiques étaient les suivantes : (1) expansion de la pratique en médecine familiale traditionnelle, (2) création de réseaux de soins primaires et (3) augmentation du nombre de centres de santé communautaires, lesquels offrent le plus large éventail de soins de santé et de services sociaux. Les initiatives d'intégration se limitaient aux services médicaux. Des investissements financiers et stratégiques supplémentaires seront nécessaires pour répondre, au niveau du système, aux besoins globaux des patients ayant des besoins complexes en matière de santé et de services sociaux.

Introduction

The *Medical Care Act* (Government of Canada 1966) is a great Canadian policy achievement that removed direct cost barriers for medically necessary services (Marchildon 2012). However, the public payment of ambulatory physician services negotiated with physician organizations guaranteed private delivery (Naylor 1986). Consequently, primary care was delivered predominantly by general practitioners or family physicians in autonomous family practices funded through public fee-for-service remuneration of physicians.

Medicare came of age at the same time as the "primary healthcare" movement, which envisioned a comprehensive range of community-based services and holistic care of patients (WHO 1978). In Canada, this vision was expressed in the creation of community health centres, which extended the scope beyond general medical services to include broader health services, such as nutrition, social work and psychology, as well as public health and community development (Albrecht 1998). Early exemplars of this model – the nurse-led community

centres in Saskatchewan (SK) and the first Community Health Centre in Manitoba (MB) – were echoed elsewhere in Canada, especially in Quebec (QC) and Ontario (ON). In 1974, QC rolled out a province-wide policy of geographically based local community service centres (CLSC), which offered services adapted to the community; not all included general medical services. In ON, Community Health Centres opened as experimental pilot projects and were mainstreamed in 1983 in various regions.

The First Ministers Health Accords of 2001 through 2003 (Health Canada 2006) launched a federal investment through the Primary Health Care Transition Fund (PHCTF) to make primary care in Canada more available, comprehensive and coordinated than what was offered in the autonomous general practice model that was predominant in 2000 (Health Canada 2005). A 2009 review of primary care initiatives by Hutchison et al. (2011) concluded that the federal policy had engaged physicians and expanded the disciplinary mix of primary care professionals, but that it was well established only in four provinces. In this article, we aim to identify the extent to which the primary health renewal models were prevalent in 2018 in all 10 provinces and the extent to which primary care models were more comprehensive and integrated with other health and social services.

This was part of a larger research program to describe and compare the structures and policies in Canadian provinces that govern primary care and facilitate integration of health and social services required for patients with complex healthcare needs (Haggerty et al. 2023). Valentijn et al. (2013) proposes that integration between health and social services is essential to achieve comprehensive primary care for a defined population. Comprehensiveness is defined in multiple ways (Haggerty et al. 2007), but we defined it as the provision of the broad range of health and social services required for patients with complex healthcare needs. Comprehensiveness can be achieved either by a broad range of intramural services or through facilitated coordination with extramural providers that characterizes integrated care. The extent to which complex needs of patients are met in a coordinated manner will reflect the organizational structures, rules and guidelines that support intramural comprehensiveness and extramural integration.

Methodology

We conducted a scan of government and healthcare websites in the 10 Canadian provinces to identify the primary care renewal model that was introduced with the PHCTF and the extent to which the model has evolved or been deployed since 2018. We also identified any strategic policies relating to primary healthcare or primary care. The Macro Policy Data Collection Template was used to collect relevant data for each province between September 2017 and September 2018 (Appendix 1, available online at www.longwoods.com/content/27186). The information for each province was summarized in narrative form, and this was presented to a provincial key informant who was a decision maker within the provincial ministry of health and was often a member of the larger research team. The narrative summary was amended to reflect the situation at the time the information was collected.

"Provincial Narrative Summaries" provides the date of validation and the document source for each provincial summary, and resides here: https://cpcrn-rcrsp.ca/wp-content/uploads/2023/08/PIHCIN-Provincial-Narrative-Summaries_Health-Governance-and-Primary-Care-Structures_Scan_FINAL.pdf.

The validated provincial summaries were read independently by three team members (JH, CS, YC) using an immersion–crystallization process (Borkan 1999). The initial insights from independent reading were challenged to ensure that insights were based on the data and not pre-existing positions or personal knowledge. The subsequent immersion in the data and initial insights to identify patterns and trends was followed by synthesis and sense making to discern policy-relevant patterns across provinces and identify emerging trends. Comprehensiveness of services was presumed from the disciplinary healthcare team within the model, with the specific mention of added new services or linkages with other providers.

Results

Readers interested in any one province can refer to the Provincial Narrative Summaries (https://cpcrn-rcrsp.ca/impact-podcasts/evidence/) for the appropriate summary and documentary source for the data analyzed here.

The 2018 scan of primary care delivery models shows that seven out of 10 Canadian provinces continued or expanded their primary care renewal initiatives after the federal investment stopped in 2006 and that more than 50% of the population received care in primary care renewal delivery models in five out of 10 provinces (Alberta [AB], ON, QC, New Brunswick [NB] and Nova Scotia [NS]). Although primary care investments continued in MB and SK, consolidation around specific team-based delivery models only emerged in recent years. Three provinces – British Columbia (BC), Newfoundland and Labrador (NL) and Prince Edward Island (PEI) – used PHCTF to invest mostly at a system level: BC in chronic disease management; NL in linking care across the continuum of medical services, including electronic record linkage; and PEI in health promotion and palliative care. These three provinces trialled various delivery models and more recently have begun to invest in specific models used in other provinces.

Through our analysis, we identify three types of primary care renewal delivery models and two approaches to policy implementation. We also highlight some unanticipated findings that have important policy implications, and we end with some observations regarding comprehensiveness.

Three types of primary care renewal delivery models

The labels and specific arrangements for primary care renewal differed by province, but they can be broken into three general organizational forms: (1) expansion of the traditional family practice model; (2) increasing the number of Community Health Centres; and (3) geographically based primary care networks.

The *enhanced family practice* model was used most predominantly in SK, MB, ON, QC and NS, and in the pilot projects that were trialled in BC, NL and PEI. Comprehensive care was expanded in primary care renewal models by making larger groups of family physicians (co-located or networked) and adding new health professionals. Additional funding was provided to integrate primary care nurses with an expanded scope of practice. Other health professionals were present in intensities and configurations that varied within and between provinces, and these commonly included pharmacists, nurse practitioners, psychologists or social workers and nutritionists or dietitians.

In ON, QC and NS, comprehensiveness was increased by adding new health professionals after the initial physician–nurse model was stabilized. In other provinces, such as ON and SK, we observed an early attempt to implement a very comprehensive primary care model followed by adaptations to increase uptake by existing family practices. The initial model in SK – the primary healthcare team – proposed a care team composition reflecting the needs of the community, but participation by family physicians was minimal until the model allowed fee-for-service payment. ON's first primary care renewal model in 2001, the family health network, emphasized formal registration of patients, 24/7 accessibility arrangements (including linkage to telephone helplines), improved chronic care management and physician remuneration based on capitation and performance incentives. When physician uptake was low in 2003, a new model – the family health group – made patient enrollment easier by basing enrollment on previous medical services billing and allowing fee-for-service remuneration from the start. The family health team model, introduced in 2006, and then the family health organization, in 2007, included an even broader mix of health disciplines and offered a broad basket of services. This suite of family health models co-existed.

In most provinces, enhanced family practice models included some form of integration between primary care and the rest of the healthcare system, usually better information linkages to hospitals and emergency rooms rather than to other community-based health and social services. In NL, linkage across the continuum, including non-health ministries, was supported by its 2015 strategic policy of Health-In-All-Policies, but we did not find data on how it impacted primary care.

The *community health centre* was the most comprehensive primary care delivery model. This is not a renewal delivery model per se because the model was already well established in various provinces; but increasing the number of community health centres was the renewal strategy in AB, MB, ON and NB. Unlike family practice, this model is governed by a community board, and all health professionals (typically physicians, nurse practitioners, dietitians and social workers) are salaried. The model offers a broad range of intramural health services to their population through the interdisciplinary team, and activities usually include some form of community engagement or development. This is the model where social services and population health approaches are core elements of service delivery. In ON and MB, the community health centres tended to serve hard-to-reach populations in urban areas or rural

communities. The ACCESS Winnipeg models offered medical care, social services, mental health, home care, employment and income assistance programs.

The community health centre was the predominant primary care renewal strategy for NB. In 2018, in NB, there were 10 geographically based community health centres and 29 associated health service centres. In MB, ON and AB, additional community health centres were created as part of the primary care renewal. In QC, although community health centres (referred to as CLSCs) are well established, they were not the focus of primary care renewal efforts. However, QC's strategic primary care policy intended to create better integration between health and social services by assigning CLSC nurses to the expanded family practice renewal model (family medicine groups) in their geographic area. In 2018, community health centres were well established in QC, ON, NB, MB and AB (in the decreasing order of per capita coverage); they were increasing in BC, SK and NS; and absent in PEI and NL.

The *primary care network* was the primary care renewal model in AB. Existing family practices in a geographically defined area were invited to join their local network voluntarily to have access to interdisciplinary teams (nurse practitioners, nurses, dietitians, social workers and pharmacists) to strengthen health promotion, chronic disease management and care coordination. In large family practices, the interdisciplinary team is intramural; multiple small family practices share a common team. The network included funding for increased administrative support, equipment and space, and it included arrangements for extended office hours and 24/7 access to appropriate primary care.

A 2008 change to the funding model extended services beyond the medically insured services to include some public health, wellness and chronic disease management services. In 2018, over 80% of family physicians were members of the 42 primary care networks and covered 85% of the population. As of 2017, there was joint network governance by physicians and the ministry of health (Alberta Health Services). In 2003, AB was the only province with this primary care renewal model but the success, and especially physician uptake, has raised interest elsewhere in Canada. In PEI, existing services were organized into primary care networks in 2011, and in BC, in 2018. The My Health Team model in MB also resembles the primary care network model.

Two policy approaches to primary care renewal model implementation

Five provinces promoted a single delivery model; five deployed multiple models. The single delivery models in the five provinces were: primary care networks (AB); primary health care teams (SK); family medicine groups (QC); collaborative family practice teams (NS); and community health centres and associated health service centres (NB). Policies supporting these renewal models were centralized at the ministries of health. Most of these were enhanced family practice models, and most retained fee-for-service remuneration of physicians, with additional remuneration for coordination activities and funding to include other health professionals working within the delivery model.

Multiple models were deployed in the other provinces. BC, PEI and NL used the PHCTFs to invest in several demonstration primary care delivery models but without clear evidence of unifying strategic policy. In contrast, ON deployed its suite of family health models sequentially within a unifying strategic policy designed to promote physician uptake and patient enrollment, establish minimal panel sizes, shift away from fee-for-service reimbursement of physicians, make 24/7 accessibility arrangements and include additional health professionals. When voluntary physician adherence was low in the initial robust expression of this policy (the family health network model), the Ontario Ministry of Health worked closely with physician associations to tweak the design to facilitate physician adherence while keeping their strategic priorities. The suite of models included the comprehensive care model, which grouped several solo practitioners into a cohesive delivery model. The success of this policy was evidenced by 85% of ON physicians practising in one of the family health models in 2018.

A unifying strategic policy was not obvious in MB. It used PHCTF to invest in information infrastructure, which was conducive to care integration. But in terms of primary care delivery models, there have been a series of model labels that seem to both reinforce and expand the traditional family practice model. In 2018, the systems-level and physician-oriented policies seemed to be converging into networking arrangements that increased access via existing family practices to interprofessional teams and collaboration between physicians and other health professional associations through a new service delivery governance and planning entity, Shared Health. The My Health Team model, introduced after 2018, includes collaborative arrangements with community organizations and shared access to a broader disciplinary set of care providers – suggesting a policy move toward configuring primary care models to deliver greater integration and interdisciplinary collaboration; but in 2018, a unified provincial approach was still not evident.

Unanticipated Findings

The following three unanticipated findings have important policy implications for both primary care comprehensiveness and linkage across services: (1) structures to accommodate unattached patients; (2) mental health access centres; and (3) Patient's Medical Home.

Unattached patients

Lack of affiliation to a most responsible family physician provoked a policy response in several provinces. Five provinces (BC, MB, ON, QC and NB) had established centralized waiting lists for family physicians. Two provinces (BC, QC) had set up specific primary care delivery models as an alternative to hospital emergency rooms where unattached patients could get first-contact care and access-needed diagnostic and therapeutic services, such as urgent primary care centres (BC) and cliniques réseaux (network clinics) (QC). Nurse-led clinics were used in four other provinces (SK, MB, ON, NB) to meet the needs of unattached patients. MB had piloted various delivery models to serve unattached patients and populations not

covered by traditional family practices (quick care nurse-led clinics, mobile clinics, walk-in connected care clinics). The emergence of these models made evident the fact that access to the most basic form of comprehensive care beyond acute needs requires having a responsible primary care provider – either a family physician or a nurse practitioner. Canadians without this privileged status may have been able to get free acute episodic care in the health system but their broader care needs were very poorly met – and if they had complex needs, they could be guaranteed that services would not be coordinated or connected.

Mental health access centres

At the time of data collection in 2018, five provinces had put community-based mental health centres in place. These one-stop shops have immediate access to a variety of mental healthcare providers and ensure rapid access and coordination with specialized mental health services. They cater especially to the needs of youth, many of whom are also unattached patients. These delivery models were designed to capitalize on any encounter to provide a comprehensive response adapted to the intensity of need. They had many shared features across provinces, which need to be evaluated because they hold promise for comprehensive primary care, especially for populations with complex care needs.

Patient's Medical Home

In five provinces (BC, MB, NB, NS, NL), we observed provincial family physician associations promoting models inspired by the Patient's Medical Home policy put forward by the College of Family Physicians of Canada (CFPC 2011). They were: home clinics (MB); family medicine (NB); a person-centred Health Home model (NS); a Health Home model (NL). These models had emerged since 2016, and while they included various features of the family practice renewal models (team-based, formal patient enrollment, enhanced accessibility arrangements), physicians played a key role in governance and leadership.

Discussion

This scan of primary care delivery models in Canada shows that in seven provinces, primary care renewal extended well beyond the initial federal investment of 2002–2006. In 2018, primary care renewal delivery models were predominant in AB, ON, QC, NB and NS. Most renewal models are enhanced family practice models; AB alone established primary care networks as a de novo governance and delivery model. Primary care renewal had been most successful in provinces with a unified strategic policy that either promoted a single delivery model (AB, QC, NS) or combined a solid core of orienting principles with organizational flexibility designed to maximize uptake (ON). In 2018, there was evidence of cross-provincial learning in provinces such as BC, SK, MB and PEI that were implementing primary care renewal strategies that had been successful in other provinces.

Similar to the 2009 status report on primary care renewal in Canada by Hutchison et al. (2011), our 2018 scan finds that primary care renewal models were the norm in AB,

ON and QC, but it adds NB and NS and sees even more development in other provinces. After a bumpy start, renewal models were well under way in MB and, to a lesser extent, in SK. Primary care networks have spread to BC, PEI and NFL. While Hutchison et al. (2011) included BC in the provinces with the most far-reaching transformation, this was not reflected in the implementation of primary care delivery models per se. Instead, BC invested in engaging family physicians in collaboratives to promote concerted quality improvement and full-service family practice (Cavers et al. 2010), with over 90% of family physicians enrolled in geographically based Divisions of General Practice in 2018. A rapid review of primary care policies from 2007 to 2017 also gave BC low marks for policy innovation, and included NB in that list (Peckham et al. 2018). The fact that primary care renewal continued beyond the PHCTF may also be due to the requirement of formal evaluation of initiatives that made results available to policy makers in other provinces such as BC, SK, MB and PEI that are building on what was learned.

One of the major policy achievements of primary care renewal has been to bring a significant proportion of autonomous family practices into the governance orbit of ministries of health through contractual arrangements of increased resources and funding in return for some accountability. Gaining access to increased resources required family practices to undergo some process of accreditation and commitment to providing minimal services. Engagement of physicians seemed to be a major consideration in the design of delivery models in most provinces, hence the predominance of enhanced family practice as the primary care renewal model across Canada. Family physicians embrace the idea of collaborative interdisciplinary practice (Wilson et al. 2005) and value-based remuneration (Kessels et al. 2015), but the policy and regulatory structures are not yet fully supportive. This speaks to the ongoing tension in policy making between public governance of the health system and the autonomy of the medical profession. This tension is particularly evident in parallel (but hopefully converging) primary care renewal tracks in MB and in the low uptake of the primary health care teams in SK until fee-for-service remuneration for physicians was allowed. The unanticipated emergence of the Patient's Medical Home as a competing delivery model was happening in BC, MB, NB, NS and NL – provinces where physicians had a strong role in determining health policy. We agree with the analysis of Peckham et al. (2018) that the negotiating table between organized medicine and the government make it challenging to translate innovative governance arrangements into meaningful coordination and integration at the front lines of care. We find that physician uptake was an objective in both ON's and AB's primary care delivery model design. ON intentionally adapted its policy on the family health suite of renewal models to engage physicians. AB's unique solution of primary care networks allowed for rapid deployment through joint governance between family physicians in non-profit corporations and Alberta Health Services. More recently, disputes in these provinces with physician associations demonstrate the challenge of the legacy of the medical social contract that was negotiated to achieve Canadian medicare.

Our findings reflect the limited time and resources to obtain needed information. The provincial summaries were based on information obtained within a given time budget, and we know that they were incomplete. This reflects the lack of publicly available and comparable information about our health systems across Canada (Stewart et al. 2023). We chose to be rigorous in basing our results and crystallization only on the collected data, not on other sources, and others with more knowledge of their provincial system may draw different conclusions. We are relieved to see that our results are largely coherent with the more comprehensive policy review by Peckham et al. (2018) with a slightly different aim. Both studies are responding to the expressed need by primary care researchers and decision makers to have comparative health system information across Canada and to accelerate the adoption of what works in other jurisdictions.

We recognize that our findings are time-stamped in 2018. Since the completion of this scan, primary healthcare models have continued to evolve, or devolve, particularly during the COVID-19 pandemic. Prior to the pandemic, digital strategies were emerging as an option to improve access to timely care from various health professionals. Companies such as the UK-based Babylon Health and Telus Health quickly responded to the perceived potential of digital primary healthcare service delivery in Canada. During the pandemic, the potential of virtual care options was clearly evident, and this has implications for enhanced coordination and integration of care. However, such innovations mostly address the needs of persons already attached to a primary care provider. Such ongoing change emphasizes the need for comprehensively and efficiently capturing cross-provincial and national primary healthcare renewal policies and models.

Where does this leave patients with complex healthcare needs? The comprehensiveness of services that these patients can expect to receive in primary care has clearly increased compared to the autonomous family practice model prevalent in 2001 – that is, if patients are fortunate enough to be enrolled in a primary care renewal delivery model. During the timeframe of this scan, their likelihood of being enrolled was high in AB, ON, QC, NB and NS. Models from ON and AB included a broad set of disciplines, such as pharmacists, social workers or psychologists and nutritionists or dietitians. In other provinces, such as QC and NS, the disciplinary mix was growing slowly beyond the physician–nurse team. Patients in AB, MB, ON and NB who are fortunate enough to be cared for in community health centres would have comprehensiveness that includes social as well as health services, and patients with complex healthcare needs may be encouraged to see the growth of community health centres in BC, AB, MN, ON and NB.

Less clear is the extent to which primary care renewal has achieved coordination and integration compared to primary care, especially between health and social services. Our findings concur with those of Peckham et al. (2018) that primary care renewal initiatives addressed linkage and exchange with other healthcare organizations and services through improved health information technology, but linkage was limited to medical services, especially hospitals. Most Canadians with complex care needs would not have access to a wide

range of services from their primary healthcare provider and would be dependent on their provider's or carer's capacity to coordinate connection with needed services.

Conclusion

This high-level impressionistic portrait of the state of primary healthcare renewal in Canada is a testament to the extent of transformation and change that is possible with federal health policy initiatives, such as the Health Accords, and targeted and harmonized investments, such as the PHCTF. The movement toward more comprehensive models of primary care extended beyond the end of the PHCTF in 2006. However, the integration between health and social services beyond the walls of primary care remains largely incipient and, sometimes, still dependent on heroic efforts of individual providers and caregivers. As the proportion of patients with complex care needs increases, surely it is time for a federal accord on integrating health and social services to provide truly comprehensive and integrated care for every Canadian.

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References

Albrecht, D. 1998. Community Health Centres in Canada. *Leadership in Health Services* 11(1): 5–10. doi:10.1108/13660759810202596.

Borkan, J. 1999. Immersion/Crystallization. In B.F. Crabtree and W.L. Miller, eds., *Doing Qualitative Research (2nd ed.)* (pp. 179–94). Sage Publications, Inc.

Cavers, W.J.R., V.H.F. Tregillus, A. Micco and M.J. Hollander. 2010. Transforming Family Practice in British Columbia: The General Practice Services Committee. *Canadian Family Physician* 56(12): 1318–21.

The College of Family Physicians of Canada (CFPC). 2011, September. A Vison for Canada: Family Practice – The Patient's Medical Home. Position Paper. Retrieved April 11, 2018. <https://www.cfpc.ca/en/policy-innovation/health-policy-goverment-relations/cfpc-policy-papers-position-statements/a-vision-for-canada>.

Government of Canada. 1966. An Act to Authorize the Payment of Contributions by Canada Towards the Cost of Insured Medical Care Services Incurred by Provinces Pursuant to Provincial Medical Care Insurance Plans. Statutes of Canada 1966, Chapter 64, 1st session, 27th Parliament. Retrieved August 22, 2023. <https://publications.gc.ca/site/eng/9.841612/publication.html>.

Haggerty, J., F. Burge, J.-F. Lévesque, D. Gass, R. Pineault, M.-D. Beaulieu et al. 2007. Operational Definitions of Attributes of Primary Health Care: Consensus among Canadian Experts. *Annals of Family Medicine* 5(4): 336–44. doi:10.1370/afm.682.

Haggerty, J., C.M. Scott, Y. Couturier, A. Quesnel-Vallée, É. Dionne, T. Stewart et al. 2023. Connecting Health and Social Services for Patients with Complex Care Needs: A Pan-Canadian Comparative Policy Research Program. *Healthcare Policy* 19(Special Issue): 10–23. doi:10.12927/hcpol.2023.27182.

Health Canada. 2005, April. *Primary Health Care Transition Fund: Interim Report*. Retrieved August 23, 2023. <https://publications.gc.ca/collections/collection_2008/hc-sc/H21-245-2005E.pdf>.

Health Canada. 2006, May 8. Archived – 2003 First Ministers Health Accord. Retrieved August 23, 2023. <https://www.canada.ca/en/health-canada/services/health-care-system/health-care-system-delivery/federal-provincial-territorial-collaboration/2003-first-ministers-accord-health-care-renewal/2003-first-ministers-health-accord.html>.

Hutchison, B., J.-F. Lévesque, E. Strumpf and N. Coyle. 2011. Primary Health Care in Canada: Systems in Motion. *Milbank Quarterly* 89(2): 256–88. doi:10.1111/j.1468-0009.2011.00628.x.

Kessels, R., P. Van Herck, E. Dancet, L. Annemans and W. Sermeus. 2015. How to Reform Western Care Payment Systems According to Physicians, Policy Makers, Healthcare Executives and Researchers: A Discrete Choice Experiment. *BMC Health Services Research* 15: 191. doi:10.1186/s12913-015-0847-7.

Marchildon, G.P. (ed.). 2012. *Making Medicare: New Perspectives on the History of Medicare in Canada*. University of Toronto Press.

Naylor, C.D. 1986. *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911–1966*. McGill-Queen's University Press.

Peckham, A., J. Ho and G. Marchildon. 2018, March. *Policy Innovations in Primary Care across Canada. A Rapid Review Prepared for the Canadian Foundation for Healthcare Improvement*. North American Observatory on Health Systems and Policies. Retrieved August 23, 2023. <https://naohealthobservatory.ca/wp-content/uploads/2019/08/NAO_RR1.pdf>.

Stewart, T., É. Dionne, R. Urquhart, N.D. Oelke, J.L. McIsaac, C.M. Scott et al. 2023. Lack of Publicly Available Documentation Limits Spread of Integrated Care Innovations in Canada. *Healthcare Policy* 19(Special Issue): 88–98. doi:10.12927/hcpol.2023.27176.

Valentijn, P.P., S.M. Schepman, W. Opheij and M.A. Bruijnzeels. 2013. Understanding Integrated Care: A Comprehensive Conceptual Framework Based on the Integrative Functions of Primary Care. *International Journal of Integrated Care* 13(1): 655–79. doi:10.5334/ijic.886.

Wilson, D.R., D.G. Moores, S.C. Woodhead Lyons, A.J. Cave and M.G. Donoff. 2005. Family Physicians' Interest and Involvement in Interdisciplinary Collaborative Practice in Alberta, Canada. *Primary Health Care Research and Development* 6(3): 224–31. doi:10.1191/1463423605pc243oa.

World Health Organization (WHO). 1978, September. *Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12*. Retrieved August 23, 2023. <https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2>.