

Do you have a Family Doctor?: A Mixed-methods Health Policy Analysis of
Primary Care Reform in Canada

by

Nicole Herpai

A Thesis submitted to the Faculty of Graduate Studies of
The University of Manitoba
in partial fulfilment of the requirement of the degree of

MASTER OF SCIENCE

Department of Community Health Sciences
University of Manitoba
Winnipeg

Copyright © 2018 by Nicole Herpai

Acknowledgements

I would like to thank my thesis supervisor Dr. Evelyn Forget of the Community Health Sciences Department at the University of Manitoba for offering her perpetual guidance, expertise, and insightfulness during this project. I would also like to thank the committee members Dr. Alan Katz of the Community Health Sciences Department and Dr. Ian Hudson of the Economics Department both at the University of Manitoba for their observations and comments in preparation of this manuscript. Dr. Ian Clara at the Research Data for assisting in accessing the data and vetting the output. Janice Linton for her advice on the search strategy of the second phase of this study.

I would like to recognize the funding support of the Western Regional Training Center, the Research Data Center, the John (Jack) MacDonald Lederman and John MacDonell Bursary, and the Faculty of Graduate Studies.

Finally, I must express my profound gratitude to my spouse Daniel Herpai for providing unfailing support and encouragement throughout my years of study and through the process of researching and writing this thesis.

Thank you

Nicole Herpai

Table of Contents

<i>Title Page</i>	<i>i</i>
<i>Acknowledgements</i>	<i>ii</i>
<i>Table of Contents</i>	<i>ivii</i>
<i>List of Figures</i>	<i>iv</i>
<i>List of Tables</i>	<i>iv</i>
Abstract	v
1.0 Why Study Access to Primary Care?	1
1.1 Introduction	1
1.2 Primary Care and Primary Health Care	2
1.3 Background	2
1.4 Study Objectives.....	4
1.5 Research Questions	5
2.0 Phase 1: How do the provinces compare?	5
2.1 Review of the Literature	5
2.1.1 What is Access?	5
2.1.2 Province and Access	7
2.1.3 Other Factors Associated with Access.....	8
2.1.4 Primary Care Reform Analysis	10
2.2 Research Question #1	12
2.3 Methods	12
2.3.1 Data.....	12
2.3.2 Population of Interest.....	13
2.3.3 Independent Variable (Predictor Variable)	13
2.3.4 Dependent Variable (Outcome Variable)	13
2.3.5 Covariates (Independent Variables)	14
2.3.6 Statistical Analysis	15
2.3.7 Weighting and Bootstrapping	15
2.3.8 Evaluation of Assumptions	16
2.4 Results	17
2.4.1 Descriptive Statistics.....	17
2.4.2 Unadjusted Odds Ratios	19
2.5 Discussion	22
2.5.1 Influences on having a regular family physician	22
2.5.2 Immigration, cultural/racial background, and language.....	25
2.5.3 Provinces.....	26
2.6 Limitations	31

3.0 Phase 2: The 3Is – Ideas, Institutions and Interests.....	32
3.1 Research Question #2.....	32
3.2 Theoretical Framework.....	32
3.2.1 Health Policy Analysis	33
3.3 Methods	40
3.3.1 Data Collection & Search Strategy	41
3.3.2 Analysis	42
3.4 Results	43
3.4.1 Ideas.....	44
3.4.2 Institutions.....	50
3.4.3 Interests (of actors)	56
3.5 Discussion	63
3.5.1 Ontario.....	63
3.5.2 Manitoba	68
3.6 Limitations	75
4.0 Conclusions and Recommendations	76
4.1 Ethical Consideration.....	76
4.2 Future Research	76
4.3 Conclusion	77
References.....	80

List of Figures

FIGURE 1: PHASE 2: 3I RESULTS	43
--	-----------

List of Tables

TABLE 1: PHASE 1: DEPENDENT VARIABLE: DO YOU HAVE A REGULAR MEDICAL DOCTOR?	17
TABLE 2: PHASE 1: DESCRIPTIVE STATISTICS FOR THE REGULAR FAMILY DOCTOR VARIABLE.....	18
TABLE 3: PHASE 1: LOGISTIC REGRESSION MODELS: DO YOU HAVE A REGULAR MEDICAL DOCTOR?	21
TABLE 4: 3I FRAMEWORK	36
TABLE 5: PHASE 2: SEARCH STRATEGY.....	41

Abstract

At the turn of the millennium accessibility to health services in Canada fared poorly compared with other OECD countries. Satisfaction with the healthcare system was at a low which was attributed to years of funding retrenchment and unprecedented changes to health care delivery systems. In response, over the past two decades federal and provincial governments have provided substantial political will and considerable resources into making improvements; one of the focal aims was primary care reform.

The objectives of this study were to compare primary care accessibility across the provinces and to identify the key ideas, institutions and interests (the 3Is) that have contributed to the formation of primary care policy reform around accessibility to primary care. The objectives were assessed with a mixed-methods design. First, data from the 2013/14 Canadian Community Health Survey was examined using logistic regression to determine if there was a difference in accessibility across the provinces as measured by whether or not respondents (aged 18 and older living in one of the 10 provinces in 2014) had a “regular medical doctor” ($n = 115,220$). Second, a documentary analysis was conducted of publicly available primary health care policy literature published from 2000 – 2013 ($n = 103$).

Differences in accessibility to a regular family physician between the provinces were observed, suggesting that provincial primary care policies directly affect residents’ access to primary care. Ontario residents had the best access to primary care of the 10 provinces. The *ideas, institutions* and *interests* identified at the national level have produced somewhat different outcomes for primary care reform in the provinces, as provincial priorities make national goals concrete.

1.0 Why Study Access to Primary Care?

1.1 Introduction

It is widely accepted that a high quality and easily accessible primary care system is fundamental to sustaining a healthy population. The evidence of a positive association between accessibility to primary care and improved population health has been summarized in numerous systematic reviews (Kringos et al., 2010; Starfield, Shi & Macienko, 2005; Ansari, 2007; Sans Corrales et al., 2006). “[Primary health care] is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (WHO, 1978, VI). Primary care provides person-focused, continuous, comprehensive and coordinated care for common conditions by delivering an array of preventative, curative and rehabilitative services to the community.

In Canada, primary care further functions as an important entry point into the wider healthcare system; individuals without a regular family doctor are likely to experience difficulties accessing routine care and secondary care (Sanmartin & Ross, 2006; Sanmartin et al., 2004; McIssac et al., 2001; Dunlop et al., 2000). Primary care systems are complex in Canada and involve many stakeholders. The Canada Health Act (1984) is essentially a promise made by the federal government to provide universal access, however provinces have constitutional responsibility for the organization and delivery of healthcare, while those who are responsible for the direct provision of primary care, largely family doctors, are private actors whose practices operate like small businesses. Given this complexity it is not surprising that primary care systems differ across the provinces.

1.2 Primary Care and Primary Health Care

The terms primary care and primary health care are often used interchangeably and require clarification. Their meanings have undergone substantial discussion and debate over time. In Canada, primary care is more often understood as “the diagnosis, treatment and management of health problems with services delivered largely by physicians.” (Fooks, 2004, p.3) Primary health care on the other hand is inclusive of the broader social determinants of health¹; it encompasses primary care with the addition of public health, health promotion and prevention, and may be provided for by other health care practitioners with different specialties such as dietitians, physiotherapists and dental hygienists. Both terms will be used in this text and should be understood as they are described here. It is important to note that they may be interchanged when quoting or referencing other literature, given that the authors will have their own nuanced understandings of the terms.

1.3 Background

At the turn of the millennium the primary care reform agenda was prompted by public concern for access and quality, concern from provincial premiers for the sustainability of healthcare financing, recommendations by provincial and federal commissions, and increased support from the federal government for primary care reform (CIHI, 2012). Accessibility to health services in Canada and overall satisfaction with the healthcare system fared poorly when compared with other OECD countries (The Commonwealth Fund, 2001). “The Commonwealth Fund 2001 International Health Policy Survey finds a steep decline in the Canadian public’s

¹ The social determinants of health include: income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture (Government of Canada, 2011).

satisfaction with their national health care system over the past 14 years” (ibid, p.1). The concerns were widespread in the media during the time, with an emphasis on the overcrowding of emergency rooms which the media related to a lack of access to primary care for citizens (Hutchison, 2011). The discontentment was attributed to years of funding retrenchment, due to the dramatic reduction in federal transfer payments during the 1990s, and consequent changes to health care delivery systems (Wilson, 2004; Tuohy, 1999). Premiers and Territorial Leaders also expressed their concern for the sustainability of their healthcare systems in an open letter to the federal government in 2000 forecasting a dim future of Canadian healthcare due to decreased funding and calling for an urgent First Ministers meeting on health care (Provincial and Territorial Ministers of Health, 2000a). By 2000, the combined total of provincial and federal government budgetary surpluses of over \$16 billion and “in this context, one of the highest priorities for reinvestment was health care” (Tuohy, 2012, p. 466). The response, to the public discontent and increased funding potential, by federal and provincial governments and the policy-making community was to undertake a series of high profile studies and commissions (notably the Commission on the Future of Health Care in Canada 2002 and the Senate Standing Committee on Social Affairs, Science and Technology 2002), and establish three Health Accords with the First Ministers, with the aim of improving the healthcare system overall (Wilson, 2004). “Policy makers who were preoccupied with cost containment in the early 1990s are now overwhelmed by a crisis in accessibility to healthcare” (Hogg, 2008, p.308). One of the key items to come out of the commissions and studies was the importance of reforming primary care in Canada and improving access to it.

From 2000 to 2004 the federal and provincial governments jointly made substantial gains in planning and collaborating around shared goals for health policy reform; a vision was created,

goals were well-established, considerable financial support was organized for distribution over the coming years, and an objective mechanism for measuring progress was in place (The Health Council of Canada). Although a nation-wide commitment was made to bring about systematic improvements to primary health care, it has materialized differently across the country. The Health Council launched into their 2013 progress report stating that each province and territory had developed its own approach for improving access to primary care services and it was therefore difficult to assess the overall progress towards the health accord commitments (Health Council, 2013). Change has occurred across Canada, but it has been uneven and slow: “although each jurisdiction has undertaken considerable work on the health accord themes, the shared vision expressed 10 years ago has not been fully realized” (Hutchison et al., 2011, p.4).

Despite renewed efforts, a decade later Canada continued to fare inadequately when compared with other OECD countries on the themes of access to primary care services (The Commonwealth Fund, 2013; Schoen et al., 2010), access for same-day and next day primary care services (Canadian Institute for Health Information, 2012b, and inequity in access (Weaver et al., 2014; Canadian Institute for Health Information, 2012a;). In 2003, 15% of Canadians did not have a regular family physician; by 2011 this had increased to 17% (Canadian Institute for Health Information, 2013). These observations are remarkable in light of the significant financial investments made and the widespread intent expressed for broader system-level change in the early 2000s.

1.4 Study Objectives

This project [1] compares primary care accessibility across the provinces and [2] identifies the key ideas, institutions and interests that have been influential in policy reform about accessibility to primary health care.

1.5 Research Questions

1. Is there an association between which province a Canadian lives in and their ability to access primary care services as measured by whether or not they have a regular family physician after adjusting for sex, age, education, self-perceived general health, income, cultural/racial background, language, immigration status, and urban/rural geography?

It was hypothesized that while holding the other variables constant, province of residence would be associated with access to a regular medical doctor.

2. What are the ideas, institutions, and interests (the 3Is) that have contributed to the formation of primary care policy reform for the improvement of access to primary care across the country?

There was no hypothesis for the second question because requires qualitative analysis which is ill suited to hypothesis testing.

This project is a mixed-methods health policy analysis conceptualized through the lens of political economy. This perspective accounts for a wide range of influential factors that affect downstream realities shaped by health policies; it is therefore a suitable approach to addressing complex questions of health policy.

2.0 Phase 1: How do the provinces compare?

2.1 Review of the Literature

2.1.1 What is Access?

Accessibility to healthcare is an extensive domain of study. Consequently, the literature examining the influences which condition accessibility and utilization is wide-ranging: there are numerous factors to measure and ways to measure them (Borges Da Silva et al., 2011; Kringos et

al., 2010). To assist in peeling back the layers of this concept for the purpose of measurement, this study views access as defined by Andersen: “the actual use of personal health services and everything that facilitates or impedes the use of personal health services” (Andersen & Davidson, 2011, p.3). In his model, termed the Health Behaviour Model, access to healthcare services is conceptualized as having two components: *potential access*, defined as the process of accessing care, and *realized access*, defined as the actual use of services (Andersen, 1995; Aday and Andersen 1974, 1981). Ease of accessing primary care services is included in the Pan-Canadian Primary Health Care Indicators created by the Canadian Institute for Health Information (CIHI). The indicators include: the population with a regular primary care provider, wait time for immediate care for minor health problems, difficulty obtaining urgent primary care on evenings and weekends, and available after-hours primary care coverage (2012; 2006).

For the purpose of this study access to primary care is measured by whether or not the respondent has reported having a regular family physician. The outcome variable for this quantitative phase was chosen as it relates to the qualitative phase which focuses on primary care policy reform at a time when providing all Canadians with a regular source of primary care 24/7 was a top policy priority. Throughout the decade and a half following the September 2000 First Ministers’ Communique on Health Meeting concrete goals and funds were committed to improving primary care and attaching Canadians to a continuous source of care; family physicians have historically been the main source of primary care services for Canadians (Government of Canada, 2012). Province was chosen as the independent variable of priority to establish how the provinces compare when controlling for other factors.

2.1.2 Province and Access

Canadian studies assessing the association between province of residence and access to primary care are few. The majority of academic studies which examine accessibility focus within a province or city (Premji, 2018; Khandor et al., 2011; Wong & Regan, 2009; Haggerty et al., 2004) or on other predicting variables. Devlin & Rudolph-Zbarsky have examined the role which social support networks play, concluding that individuals who felt a weak connection to his or her community were 68% less likely to have a regular family physician (2014). In other studies, Canadians have been found to access alternative sources of primary care over their regular primary health care provider due to barriers such as the convenience of location (Salisbury & Munro, 2002) and perceptions of accessibility (Leibowitz, Day & Dunt, 2003).

Comparisons made between the provinces and/or territories have been published largely in the form of descriptive statistics within reports (CIHI, 2017; Statistics Canada, 2015b; Kitts, 2013) and health policy descriptions or analysis (Levesque et al., 2015; Health Council of Canada, 2013; Strumpf et al., 2012; Hutchison, 2011). One Canadian study has thoroughly compared adjusted rates of self-reported unmet healthcare needs, a commonly used indicator for determining accessibility to primary care, across the provinces and observed large variations (Sibley & Glazier, 2009). The study found that the most common reason for an unmet need was availability of healthcare; this likewise varied by province. While assessing the degree to which primary care clinics across Canada fulfil the goals of the Patient Medical Home (PMH)², Katz et al. found little variation in the provincial comparisons (2017). This study included each goal which makes up the PMH model as defined by the College of Family Physicians Canada (CFPC)

² The Patient Medical Home is a model for best practice introduced by the College of Family Physicians Canada.

individually, and as a composite measure. Ontario was found to have better timely access than other provinces and scored higher than the national average on achievement of the PMH goals.

2.1.3 Other Factors Associated with Access

Phase 1 of this study has included several co-variates to narrow the effect of province on access and while observing their potential effects. The selection of covariates was informed by Anderson's health care utilization model and subsequent studies which have employed it (1995)³. The Canadian Institute for Health Information (CIHI) recognizes that there are various characteristics which may impede or facilitate access to primary care including sex, cultural/racial background, socio-economic factors, other socio-demographic factors, and geography (2012c).

Age and sex are consistent predictors of healthcare utilization (Glazier et al, 2009; Laporte, 2008; Bertakis 2000). In one study the odds of being without a regular doctor decreased by 19% with every decade of age; and men were more than twice as likely to be without a regular doctor as women (Talbot, 2001). Women have been found to use more health services than their male counterparts (Thompson et al., 2016; Noone & Stephens, 2008; Redondo-Sendino, 2006; Bertakis, 2000).

It is essential to account for variables which represent socio-economic status (SES), however the literature on their effects is somewhat inconsistent (Hwang, 2017; Glazier et al., 2009; Laporte, 2008; Dunlop, 2000). One study found that those in a lower income bracket had higher use of primary care services but were less likely to see a specialist (Dunlop, 2000). Conversely, lower educational attainment and lower income have been associated with more difficulty accessing necessary health care services (Hwang, 2017). Another Canadian study

³ See Babitsch, B., Gohl, D., & von Lengerke, T. (2012) for a systematic review of studies from 1998-2011 which have employed Andersen's Behavioral model.

found no association with income but found those with a higher education were more likely to see a specialist, circumventing primary care (Glazier et al, 2009). Inequity in access to continuous primary care in a Quebec study was found in relation to socio-economic status (Ouimet et al, 2015).

The extensive literature on the effects of SES supports the finding that lower SES is associated with poorer health outcomes and greater need (Shields & Shooshtari, 2000; McIsaac et al., 1997; Katz et al., 1996). Greater need is often measured as lower self-perceived health status, or presence of one or many chronic conditions, and has been linked to higher utilization or higher odds of having a regular family physician (Devlin & Rudolph-Zbarsky, 2014; Dunlop et al, 2000). These studies demonstrate the important role primary care plays in mitigating the downstream effects of lower SES and other social determinants of health.

The literature on the effects of cultural/racial/ethnic background in relation to access to primary care has been principally concentrated in the United States (Arnett et al, 2016; Shi et al, 2014; Stevens & Shi, 2003; Mayberry et al., 2000). Some Canadian studies have explored this area, adding both qualitative and quantitative studies to the literature (Browne et al, 2011; Tang & Browne, 2008; Wang et al, 2008; Shah et al, 2003). It is clear from their work that it is necessary to account for cultural/racial background in this regression.

Canadian literature on the effects of immigration status on primary care access has been conflicting. One study found no difference between health care utilization by immigrants and Canadian-born adults (Laroche, 2000), while others have reported that immigrants had fewer unmet health care needs compared with Canadian-born respondents and reported better access to a regular doctor which improved over time (or duration of stay) (Wu et al.,2005; Setia et al, 2011). Similarly, one Canadian study demonstrated that immigrants who had been in Canada for

longer than 5 years were less likely to report difficulties accessing primary care than Canadian-born respondents, however new immigrants were much more likely to report having difficulties accessing immediate care than Canadian born respondents (Sanmartin & Ross, 2006). One study found that foreign birthplace was a barrier to care in the United States and Canada (Lebrun & Shi, 2011) and others have found that immigrants have more difficulty accessing primary care (Hwang, 2017; Devlin & Rudolph-Zbarsky, 2014; Laporte, 2008; Glazier et al., 2004; Talbot, 2001). The conflicting literature can be explained in a variety of ways: notably each study is conducted at a different point in time which accounts for different groups of people immigrating, and the studies are conducted differently. Language has similarly proven a barrier to access for linguistic minorities in Canada, immigrants and Canadian-born (Bissonette et al., 2012; Asanin & Wilson, 2008; Ahmad et al., 2004).

Where someone lives has been shown to affect health utilization (Roos et al., 2007; Veugelers et al., 2003). Many of the multivariate studies examining access to primary care have included urban and rural status as a covariate (Devlin & Rudolph-Zbarsky, 2014; Glazier et al., 2009; Dunlop et al, 2000). Neighbourhood has been associated with access to primary health care (Bissonette, 2012). Accessing health care has proven more difficult in geographically vast territories, such as Canada, which has lower density and can be restrictive due to travel difficulties (Smith et al., 2008). It is therefore essential to account for whether or not a respondent is urban or rural residing.

2.1.4 Primary Care Reform Analysis

Numerous studies were published over the past 2 decades which have analyzed various aspects to primary (health) care reforms: comparisons of different models of care (Kiran et al, 2014; Beaulieu et al., 2013; Liddy et al., 2011; Breton et al., 2011), alternative remuneration

schemes (Wranik & Durier-Copp, 2010; Sarma et al., 2010; Glazier et al., 2009; Devlin & Sarma, 2008), provider perceptions of reforms (Kreindler et al., 2018, May 30; Moores et al., 2007), patient perceptions of primary care post-reforms (Tourigny 2010), and changes particular to a specific province (Ouimet et al., 2015; Hutchison & Glazier, 2013, Rosser et al, 2011). While it was operating, the Health Council of Canada routinely published progress reports on the various aspects of health care renewal, including primary care (2014a, 2014b, 2013, 2011a, 2011b, 2007 & 2005.).

Few policy analyses concerning primary care reform from a macro perspective have been undertaken. Hutchison et al. (2011) conducted a policy analysis using gray literature and semi-structured interviews with informed observers. The study found that primary health care reform was being achieved across the country at varying degrees through strong government and professional leadership. Levesque et al. (2015) compared the policies of 5 provinces through publicly available literature and expert opinion from stakeholders, and concluded that primary care reform was undertaken differently in all provinces. They established that the main barriers to change were lack of financial investment, resistance from professional associations, and excessive centralized top-down approach from the government which lacked adaptability. The study found the main perceived facilitators were a strong financial commitment, professional cooperation and incremental change paired with flexibility which allowed for local adaptation. To date, no studies have taken the theoretical lens of this study (3I framework) and applied it to primary care reform which has taken place in Canada since 2000. Lazar et al. (2013) used the same framework while merging it with Kingdon's (2003) model of the agenda-setting process, but did not address primary health care across all the provinces.

2.2 Research Question #1

Is there an association between which province a Canadian lives in and their ability to access primary care services as measured by whether or not they have a regular family physician after adjusting for sex, age, education, self-perceived general health, income, cultural/racial background, language, immigration status, and geography?

It is hypothesized that while holding the other variables constant, using logistic regression techniques, province will be associated with access to a regular medical doctor with some provinces having a stronger effect than others.

2.3 Methods

The first research question was analyzed using logistic regression techniques, a statistical method for analyzing quantitative data with a dichotomous outcome and one or more predictor variables.

2.3.1 Data

Data from phase 1 were drawn from Statistic Canada's 2013-2014 iteration of the Canadian Community Health Survey (CCHS) master file housed at the Research Data Centre (RDC) on the University of Manitoba Bannatyne campus. The CCHS is a cross-sectional survey collected annually on data related to health status, health care utilization and health determinants of Canadians at the sub-provincial level (Statistics Canada, 2015). The survey includes humans 12 years of age and older living in the 10 provinces and the 3 territories. Three percent of the Canadian population is excluded from the survey: persons living on "Aboriginal settlements" in the provinces, full time members of the Canadian Forces, persons who are institutionalized, children living in foster care, and those living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James (ibid). Data is collected directly from

survey respondents using computer assisted personal and telephone interview software. The interview is offered in English and French however each of the Statistics Canada Regional Offices includes interviewers with a wide range of language competencies to be provided to respondents when necessary. Responding to the CCHS is voluntary, the household-level response rate was 75.9% and the person-level response rate was 87.3% (McMaster University Maps, Data and GIS Centre, 2016).

2.3.2 Population of Interest

Humans aged 18 and older residing in the provinces were selected from the dataset; it was assumed at this age they were making their own decisions about health care utilization. The territories were omitted as the purpose of the analysis was to structure phase 2 which centers on provincial policies. Respondents who answered “don’t know” or “refused” for the main outcome variable (i.e. do you have a regular medical doctor?) were coded as missing and dropped from the analysis. From the sample approximately 10.01% of those selected did not respond to the family physician question, leaving 115,220 for the analysis.

2.3.3 Independent Variable (Predictor Variable)

The main independent variable in this study question is province which was coded categorically as one of the ten provinces. It was chosen to get a sense of how access to primary care by way of a family physician differs between the provinces. Ontario was chosen as the reference category as it has the largest population.

2.3.4 Dependent Variable (Outcome Variable)

The dependent variable is whether the respondent has a regular family doctor. This information was obtained from the following question: “Do you have a regular medical doctor?” Responses were coded as “yes”, “no” or “I don’t know/refused to answer”. The refusals were

omitted from this study and the outcome variable was analyzed as a dichotomous variable. In Canada, continuous primary care is principally provided by family physicians; although nurse practitioners and other options are slowly becoming more common they still represent a small proportion. For the majority of Canadians having access to a regular family physician represents access to primary care services (Government of Canada, 2012).

2.3.5 Covariates (Independent Variables)

The covariates included in this analysis are age, sex, education, self-perceived general health, household income, language, urban/rural status and immigration status. All of these variables are included in the CCHS survey. Age was grouped in the following categories: 18-24, 25/34, 35-44, 45-54, 55-64, 65-74, 75+ years. Sex was coded as male or female. Cultural/racial background was also coded dichotomously as “white” and “not white”, where the latter included Indigenous identity. Education was coded categorically as less than secondary school, finished secondary school, some post-secondary school and finished post-secondary school. Self-perceived general health was coded ordinally from 1 as “excellent” to 5 as “poor”. Total household income is reported by provincial deciles. It is a relative measure of the respondents’ household incomes to the household incomes of all other respondents in the same province⁴. This variable is imputed, therefore missing values due to either respondent refusal or lack of knowledge were completed using statistical techniques by Statistics Canada; further information can be found in the derived variables documentation and income imputation (Statistics Canada, 2015 June). The language variable used in this analysis describes the language most often spoken at home. There is more than one language variable in the CCHS, this one was chosen as it was deemed to best represent when a respondent may have had difficulty speaking one of the official

⁴ Other variations of the income variable were tested in the model with little difference in the effect. This variable was chosen for its representativeness of income according to province, the focal predicting variable.

languages – English or French. The response was open and could include any language; it was recoded into a dichotomous variable “English or French with or without another language” and “not English nor French”. Urban/rural status is a dichotomous variable created by Statistics Canada characterizing where the respondent lives: in a population centre or a rural location. “Population centres are those continuously built-up areas having a population concentration of 1,000 or more and a population density of 400 or more per square kilometer based on current population counts” (ibid, p.57). Immigration status is a derived variable produced by Statistics Canada (2015, June). It is produced from asking respondents if they were born in Canada, and at what age they first moved to Canada. It is coded dichotomously as “not an immigrant” and “immigrant”. The factors included as covariates were selected based on the literature which has been noted to facilitate or hinder access to primary care. See above, pp. 20-22.

2.3.6 Statistical Analysis

Statistical analysis was conducted using STATA 13 in the Research Data Centre (RDC). Frequencies were calculated for each variable, then each independent variable was cross tabulated with the outcome variable and unadjusted odds ratios were calculated using logistic regression. Significance was determined at a p-value of < 0.05 , and a 95% confidence interval. This provided a measure of the odds of having a family physician for each covariate and the main independent variable: province. Subsequently, unadjusted and adjusted odds ratios were calculated in three logistic regression models. Interactions were tested between the covariates and province and found insignificant.

2.3.7 Weighting and Bootstrapping

Weights and bootstrapping methods were applied to the statistical analysis as recommended by Statistics Canada in the use of this survey. Consequently, the analysis is more

fully representative of the Canadian population as opposed to the sample itself as some sub-populations may have been overrepresented in the survey. Bootstrap and sample weights were provided by Statistics Canada.

2.3.8 Evaluation of Assumptions

The assumptions for logistic regression analysis were tested using non-weighted data. To ensure proper adequacy of expected frequencies and power, cross tabulations of the predicting variables to the outcome variable were inspected and confirmed that all expected frequencies were greater than one, and no more than 20% were less than five (Tabachnick & Fidell, 2007).

All variables were checked for multicollinearity. Spearman's correlation coefficient showed that none of the variables had a higher correlation coefficient than the standard 0.8. The most highly correlated variables were immigration and language with a coefficient of 0.52. Additionally, the variation inflation factor (VIF) was calculated and none of the values were larger than 10, demonstrating that there was not enough collinearity between two variables to significantly affect the variance of the coefficient (standard error) (ibid).

Both the Pearson and Hosmer–Lemeshow goodness-of-fit tests produced non-significant p-values, therefore the fit of the model is satisfactory.

No tests were done concerning the distributions of the predicting variables because they need not be normally distributed, have equal variance within each group or be linearly related when performing logistic regression (Tabachnick & Fidell, 2007). An examination of the linearity of the logit was unwarranted as there are no continuous predictors in this analysis. Independence of cases were not tested for using statistical methods as the CCHS survey methodology is developed in collaboration with specialists from Statistics Canada, other federal and provincial departments and/or academic fields. It is therefore highly unlikely that

respondents were included twice. The data is taken at one point in time, and there are no other conceivable reasons for non-independence between cases to exist.

2.4 Results

2.4.1 Descriptive Statistics

Descriptive statistics of the sample are provided in tables 1 and 2. The survey sample for this study includes 115,220 individuals aged 18 or older that lived in one of the ten Canadian provinces in 2014. After applying the sampling weights, the sample represents approximately 27,549,585.2 people. Fifteen percent (15.33%) of respondents reported they did not have a regular medical doctor and 84.67% reported they did.

Table 1: Do you have a regular medical doctor? (*weighted n=27,549,586*)

Dependent Variable	
Has a regular medical doctor	% (weighted <i>n</i>)
No	15.33% (4,223,072.2)
Yes	84.67% (23,326,513)
Total	100.00% (27,529,585.2)

Note: Total unweighted $n=115,220$. Missing data made up 10.01% of the total sample population and is not included in the analysis.

The sample was 50% female and the smallest age group was those over 75 years (7.54%), 45-54 year-olds constituted the largest (18.24%). The majority of the sample finished post-secondary education of some sort (60.15%) conversely 13.42% of the sample did not finish high school. The majority of respondents rated their general health as good, very good or excellent, 8.83% rated it fair and 3.07% poor. The household income variable is distributed evenly in deciles which have been adjusted by province. Of the sample 23.05% of population were not white, 25.59% were immigrants, and 14.09% exclusively spoke a language other than French or English at home. Eighteen percent of the sample lived rurally.

Table 2: Descriptive Statistics for the Regular Family Doctor Variable (*weighted n=27,549,586*)

Independent Variables	Dependent Variable – Has a regular medical Dr.		Total
	No % (weighted <i>n</i>)	Yes % (weighted <i>n</i>)	% (weighted <i>n</i>)
Sex			
Male	19.31% (2,615,163.5)	80.69% (10,928,629)	49.16% (13,543,793)
Female	11.48% (1,607,908.7)	88.52% (12,397,884)	50.84% (14,005,793)
Age Group			
18-24	25.86% (832,379.87)	74.14% (2,385,835.3)	11.68% (3,218,215.2)
25-34	26.57% (1,241,611.4)	73.43% (3,431,391.8)	16.96% (4,673,003.2)
35-44	17.53% (822,480.6)	82.47% (3,870,531.1)	17.03% (4,693,011.7)
45-54	12.54% (630,334.96)	87.46% (4,395,933.6)	18.24% (5,026,268.6)
55-64	9.36% (444,173.32)	90.64% (4,301,521.8)	17.23% (4,745,695.1)
65-74	5.98% (186,500.16)	94.02% (2,929,884.6)	11.31% (3,116,384.7)
75+	3.16% (65,591.94)	96.84% (2,011,415.2)	7.54% (2,077,007.2)
Educational Attainment			
Less than High School	13.42% (487,699.76)	86.58% (3,147,440.5)	13.42% (3,635,140.3)
High School Graduate	14.88% (841,867.56)	85.12% (4,816,067.9)	20.88% (5,657,935.5)
Some Post-Secondary	20.41% (307,198.59)	79.59% (1,197,915)	5.55% (1,505,113.6)
Post-Secondary Graduate	15.38% (2,506,948.5)	84.62% (13,791,812)	60.15% (16,298,761)
Self-perceived general health			
Excellent	16.85% (947,454.97)	83.15% (4,674,041.7)	20.43% (5,621,496.7)
Very Good	16.09% (1,681,023.5)	83.91% (8,767,334.8)	37.97% (10,448,358)
Good	14.93% (1,220,289.2)	85.07% (6,955,062.7)	29.71% (8,175,351.8)
Fair	12.61% (306,404.65)	87.39% (2,123,832.6)	8.83% (2,430,237.3)
Poor	7.83% (66,163.35)	92.17% (778,776.63)	3.07% (844,939.98)
Household Income Deciles – by province			
1	21.98% (588,852.96)	78.02% (2,090,047.8)	9.72% (2,678,900.8)
2	17.55% (484,120.59)	82.45% (2,273,907.5)	10.01% (2,758,028.1)
3	16.90% (470,517.19)	83.10% (2,314,154.6)	10.11% (2,784,671.8)
4	14.45% (394,353.93)	85.55% (2,334,016.6)	9.90% (2,728,370.5)
5	15.15% (419,027.29)	84.85% (2,347,478.8)	10.04% (2,766,506.1)
6	14.74% (398,557.84)	85.26% (2,304,556)	9.81% (2,703,113.9)
7	13.48% (381,506.34)	86.52% (2,448,628.9)	10.27% (2,830,135.2)
8	13.11% (357,568.34)	86.89% (2,369,770.9)	9.90% (2,727,339.3)
9	13.72% (378,391.51)	86.28% (2,379,664.8)	10.01% (2,758,056.3)
10	12.44% (350,176.25)	87.56% (2,464,287.5)	10.22% (2,814,463.7)
Cultural/racial background			
White	14.10% (2,888,599.7)	85.90% (17,599,449)	76.95% (20,488,048)
Not white	19.43% (1,191,956.6)	80.57% (4,943,417.3)	23.05% (6,135,374)
Language spoken at home			
English and/or French with or without another language	14.83% (3,374,983.9)	85.17% (19,389,300)	85.10% (22,764,284)
Solely language other than English or French	18.19% (725,214.06)	81.81% (3,261,106.8)	14.90% (3,986,320.8)
Immigrated to Canada			
No	14.67% (2,900,546)	85.33% (16,867,197)	74.41% (19,767,743)
Yes	17.22% (1,171,101.6)	82.78% (5,628,475)	25.59% (6,799,576.6)
Geography			
Rural	12.01% (595,411.98)	87.99% (4,363,583)	18.00% (4,958,995)
Urban	16.06% (3,627,660.3)	83.94% (18,962,930)	82.00% (22,590,591)
Province			
Newfoundland and Labrador	11.06% (46,418.63)	88.94% (373,154.99)	1.52% (419,573.62)
Nova Scotia	10.40% (77,944.16)	89.60% (671,192.73)	2.72% (749,136.89)

PEI	11.36% (12,985.55)	88.64% (101,297.49)	0.41% (114,283.04)
New Brunswick	7.49% (44,359.83)	92.51% (548,039.45)	2.15% (592,399.28)
Quebec	24.99% (1,620,456.7)	75.01% (4,864,010.9)	23.54% (6,484,467.6)
Ontario	8.51% (912,980.43)	91.49% (9,810,107.1)	38.92% (10,723,088)
Manitoba	16.72% (154,943.54)	83.23% (771,823.69)	3.36% (926,767.23)
Saskatchewan	19.68% (157,127.47)	80.32% (641,421.72)	2.90% (798,549.19)
Alberta	20.19% (621,230.24)	79.81% (2,455,739.9)	11.17% (3,076,970.2)
British Columbia	15.68% (574,625.74)	84.32% (3,089,725.4)	13.30% (3,664,351.1)

Note: Total unweighted $n=115,220$. Weighted n in title reflects the crosstab with the highest n . Complete case analysis results in slightly different n for each crosstab due to missing data. Missing data: Educational attainment 1.58%, cultural/racial background 3.29%, language spoken at home 2.70%, immigrated to Canada 3.12%.

2.4.2 Unadjusted Odds Ratios

Unadjusted odds ratios demonstrate the odds of having a family physician for each variable independently and can be found in table 3. With the exceptions of Manitoba and British Columbia each unadjusted odds ratio was significant. The younger age groups were less likely to have a regular family physician, the odds of having a regular family physician increased with age (OR=1.45; 95% CI 1.42 – 1.47). Women had much higher odds of having a regular medical doctor (OR=1.85; 95% CI 1.72 – 1.97). Adults in a higher income decile had slightly higher odds of having a regular family physician (OR=1.06; 95% CI 1.05 – 1.08). Educational attainment was narrowly significant but demonstrated that as educational attainment increased the odds of having a regular family physician decreased (OR=0.96; 95% CI 0.94 – 0.99). As self-reported health decreased (from excellent to poor) the odds of having a regular family physician increased (OR=1.14; 95% CI 1.10 – 1.17). Adults who responded that they were not white had significantly lower odds of having a regular medical doctor (OR=0.68; 95% CI 0.63 – 0.74). Where a language other than English or French was spoken at home respondents had lower odds of having a regular medical doctor (OR=0.78; 95% CI 0.70 – 0.87). Immigrants had lower odds (OR=0.83; 95% CI 0.76 – 0.90) and urban dwellers had lower odds as well (OR=0.71; 95% CI 0.66 – 0.77). Provinces Ontario, Newfoundland and Labrador, Prince Edward Island and New Brunswick had odds ratios higher than 1. Ontario had an odds ratio of 2.63 (95% CI 2.43 – 2.85).

Quebec, Saskatchewan, and Alberta had odds ratios lower than 1; Quebec's odds ratio was 0.42 (95% CI 0.40 – 0.45). Manitoba and British Columbia were not significantly different from 1.0.

2.4.3 Logistic Regression Results of Having a Regular Medical Doctor

The logistic models and adjusted odds ratio are summarized in table 3. All models demonstrate that the hypothesis holds true: while holding the other variables constant province is associated with access to a regular medical doctor with some provinces having a stronger effect than others. Model 1 contains only the main predictor variable, province, using Ontario as the reference category. All the provinces are significant with the exception of New Brunswick. Compared to Ontario the adjusted odds ratios of all provinces are lower than one. Quebecers have the lowest odds of having access to a regular family physician (OR=0.28; 95% CI 0.26 – 0.30) and Nova Scotians have the highest (OR=0.80; 95% CI 0.67 – 0.96).

The second model includes all the covariates while maintaining Ontario as the reference province. Educational attainment, cultural/racial background and language become insignificantly different from 1.0 in this model while the odds ratios of the other covariates remain stable with the exception of immigration and urban/rural geography. The adjusted odds ratio for cultural/racial background becomes significant in the third model where immigration is omitted (OR=0.88; 95% CI 0.80 – 0.96). It was surprising in the second model that cultural/racial background was not significant and we therefore tested if it would become significant in the absence of immigration status. These themes are highly intertwined. The other odds ratios in model 3 remain similar to those of model 2 except that language becomes significant (OR=0.92; 95% CI 0.80 – 1.04). The adjusted odds ratios of the provinces remain stable.

Table 3 – Logistic Regression Models – Do you have a regular medical doctor?

Logistic Regression Models – Do you have a regular medical doctor? Yes	Unadjusted**	Model 1**	Model 2**	Model 3**
	β(se)	β(se)	β(se)	β(se)
Intercept		2.37 (0.04)	0.10 (0.11)	-0.07 (0.11)
Independent Variables	OR (95% CI)		OR (95% CI)	OR (95% CI)
Age Group	1.45 (1.42 – 1.47)*		1.46 (1.43 – 1.49)*	1.44 (1.42 – 1.47)*
Sex (Ref=Male)	1.85 (1.72 – 1.97)*		1.97 (1.83 – 2.12)*	1.97 (1.83 – 2.12)*
Household Income Deciles – by province	1.06 (1.05 – 1.08)*		1.07 (1.06 – 1.09)*	1.08 (1.07 – 1.09)*
Educational Attainment	0.96 (0.94 – 0.99)*		0.97 (0.94 – 1.0)	0.96 (0.93 – 0.99)*
Self-perceived general health	1.14 (1.10 – 1.17)*		1.07 (1.04 – 1.11)*	1.07 (1.04 – 1.11)*
Cultural/Racial Background (Ref = White)	0.68 (0.63 – 0.74)*		0.96 (0.86 – 1.06)	0.84 (0.76 – 0.92)*
Language spoken at home (Ref = English and/or French with or without another language)	0.78 (0.70 – 0.87)*		1.12 (0.96 – 1.30)	0.92 (0.80 – 1.04)
Immigration (Ref=Did not immigrate)	0.83 (0.76 – 0.90)*		0.68 (0.61 – 0.76)*	-
Urban/Rural Geography (Ref = Rural)	0.71 (0.66 – 0.77)*		0.90 (0.82 – 0.98)*	0.88 (0.80 – 0.96)*
Provinces (Ref = Ontario)				
Ontario	2.63 (2.43 – 2.85)*			
Newfoundland & Labrador	1.46 (1.24 – 1.73)*	0.75 (0.63 – 0.89)*	0.58 (0.48 – 0.70)*	0.62 (0.51 – 0.75)*
Prince Edward Island	1.41 (1.13 – 1.77)*	0.73 (0.57 – 0.92)*	0.55 (0.43 – 0.71)*	0.57 (0.44 – 0.73)*
Nova Scotia	1.58 (1.33 – 1.87)*	0.80 (0.67 – 0.96)*	0.63 (0.51 – 0.77)*	0.65 (0.53 – 0.80)*
New Brunswick	2.27 (1.92 – 2.67)*	1.1 (0.96 – 1.37)	0.87 (0.72 – 1.07)	0.90 (0.74 – 1.11)
Quebec	0.42 (0.40 – 0.45)*	0.28 (0.26 – 0.30)*	0.22 (0.20 – 0.25)*	0.23 (0.21 – 0.25)*
Manitoba	0.90 (0.79 – 1.01)	0.46 (0.40 – 0.54)*	0.41 (0.35 – 0.49)*	0.42 (0.36 – 0.50)*
Saskatchewan	0.73 (0.65 – 0.82)*	0.38 (0.33 – 0.43)*	0.33 (0.28 – 0.38)*	0.34 (0.29 – 0.39)*
Alberta	0.68 (0.62 – 0.76)*	0.37 (0.32 – 0.42)*	0.36 (0.31 – 0.41)*	0.36 (0.32 – 0.42)*
British Columbia	0.97 (0.88 – 1.07)	0.50 (0.44 – 0.57)*	0.48 (0.42 – 0.54)*	0.47 (0.41 – 0.54)*
*p<0.05, OR Odds Ratio, 95% CI Confidence Interval				

Note: All odds ratios were calculated using weights.

Unadjusted – OR of each variable individually

Model 1 – Province is the only variable in the model with Ontario as the reference category (covariates omitted)

Model 2 – Full model with all variables

Model 3 – Full model excluding immigration

2.5 Discussion

2.5.1 Influences on having a regular family physician

True to the literature, women and elderly cohorts were more likely to have access to a regular family physician. Women consistently demonstrate higher health care utilization (including primary health care) which has been attributed to conditions specific to sex, lower self-reported general health, and a greater likelihood to seek services for prevention and illness (Bertakis et al, 2000; Cleary et al., 1987; Hibbard & Pope, 1983). It is similarly well established that elderly people have higher health care needs, the majority of whom live with one or more chronic conditions (Osborn, 2014; CIHI, 2011). Those who reported poorer health were more likely to have a regular family physician. Laporte et al. (2008) and Dunlop et al. (2000) both concluded that after controlling various covariates it seemed health need was the biggest driving force behind visits to a family physician. The results of this phase are encouraging; the groups with greater needs are more likely to report having a regular family physician thus more easily accessing primary and therefore secondary health care systems.

In this analysis household income had little effect on access to a family physician. This is comparable to other studies which demonstrated minimal effect (Devlin & Rudolph-Zbarsky, 2014), and no effect (Sanmartin and Ross, 2006) when adjusting for other variables. Income parity related to annually visiting a family physician has been observed in a Canada while lower income groups have been noted to have more frequent primary care visits (Dunlop et al, 2000). Dunlop's study illustrates there may be a greater need for healthcare services in lower income groups due to overall poorer health. Health disparities related to income have been well documented in Canada: in general affluent Canadians tend to be healthier than poorer Canadians (CIHI, 2015). Programs to reduce such inequalities such as universal access to health care may

mitigate these gaps in health. Although the results of this study demonstrate a negligible gap in access when considering income inequalities, patients may still encounter discrimination when making an appointment. Olah et al. (2013) found that those patients presenting a higher income status were more likely to obtain an appointment with their family physician. Further to this, Dunlop et al (2000) learned that patients in a higher income were more likely to receive specialist appointments. This study has concluded that someone's income status has little effect on whether or not someone has a regular family physician but is limited in its ability to further pull apart the effects of income or status on access to primary care.

The effects of educational attainment in this study were minimal if at all significant, consistent with a study using the same data to analyze access to primary care (Devlin & Rudolph-Zbarsky, 2014). Devlin & Rudolph-Zbarsky attributed this to other variables in the model such as income which represented and paralleled education and age. Socio-economic status indicators are closely linked and it is difficult to assign the effects to specific attributes. Glazier et al (2009) similarly found no effect of education on access to primary care however he also discovered that well educated patients had preferential access to specialist services, concluding that they were more likely to bypass primary care to obtain secondary care services. This is analogous to Dunlop's study (2000) which concluded that higher income earners had a comparable advantage.

The urban/rural geography result of this regression comes as a surprise; intuitively it is expected that rural populations in Canada have reduced access to health care services compared to urban populations due to the spread of inhabitants over such a large territory, and difficulties in recruiting and retaining physicians (Canada, 2002). The recruitment and retention of physicians to work rurally has been an ongoing issue in Canada therefore when rural family

physicians are recruited it receives a lot of media attention (Gerster, 2017 September 27; Gerster, 2017 September 28). Our counter-intuitive results may have a few causes. Firstly, this study dichotomized urban and rural status, Sibley and Weiner (2011) have argued that this variable is more complex and should be considered as a rural-urban continuum. In their study residents of the most urban and most rural communities were less likely to have a regular medical doctor which was attributed to maldistribution of rural doctors in the most remote regions and the availability of walk-in clinics in densely urban areas. If this is the case in this study our dichotomous variable would be distorted. Secondly, it is possible that respondents considered a nurse or nurse practitioner as their regular family physician when asked this question. Sometimes referred to as “outpost nurses” these nurses stationed at rural and remote locations across the country provide primary care and public health services (Misener, 2008). In 2015, approximately 46,000 (12%) of regulated nurses in the provinces provided care in rural or remote areas of the provinces (CIHI, 2016). That being said, these nurses are almost exclusively in Indigenous communities who have been excluded from the CCHS. Lastly, the results may demonstrate an improvement in rural access given that provinces have dedicated resources to advancing physician availability rurally. However, we must not forget that It is important to note that the data do not reflect whether the respondent’s primary care provider was in the same geography that they live. It is possible that although a respondent reported having a regular family doctor, that doctor may have been geographically distant and therefore difficult to access.

It is important to note that although rural respondents demonstrate a greater likelihood of having a regular family physician they may nonetheless experience difficulties obtaining an appointment due to constraints specific to living rurally, such as geographic distance. According

to a 2001 study, more than two-thirds of remote northern residents in Canada lived more than 100 km from the nearest physician, many of whom were First Nations (Kulig, 2001).

2.5.2 Immigration, cultural/racial background, and language

Immigrants are recognized under the Canada Health Act as insured and should not have differential treatment to the Canadian-born population however the results of this study reflect a different story. Immigrants were less likely than non-immigrants to have access to a regular family physician and the effect of immigration was even greater after controlling for the other covariates. Although these results corroborate the findings of some other studies (Devlin & Rudolph-Zbarsky 2014; Asanin & Wilson, 2008) it is not without contradictions from others. A longitudinal study by Setia et al. (2011) found that immigrants had similar access to family physicians as the Canadian born population. Setia's study and others have further demonstrated that the longer an immigrant is in the country the more likely they are to report having a family physician (Sanmartin & Ross, 2006). A recent study on immigrants in Toronto revealed that recent immigrants had the highest reported unmet health care need (Hwang, 2017). The major barriers to primary care access identified by immigrants are related to personal circumstances, such as geographic access, language, economic constraints, lack of information about where to go for care, and culturally appropriate health care (Asanin & Wilson, 2008; Sanmartin & Ross, 2006). In one study this ultimately resulted in immigrants avoiding the health care system (Asanin & Wilson, 2008). This study has not distinguished between recent and long term immigration; a more thorough investigation into the causes of disparate access in relation to immigration status may reveal improvements over time.

A cultural/racial disparity in access to primary care was evident in this study before controlling for other variables. White people were almost twice as likely as people of colour to

have a family physician however this effect nullified out in the full model. When immigration status was omitted a cultural/racial disparity was once more evident. In Canada the research on the effects of cultural/racial background on accessibility to primary care has been sparse. In Setia et al.'s study (2011) where white and non-white immigrants were compared no difference was found in utilization though their study was limited by a smaller sample. In the UK and the US ethnic minorities report more difficulty accessing primary care than their white counterparts (Campbell, 2001, Lieu et al, 1993).

Respondents who did not speak English or French at home were less likely to have access to a family physician yet when the other variables were being controlled for language had no effect. To the author's knowledge this was the first time this particular variable was used to describe language when examining access. Unfortunately for simplicity's sake and sample size we have not differentiated according to the minority language depending on community, region, or province. In all likelihood that the language was insignificant in this study points to a strong correlation with immigration and/or cultural/racial background. In other studies language has proven a significant barrier to access for immigrants (Asanin & Wilson, 2008; Wu et al., 2005).

Whether or not racial/cultural disparities in health care utilization exist is difficult to determine given the correlation with the immigration effect. Although it is difficult to ascertain what exactly is making a difference to accessing primary care it warrants further investigation given that the proportion of immigrants living in Canada continues to grow (currently 21.9%) and 7.7 million Canadians report belonging to a visible minority group (Statistics Canada, 2016).

2.5.3 Provinces

This study phase set out to unearth whether there were differences across the provinces in whether residents had access to a regular medical doctor while adjusting for other factors; the

results demonstrate a clear association between province of residence and access. Given that provincial jurisdictions have primary constitutional responsibility for managing and providing health care (and therefore primary care) the existence of variation is not surprising. It is noteworthy that when ranked, the provinces appear as regional blocks. From highest odds descending Ontario comes out on top, followed by the Atlantic Provinces⁵, BC, the Prairie Provinces, and lastly Quebec.

Ontario residents have the best access to primary care of the 10 provinces as defined by having a regular family physician. Recently, the literature has shed light on the efforts and successes of its primary care reform; nearly 75% of the population is enrolled in new models of care and physician work satisfaction has improved (Hutchison & Glazier, 2013). It has been argued that primary care transformation over the last decade has been the most far reaching in Ontario where among other things formal patient enrollment, interprofessional teams, and blended payment schemes have been well established (Hutchison & Glazier, 2013; Hutchison et al., 2011). A comparative review of the provinces and their clinics' accordance to the goals of the PMH demonstrated that Ontario outperforms the other provinces (Katz et al., 2017). The study included a composite measure of timely access which integrated the patient's perception of accessibility, physical accessibility, geographic accessibility, and wait times.

The Atlantic Provinces (New Brunswick, Newfoundland, Nova Scotia and Prince Edward Island) as a whole have performed the closest in line with Ontario. The demographics of the Atlantic Provinces differ from the other provinces; on average they are older and they account for a small proportion of Canadians. According to the Newfoundland and Labrador Medical Association the biggest concern regarding primary care is a supply side issue: difficulty

⁵ New Brunswick was not significant in the models, likely due to its results paralleling with Ontario

recruiting and retaining doctors, especially in rural areas. Each year the province loses approximately half of its medical graduates. To compound this issue, a quarter of the province's family physicians are approaching retirement. It is argued that older physicians have a different work culture, working longer hours and that two new doctors are necessary to cover their predecessors' workloads (Newfoundland and Labrador Medical Association, 2010). Minimal research has been conducted in the Atlantic Provinces on primary care. A short Scopus search of "Primary care" AND "Newfoundland and Labrador" OR "Nova Scotia" OR "Prince Edward Island" OR "New Brunswick" OR "Atlantic" yields less than 160 results. As a comparison, the same search of "Ontario" AND "Primary care" yields over 1,000 results. There is however some research emerging in relation to the Canadian Primary Care Sentinel Surveillance Network but results have not yet been published (Marshall, 2015).

British Columbia has been identified as one of the top jurisdictions where primary care transformation has been the most far-reaching (Hutchison, 2011). This is cited largely due to a targeted incentive payment program which was negotiated with the provincial medical association in the early millennium. Named the Full Service Family Practice Incentive Program, it provides payments to family physicians for caring for more "complex patients". The purpose of the program was to return to a traditional model of "full-service family practice" (Lavergne et al., 2014). According to Lavergne et al.'s study the annual incomes of participating doctors has increased significantly however access, continuity, and coordination have not improved over the ten years following its inauguration (ibid). It has also been argued that the changes were operational in nature as opposed to structural; the pre-existing system remained intact with small improvements (Tregillus & Cavers, 2011). According to Hollander and Tessaro, the new incentives have increased patient attachment and decreased costs (2011). It is possible that the

large incentives are associated with the superior access enjoyed by BC residents as compared with the Prairie Provinces and Quebec but without longitudinal comparisons this can only be speculated.

It is interesting that the Prairie Provinces, (Alberta, Saskatchewan, and Manitoba) clustered at second to last given they have taken different paths to primary care reform at different times. Alberta began reform efforts in 2003 with the introduction of the Primary Care Networks (PCN). Run by doctors and inclusive of other healthcare professionals, PCNs are a form of team-based primary care which may be located at one site or spread across many. According to Alberta Health eighty percent of primary care physicians are registered with a PCN (2017). While PCNs have been cited as innovative and having resulted in primary care improvements in Alberta (Manns et al., 2011) our results do not reflect that they have been measurably better than the other provinces in terms of accessibility. Katz et al. found that Alberta ranked among the lowest of the provinces in its ability to provide team-based care (2017).

Saskatchewan and Manitoba have been slower to implement primary care reforms following the push in the early millennium. It is possible that for this reason they are outranked by most of the other provinces in terms of accessibility. In 2009, Saskatchewan learned through a provincial government commissioned report that their system was offering low value for high costs and that basic safety and accessibility standards were not being met (Dagnone, 2009, p.36) after which they launched an initiative to transform their primary care. Subsequently the provincial government published a policy framework in 2012, *Patient Centred, Community Designed, Team Delivered: a Framework for Achieving a High Performing Primary Health Care System in Saskatchewan* (Government of Saskatchewan, 2012). According to Kathleen Peterson, Director of Health System Planning at the Saskatchewan Ministry of Health, some

improvement has been observed but more time is necessary before evidence becomes measurable (CIHR, 2013). In Manitoba, primary care reform began with decisive plans in the early millennium but not a lot of change until a decade later. In 2002, the Government of Manitoba created the Primary Health Care Policy Framework, with support from the Primary Health Care Transition Fund. Policy direction was clear and forthright, but the operationalizing of the framework was sluggish (McMaster, 2010). This is unmistakable in light of an announcement in 2010 by the Manitoba Premier that by 2015 all Manitobans would have a family physician (Government of Manitoba, 2010). The announcement arrived a decade after the policy framework was published. Saskatchewan and Manitoba provided significant political support for primary care reform much later than other provinces; on the other hand, Alberta began substantial reform efforts in 2002, and it exhibits similar accessibility in this study.

Quebec's primary care reform initiative has been recognized in the literature for its sweeping changes and its improvements in accessibility (Hutchison et al., 2011; Breton et al., 2011). The results of this study do not support these findings; Quebec falls in last place among the ten provinces. In 2002, Quebec introduced a new organizational model, Family Medicine Groups (Groupes de médecine de famille). FMGs are a team-based approach to care with the goal of an enhanced primary care model which incorporates better health promotion, disease prevention and case management (Coyle et al., 2014). The groups consist of approximately ten physicians, two nurses and two administrators (sometimes include other providers). Patients are rostered, and they offer walk-in services for weekends and holidays and a telephone response service is on call 24 hours a day outside of regular working hours (Breton et al., 2011). Additional funding is provided for operational costs and a small bonus per patient registered by the MSSS; physicians are still paid through fee-for-service. Quebec also introduced a small extra

payment for all family physicians who rostered a “complex patient” to encourage improved management of patient with chronic conditions (Coyle et al., 2014). FMGs have attracted patients who are sicker and more disadvantaged than non-FMGs in Quebec (Carter et al., 2016). According to Strumpf et al. (2016) the program has resulted in a decrease in enrolled patients’ health care utilization and costs in outpatient settings, as well as a decrease in their primary care visits. In 2012 more than half of family physicians in the province were employed by an FMG. However only 35% of Quebecers are currently enrolled in a FMG which may account for the fact that it has not had an effect on access to primary care for all Quebecers (Breton et al., 2011).

The results of this first phase of the study speak to the complexity of primary care and the differences in primary care accessibility across the country. Although provincial health systems are each distinctly different they are nonetheless similarly structured in order to meet federal conditions for cash transfers. Wide provincial variation would be better expounded by comparing the differences in policy arenas on a province by province basis to identify the factors which may account for the provincial variation. It is possible that the differences exposed in our results are illuminating the diverging paths taken by the provinces to improve access to primary care at the onset of the new millennium, something which will be further explored in the next chapter.

2.6 Limitations

The results of the first study phase have some important limitations which need to be taken into consideration while interpreting the findings. Firstly, there are constraints related to the sample selection of the CCHS such as the omission of some groups, specifically those living on reserve. This may have resulted in an overestimation of the level of access in rural areas. Secondly, some of the covariates were dichotomized in order to simplify the logistic regression but may have brought other understanding to light had they not been. As discussed earlier, if

urban/rural geography were included as a gradient it may have revealed differences within pockets of the urban/rural continuum. Immigration status may also be more complex than a ‘yes’ or ‘no’, and given our interesting results future studies would do well to include a more multipart understanding such as when someone immigrated; this would be possible with the CCHS. Thirdly, there is no comparison in this study across time which is an important limitation. This study examines the way in which provinces differ at a set point of time therefore any conclusions regarding pre-and post-reform efforts are not possible. Lastly, the characterization of access in this study is limited by the available data. Access has been defined as whether or not someone has a family physician. Access can be understood in many other terms, such as geographical access, physical access or wait times.

3.0 Phase 2: The 3Is – Ideas, Institutions and Interests

3.1 Research Question #2

What are the ideas, institutions and interests that have contributed to the formation of primary care policy reform for the improvement of access to primary care across the country?

3.2 Theoretical Framework

Political economy as a school of thought focuses on the interrelating of the “state and society, political actors such as governments, foreign donors and interest groups, which draw on historical cultural and sociological concepts to add depth to explanation” (Walt and Gilson, 1994, p.360). The 3I framework has its roots in political economy and has served as the analytical framework for this project. The 3Is stand for ideas, institutions, and interests (of actors), and the framework “holds that policy developments and choices are influenced by actors’ interests and ideas, as well as by institutions” (Gauvin, 2014).

3.2.1 Health Policy Analysis

The context within which health policy decisions are made is highly political. “Health policy decisions are not always the result of a rational process of discussion and evaluation of how a particular objective should be met” (Collins, 2005, p.194). Lazar points out how it is unique that health care issues remain so much at the forefront of Canadian citizen concerns, which are highly visible in the media and a central issue during election periods. He contends that this has been consistently true since the 1990s (2013). Given that the arena of health is so highly politicized, it is critical to recognize the importance of undertaking health policy analysis and the ways in which it plays a central role in the health policy reform process (Walt and Gilson, 1994).

Health policy analysis is unique within the realm of policy analysis for many reasons. Health policy affects all citizens, almost all of whom will directly come into contact with the health system at some point. It affects and is affected by many other policies that traverse other sectors such as the environment, labour, security, economic regulation and deregulation, and social services. It is also unique because of the status of the medical profession and its strong influence on the policy making process (Walt and Gilson, 1994). The process of undertaking policy analysis is interdisciplinary; it draws on “[...] economics, politics, science, sociology, public administration and history which makes it more congruent to studying the complex world of health policy” (ibid, p. 358).

CIHR describes health policy analysis as “an approach to public policy that aims to mobilize a range of new and existing research evidence to analyze policy options in order to provide advice to policy and decision makers about optimal strategies to pursue in the resolution of policy challenges in the health and health care sector” (2012). The focus of these

analyses is the outcomes of health policies or the effects that the policy has on people (Collins, 2005). The process may include identifying and explaining successful and unsuccessful health policies, the intended and unintended consequences of policy decisions, and obstacles that impede and/or facilitators that enable policy implementation. Health policy analysis supports evidence-informed policy development and implementation (ibid; Buse *et al.*, 2007). Gilson argues that policy analysis can be used as a tool to precede policy choice, which improves the effectiveness of its implementation (2008). Health policy analysis is therefore a practical tool for improving health policy as well as a legitimate area of academic inquiry that is substantiated by reputable academics and organizations that have undertaken it (see Suter *et al.*, 2014; Lazar *et al.*, 2013; Pomey *et al.*, 2010; Wood-Ritsatakis & Makara, 2009).

Some scholars have argued that due to its complexity, writers often prefer to describe and simplify the narrative of a policy's existence with a focus on content and technical features, rather than offer an explanation or account of the significance of the actors, processes and contexts within which it is created (John, 2012; Walt & Gilson, 2008; 1994). Walt and Gilson recognize that health policies are an “outcome of complex social, political and economic interactions” (1994, p.359) and have favored the policy triangle model of their own creation to study the context, process and actors in the health policy reform process. Their model is a simple break down of the complex interrelationships that can be viewed separately. It is comparable to the 3I framework, which works to “explain the interaction between institutions, interest and ideas in the policy process” (Walt *et al.*, 2008, p. 308).

3.2.2 Political Economy and the 3I Framework

Political economy is a congruent approach to conducting health policy analysis because of its interdisciplinary quality. The central theme of inquiry is the nature of the state and market as

two forms of organizing human endeavor and how they relate to one another (Bowels, Edwards, & Roosevelt, 2005). According to Hall (1997), political economy is composed of three domains which form the basis of the field of examination: ideas, institutions, and interests. Although he admits the three domains are flexible and utilized to varying extents, he states that “interests, institutions, and ideas figure to some degree in all analyses of the political economy” (ibid, p. 176).

One of the key shortcomings of many policy analysis methods is that they present a singular account of reality that oversimplifies the policy-making process and does not attempt to explain why policy changes in time and space (John, 2012). According to John:

To reach the potential of research, even single case studies must be comparative. Thus all good research, to an extent, combines the types of explanation, even though it may emphasize one of them. To concentrate on one level of explanation neglects the complexity of the interaction between the sets of factors (ibid, p. 182).

He goes on to write that as no singular approach in policy analysis can explain issues of policy change, stability, and variation according to sector and country, synthetic frameworks are the best means to incorporate the dynamic interplay in the analysis (ibid). Although the author cautions about incorporating a complex model of analysis for the sake of complexity, when a simpler one would do, he also states that a synthetic approach “takes the complexity, fluidity, and changeability of the modern policy processes as its baseline” (John, 2012, p. 183). A model synthesis of this sort is useful and also helps explain policy in cross-sectoral and cross-national contexts. In the wake of John’s argument, the political economy lens chosen for this study corrects for the narrow analysis that might otherwise be assumed by traditional policy analysis tools. The 3I framework is a synthesis of approaches that previously focused on each of the domains (ideas, institutions or interests) independently.

The political economy literature lends an understanding to how policy analysis can be practically applied to the health care sector and the importance of doing so (Walt and Gilson, 2008). Although the discipline is sometimes criticized for its “intellectual pluralism”, Blyth (2009) argues that pluralism is its strength and should be embraced. Its objects of study and enquiries are of “open-ended evolutionary social and economic systems” (ibid, p. 194) and therefore require a flexible and broad framework of understanding that does not narrowly attempt to construct one theory to explain all things.

The 3I framework, as it has come to be identified by some health policy researchers, has been recognized as a synthesized analytical framework for health policy analysis (Gauvin, 2014; Smith et al., 2014; Lazar, 2013; Pomey et al., 2010). In the following sections, the three domains that make up the 3Is will be described in more detail. Refer to table 4 for a quick reference guide to the 3Is as well.

Table 4: 3I Framework

Factors and Definitions	Examples
Ideas <i>Knowledge or beliefs about “what is” and values about “what ought to be” (ibid).</i>	<ul style="list-style-type: none"> - Knowledge/evidence or beliefs - Values/Culture Views
Institutions <i>“Institutions are the formal and informal rules, norms, precedents, and organizational factors that structure political behaviour” (ibid, p. 709 citing Hall, 1996).</i>	<ul style="list-style-type: none"> - Government structures (e.g. federal vs unitary government) - Policy networks (e.g. executive council-appointed committees that involve stakeholders) - Policy legacies (e.g. Canada Health Act)
Interests (of actors) <i>The agendas of stakeholders involved in the policy development process to achieve their objectives. (Pomey et al., 2010)</i>	<ul style="list-style-type: none"> - Societal interest groups (e.g. medical associations) - Elected Officials - Public servants - Researchers - Policy entrepreneurs (e.g. individuals who can couple a policy to a problem when a political window of opportunity opens)

Ideas

The role of ideas in the 3I framework is historically less developed than the other domains; however, some scholars have endeavored to explore and delineate the various forms ideas take and their influence on policy development. Ideas-oriented approaches are novel as they “capture dimensions of human interaction normally lost in other perspectives” (Hall, 1997, p. 185). According to Campbell ideas can exist at the forefront (explicitly articulated theories and concepts) or in the background (underlying and taken for granted); they can be present at the cognitive level (as descriptions and theories) or normative level (manifest as values and attitudes) (1998). In making this distinction he names four types of ideas that are distinguished by their existence at the forefront or background and the cognitive or normative levels: programs (cognitive level in the forefront); paradigms (cognitive level in the background); frames (normative level in the forefront); and, public sentiments (normative level in the background) (ibid). Examples of ideas include the notion healthcare should be a public good and universally available for Canadians, and that doctors should be the principle providers of primary care.

In Pompey et al.’s health policy analysis ideas were defined as “knowledge or beliefs about what is (e.g. research knowledge), views about what ought to be (e.g. values), or combinations of the two” (2010, p. 709). Building on this work, Gauvin proposes that ideas that affect health policy development fall into two categories: knowledge/evidence and values/culture (2014). Knowledge and evidence construct and inform how policy issues and solutions are thought of; they can therefore limit the range of possible solutions that policy makers are likely to consider when trying to resolve problems (Gauvin, 2014; Campbell, 1998). Values and culture form the parameters within which actors may see possible policy solutions as “effective, feasible, or acceptable” (Gauvin, 2014, p.2). It has been noted that the values or cultures shared by

professional groups also merits concentrated analysis, particularly in the health field where professionals have a profound influence in policy choices and developments. Their ideas, which may be group specific due to the nature of the professional community, have a significant impact (ibid).

Previously the theoretical debate pitted interests against ideas in an attempt to uncover which had more explanatory power (Campbell, 1998). Campbell concluded that what is more important is their intersection.

Indeed, to ask whether either interests or ideas are the chief determinants of policy outcomes is a misleading way to pose the issue because it neglects the possibility that it is the interaction between the two that counts and that some types of ideas are endogenous to the policy process in the sense that they are influenced by policy struggles in which interests, resources, and power loom large (Campbell, 1998, p. 379).

Institutions

Institutionalists vary in their approach as to which types of institutions they believe have causal significance; however, their analyses emphasize organizational structures that underpin the political economy. Historically the principle unit of analysis has been the nation-state, though many scholars have since emphasized the need to include organizational differences at sectoral and regional levels (Hall, 1997). More recently institutions have been described as “the formal and informal rules, norms, precedents, and organizational factors that structure political behaviour” (Pompey et al., 2010, p. 709 citing Hall, 1996). In Gauvin’s argument for utilizing the 3I framework for the purpose of health policy analysis, “institutions” is understood to include government structures, such as state governance systems and the jurisdictional relationships, their obligations and accountability to one another, policy networks, which include government, private and non-profit actors who may be at odds or working together, and policy legacies which includes constitutions and past policies (2014; Lazar, 2013).

The intersection of the ideas, institutions and interests is an important theme within the 3I framework. According to Blythe “Institutionalists want to know whether agents act according to their materially derived interests or because of the institutional context in which they find themselves. Institutional explanations focus our attention on how economies are organized and how such configurations impact agents’ interests” (2009, p.197).

Blythe contrasts the theoretical differences between Hall (1986) and North (1990) within the theory of institutionalism. He explains that while Hall argues that historically existing institutions shape the interests of actors and structure their choices, North believes that institutions are a reflection of actors’ interests as they are structures chosen by actors. Blythe does not favor one explanation over the other, but rather writes that “while interests are important, it is how they are refracted through institutions that is the explanatory *causa prima*” (2009, p.197). The institutional analysis portion of this project takes from Blythe’s argument and assumes that the dynamic of the two acts from both sides. The purpose of this analysis is not to decide which is which. Institutions link larger economic-structural changes with interests but are also causally important in their own right.

Interests

Interests—can be described as the agendas of stakeholders involved in the policy development process to achieve their objectives. The stakeholders or actors might include societal groups, elected officials, civil servants, researchers and policy entrepreneurs (Pompey et al., 2010). “How agents think about, and hence act, in the political economy is causally important” (Blythe, 2009, p. 196). Interest-based political economy is rooted in materialist theory/materialism, which focuses on actors’ economic positions in society and questions of distribution. “Interests, understood as the real, material interests of the principal actors, whether

conceived as individuals or as groups, figure in all of the work in the field [political economy]” (Hall, 1997, p.176). External changes or crises, especially those of an economic nature, will affect the preferences and priorities of domestic actors who seek power to advance their common interests. This may lead to the creation of new coalitions of common interests. Coalitions may be class-based, sectoral-based or founded on any number of other factors. An actor’s class or position of power in society are two examples of determinants of their interests. Ultimately, the question “*Who benefits?*” by the creation of new policy (or absence of a new policy) is what interest-based inquiry endeavors to uncover (Blythe, 2009).

Proponents of interest-based explanation in political economy have highlighted that “material interest is actually bound up with, and only understandable through a host of secondary variables” (Blythe, 2009, p. 198). In this way interests intersect with and are reflected through institutions and ideas. This supports the amalgamation of the three domains into one framework. They cannot be taken as isolated domains but should be understood as a whole.

3.3 Methods

The second research question was examined using documentary analysis, a form of qualitative analysis in which secondary data (published/pre-existing documents) are interpreted (Bowen, 2009). The published literature analyzed in this portion is limited to articles published from 2000 – 2013. The dates were selected based on the establishment of the 2000 Primary Health Care Transition Fund (PHCTF) when primary care reform was made a national priority and funds were committed to achieve this end and the end date to coincide with the available data used in phase 1 of this project and the last year of the 10-year plan to Strengthen Healthcare and the Health Council of Canada.

3.3.1 Data Collection & Search Strategy

Publicly available primary care policy literatures were the data sources for this analysis.

The policy analysis draws on descriptive information from the following types of public documents and gray literature: backgrounders, reports, executive summaries, casebooks, position papers or statements, policy papers, press releases, analyses in brief, evidence review summaries, commentaries, and federal and provincial policies. The search strategy employed to collect the documents can be found in table 5, which includes the date, search engine and search algorithms. Google Advanced was the search engines employed. The strategy was contrived with expert guidance from University of Manitoba librarian Janice Linton.

Table 5: Phase 2: Search Strategy

Date	Search Engine	Algorithm
May 25, 2017	Google Advanced	Policy AND “Primary Care” OR “Primary Health Care” OR “Primary Healthcare” 2000..2013
May 25, 2017	Google Advanced	Policy AND “Primary Care” OR “Primary Health Care” OR “Primary Healthcare” 2000..2013 filetype:pdf
May 25, 2017	Google Advanced	Policy AND “Primary Care” OR “Primary Health Care” 2000..2013 filetype:pdf
May 29, 2017	Google Advanced	Policy AND Canada AND “Primary Care” OR “Primary Health care” 2000..2013 filetype:pdf
May 29, 2017	Google Advanced	Policy AND Canada AND “Primary Care” OR “Primary Health Care” 2000..2013
May 30, 2017	Google Advanced	Canada AND “Primary Care” AND “Primary Health Care” 2000..2013
May 31, 2017	Google Advanced	Canada AND “Primary Care” OR “Primary Health Care” site:gc.ca filetype:pdf
May 31, 2017	Google Advanced	Canada AND “Primary Care” OR “Primary Health Care” site:gc.ca
May 31, 2017	Google Advanced	Parliament Canada AND “Primary Care” OR “Primary Health Care” filetype:pdf
May 31, 2017	Google Advanced	“Primary Care” OR “Primary Health Care” site:lop.parl.gc.ca
May 31, 2017	Google Advanced	Policy AND Access AND Canada AND “Primary Care” OR “Primary Health Care”
May 31, 2017	Google Advanced	Policy AND Access AND Canada AND “Primary Care” AND “Primary health care” filetype:pdf
June 19, 2017	Google Advanced	Hansard AND Canada AND “Primary Care” OR “Primary Health Care” 2000..2013 filetype:pdf

After the first round of searches and a first pass document review, which required a superficial examination by skimming for relevance to the topic, 145 documents remained for the analysis. Evaluating whether or not the document was fit for the analysis involved determining relevance to the research question and ascertaining authenticity, completeness, credibility, accuracy, and representativeness. The criteria for determining relevance were guided by Bowen's description in *Document Analysis as a Qualitative Research Method* (2009). Google Advanced searches typically yielded between 300,000 and 12,000,000 results which could not feasibly be reviewed; largely page 8 was a cutoff point where the subsequent pages of documents were irrelevant or repetitious. During the subsequent steps of analysis, a further 42 documents were dropped because they were duplicates or published outside the timeframe. This brought the final total documents for analysis and coding to 103.

3.3.2 Analysis

The documentary analysis involved three stages: the first was a superficial examination whereby the document was deemed relevant to the study, followed by a reading and thorough examination of the document, and finally the interpretation or coding (Bowen, 2009). The method was iterative and involved using content and thematic analyses during the coding process for the purposes of pattern and emergent theme recognition (ibid). The coding procedure was informed by the theoretical framework of the study (3I framework), as above. The analysis involved coding the collected documents, identifying and categorizing the *ideas*, *institutions* and *interests* on an overarching pan-Canadian plane. The analysis was conducted using NVivo 11, a qualitative coding program upon which the documents were first uploaded. A comprehensive list of all the documents included in the analysis can be found in appendix A and a matched coding list of which documents contained codes related to the 3I category can be found in appendix B.

3.4 Results

The Pan-Canadian *ideas institutions* and *interests* that have contributed to the formation of primary care policy reform for the improvement of access to primary care in the provinces are described in this section.

Figure 1 contains the major factors at a Pan-Canadian level which shaped primary care reform in the 2000 – 2013 period. The lists are alphabetized and intentionally not ranked by importance. The factors which emerged as themes from the documentary analysis are classified as *ideas, institutions, and interests*. The lists are not exhaustive as it would not be possible to account for each factor having an influence on this period of primary care access. Furthermore, some of the emergent themes were either unrelated to the categories or infrequently made reference to and therefore omitted from the results to focus on the most recurrently highlighted or important factors.

Figure 1: 3I Results



3.4.1 Ideas

The *Ideas*, “knowledge or beliefs about what is and values about what ought to be”, which were prominent in this period are **24/7 Universal Access; Alternative Remuneration; Collaboration; Electronic Medical Records (EMRs); Evaluation and Data; Increasing Efficiencies; Primary Care as Foundational; and System Change**. These themes were the most significant or most often discussed and debated in the gray literature. The majority of ideas to emerge from the literature have come out of the inquiries and reports which were commissioned by federal institutions to solicit the views of Canadians and identify ways to promote reform; they were endorsed by all levels of government at the First Ministers meetings.

Twenty-four/seven universal access is an *idea* which arrived as one of five objectives of the 2000 Primary Health Care Transition Fund and was later reiterated by the Romanow

Canadians should have access to an integrated continuum of care 24 hours a day, 7 days a week, no matter where they live. - *Romanow, 2002, xxviii*

Commission in 2002 as essential, and its pursuit key to improving our health care system. Universal access to health care is governed by the Canada Health Act however the notion of 24/7 access to primary care is not identified in the Act. Further supporting this *idea*, the First Ministers committed to ensuring that 50% of Canadians would have 24/7 access to primary care by 2011, with the long term goal that all Canadians would have this access (2003 First Ministers’ Accord on Health Care Renewal, 2003). The gray literature of this period evokes the *idea* and the promise made by the First Ministers regularly as something which “ought to be”. It is corroborated by claims that it will decrease pressure on downstream services, improve equity, and decrease costs. The theme reverberates throughout the literature and is not refuted: everyone should have access to primary care whenever they need it, and this is funneled through the way that primary care was historically organized, as solo or group family practices.

The notion of **Primary (Health) Care as Foundational** to the healthcare system is acknowledged as fact and is rooted in a vast sea of literature concerning the many benefits a strong primary health care system engenders to the wider healthcare system and society. While

Primary health care (PHC) is the foundation of Canada's health care system. – *Health Council of Canada, 2005, p.5*

the *idea* is present in much of the literature it is also paralleled with questions of what “primary care” and “primary health care” are and concerns with inconsistent definitions. The nationwide effort to improve primary care during the reform era motivated stakeholders to collectively define and expand the understanding of the term(s). The Health Council of Canada created a Primary Health Care Working Group to develop a definition of primary health care that would serve to inform discussion and evaluation of the reform efforts. What is clear is that consensus grew around the understandings of primary health care and primary care, and evolved to be more comprehensive to include public health, chronic disease management, comprehensiveness, health promotion, and prevention.

Collaboration was a prominent *idea* in the literature, exhibited on three levels which I have delineated as: macro, meso, and micro. At a **macro** level collaboration was a call for partnership and cooperation between jurisdictions. Given that all provinces were on the same quest, stakeholders demanded better support from the federal government and collaboration between the provinces, learning from the different provincial efforts.

On a **meso** level, collaboration represented the cooperation which occurs within the

Such a body would act as an integrative force at that level and serve as a link between government and the health care teams and professionals who are overseeing and providing the care. – *Health Council of Canada, 2010, p.6*

province between the various stakeholders (civil servants, clinics, healthcare providers, associations, and patients etc.) to collectively strive for primary care reform by sharing their concerns, ideas, processes and

support. It indicated that the input of all stakeholders was key to achieving their goal of improved access to primary care and this might be achieved through the creation of primary care governance mechanisms.

On a **micro** level, the embodiment of collaboration was primary health care teams⁶. Primary care teams were the most frequently highlighted theme concerning collaboration and one of the reform

There is a widespread belief in Canada and other countries that interdisciplinary collaboration in primary health care is the way of the future. – *Nolte, 2005, p.2*

goals most often cited and supported. The idea is that primary care providers working together in clinics (or geographically separate networks) for the wellness of their shared patients improves the health of patients (especially those suffering chronic conditions), reduces the need for downstream care, provides better access, decreases wait times, and is more cost effective. The team can be made up of one or two, or more types of health professionals. It was thought that the growing number of patients with complex social situations and/or health needs would be better served by teams which can offer better access to more comprehensive services and improved coordination of care. This goal was pursued by reformers across the country. A wide range of collaborative practice models exist in the country, some of which predate the reform era, demonstrating how this *idea* was operationalized differently across the country. Notwithstanding the different formulations of teams by provinces and professional groups, the idea was embraced throughout the literature. Most notably, the College of Family Physicians Canada recommending a specific primary care delivery model termed the “Patient Medical Home” in 2009 which included team care as one of its pillars. The purpose of this was to provide all Canadian practices a framework towards which they could strive to model their clinics.

⁶ Team as it appeared in the literature was interchangeably written and understood as multidisciplinary, interdisciplinary, transdisciplinary and transprofessional.

During the period, **alternative remuneration** emerged as a potential policy lever through which to achieve primary care reform.

Given the professional autonomy held by family physicians as self-employed private actors there was little room for provinces to enforce change. In the early millennium the vast majority of family

physicians were billing on a fee-for-service basis (Tepper, 2004). It was argued at the time that fee-for-service compensation would act as a barrier to achieving the 24/7 goal and other goals such as the creation of multi-disciplinary primary care teams. Alternative remuneration was suggested in a variety of forms: capitation, salary, pay for performance, and blended methods. The argument is that these other remuneration models incentivize delivery of care to more diverse patients, encourage physicians to take more time with the patients who need it, support interprofessional collaboration, reward performance, improve patient care, and more appropriately compensate physicians for the services they are increasingly being asked to provide. During the reform era alternative remuneration as an *idea* would later shift into an *institution* in some of the provinces as it became more utilized and embedded.

Modifying the way in which primary care physicians are remunerated is widely recognized as one area where meaningful health care reform can be undertaken. It is believed that, because primary care physicians are the first point of contact for patients and are the “gatekeepers” to the rest of the health care system, changing their mode of remuneration could have the capacity to alter the way the whole system is used. – *Library of Parliament, 2002*

The discourse on the *idea* of **increasing efficiencies** is manifest in two distinct claims in the literature. The first is that enhanced access to primary health care improves cost effectiveness of the wider healthcare system: upstream improvements in primary health care will decrease the use of more expensive

Primary care which prioritizes chronic disease management offers the greatest potential for increasing appropriateness of care and reducing system costs. – *CMA, 2003, p.8*

downstream care such as emergency rooms. This is often expressed in the context of the looming

threat posed by the costs associated to an aging population. The second argument is for the optimal use of resources; a case made in conjunction with the promotion of primary health care teams. The optimal use of resources refers to a patient receiving care from

Delegation of tasks from highly educated and relatively expensive physicians to other health care workers should help prevent the formation of waiting lists for patients and make health care more efficient. - *CAPA 2012, p.4*

the health provider who meets the minimum necessary skill level and is least expensive. For example, if a nurse can administer a flu shot instead of a physician (whose labour is more costly) it would constitute a more efficient use of resources. The argument supports the formation of primary care teams made up of various healthcare professionals.

At the time of the Health Accords of the early millennium it was agreed by many stakeholders that Canada lagged in the overall use of **Electronic Medical Records (EMRs)** and that something needed to be done. There was a consensus that primary care clinics should operate using EMRs, however to

Electronic health records and electronic medical records are valuable tools for generating performance measures for monitoring patient care, healthcare planning, evaluating innovations, and determining resource allocation. -*CFHI, 2012,*

achieve this aim government support, through funding and technical assistance, was necessary. The literature argued that EMRs would improve continuity of information between providers, patient care, and feed into an improved system of evaluation and data collection.

The notion that **Evaluation and Data** were in need of improvement was persistent in the literature. The *idea* was evoked in relation to measuring progress, comparing reform efforts, and cultivating better evidence-based policy making. Stakeholders pointed out that standard definitions, measurement methods, and indicators were necessary in order to determine what changes were effective, and compare the programs across the country. The *idea* is closely connected to the promotion of EMRs, which have the capacity to greatly improve data quality,

speed up evaluations, as well as facilitate information sharing. Furthermore, the literature cites an increasing demand for improved accountability of the provinces to the federal government regarding health transfers and of the Canadian healthcare system in general to the public by

Canada's primary health care system is lagging behind other countries and that a lack of data, research, and interoperable information systems present further barriers to advancing primary health care reform. – *Health Council of Canada, 2012, p. 14*

improving public reporting. The *idea* became manifest in various national committees, special research bodies, and councils for the purposes of agreeing on sets of indicators, measurement and

sharing of information⁷.

Although it would seem apparent, it is important to note that many publications recognized the need for **system change** in one way or another. The publications cite going beyond pilot

projects and small initiatives, a noted legacy of the culture of Canadian health policy. The prevailing consensus of the time was that the Canadian health

A desire to reform primary health care has been a constant theme over the past two decades. – *CIHI, 2002, p.8*

care system as a whole was in need of greater change and herein it was acknowledged that the primary care system as its foundation needed major changes. A notably different voice is that of the Canadian Family Physician Canada (CFPC), which argued for primary health care renewal as distinctly different from the reform, in other words that the system needed small changes but not a complete overhaul. In sum, there is a sense that the majority of stakeholders were on board for change and there was little resistance to this *idea*.

⁷ Examples of this include the Canadian Institute for Health Information (CIHI) Pan-Canadian Primary Health Care Indicator Development Project; the Canadian Survey of Experiences with Primary Health Care on behalf of the Health Council of Canada by Statistics Canada and co-funded by CIHI; the creation of CPCSSN.

3.4.2 Institutions

Institutions are the “formal and informal rules, norms, precedents, and organizational factors that structure political behaviours”. This study has found the following as the influential *institutions* constructing the space within which reform of primary health care took place during the period: **The Canada Health Act, Canada Health Transfer, Federalism, Fee-for-Service, First Ministers Accords on Health Care Renewal, Primary Health Care Transition Fund (PHCTF), and Traditional Private Physician-led Practice (solo or group).**

Canada’s **Federalism** is one of the foundational *institutions* which shapes Canada’s

As a result, federal influence over health care is exerted mainly through the leverage of revenue transfers, and federal/provincial agreement is required to establish national standards or programs. At different times, the nature of Canadian federalism has both blocked and stimulated change in

healthcare system and how primary care reform is achieved. Although the guarantee to Canadian citizens of the provision of healthcare is upheld by a federal promise, the Canada Health Act (1984), the responsibility for its organization and delivery lies

primarily with the provinces and territories. This has in turn led to Canada’s healthcare system being divided into 13 distinct healthcare systems. When the country as a whole called for improvements in the healthcare system, stakeholders appealed for a pan-Canadian consensus on the goals of the reform as well as federal involvement, especially by way of financing. As a consequence, the period under study was characterized by an unprecedented number of Accords to galvanize sweeping changes across all the provinces and territories and increases in federal cash transfers to the provinces and territories to fund the goals of those Accords.

The Canada Health Act (CHA) 1984 governs the conditions under which provinces and territories receive federal transfers (through the Canada Health Transfer) for providing health care services. The CHA was built upon the Medical Care Act (1966) and the Hospital Insurance

and Diagnostic Services Act (1957) to include the prohibition of additional extra billing to patients for medically necessary services. The conditions of the CHA are as follows: public administration, universality, portability, accessibility, and comprehensiveness. In essence the CHA sets the guidelines under which the provinces must operate by using fiscal enforcement.

The Act aspires to establish uniformity and equality across the provinces and a national vision of our health care system; this is something Canadians are proud of and consider as part of their national identity. Equal access to primary health care for all

Medicare speaks eloquently to our values as a nation, to our priorities as a people, to both our unity of purpose and sense of self in an ever more challenging and complex world. It makes us proud. – *Address by Prime Minister Paul Martin,*

residents is a concept directly connected to this. The policy legacy of the CHA in the form of the Canada Health Transfer (CHT) shapes the rules which must be followed during the process of policy reform. Additionally, the CHA regulates the bargaining process between provinces and medical professionals regarding remuneration. The Act states that the province must enter into agreement with the representative provincial associations and where a dispute arises, the resolving panel must be equally representative of all parties (province and medical association) together with an independent chairperson. The resultant decision by the panel can only be altered by an Act of legislature (Canada Health Act 1984, Section 12 [2]).

The Canada Health Transfer (CHT) is a block transfer payment program made up of tax and cash transfers for the purpose of funding health care systems in the provinces and territories. The transfer is calculated in such a way as to provide equal per-capita funding across the provinces. Provinces with higher incomes generate more revenues per capita from their tax transfers so an equalization payment accompanies the cash transfer of provinces with less revenue from the tax points. This is seen with some tension as the wealthy provinces receive less

proportionately of the cash transfer. Nonetheless, the value of the tax points in wealthier provinces exceeds the combined value of the tax points and equalization of the “have-not” provinces. The cash transfers are calculated on a per capita basis and accompanied by an escalator⁸. The CHT is the policy lever arm of the Canada Health Act; its transfers are conditional upon adherence to the five principles of the CHA described in the above paragraph. During the period under study the CHT was formulated by dividing its predecessor the Canada Health and Social Transfer (CHST) into two, separating the CHT and the Canada Social Transfer⁹. The argument for changing the CHST was that it would provide more stable and predictable health funding and it would establish better transparency and accountability for the use of federal funds which were previously fused¹⁰. Notably, although it became clearer how much money was transferred for the purposes of health system spending the transfer continued to allow provinces to spend the money how they saw fit as long as the CHA was upheld. Additional accountability was not a requirement of the new CHT.

The **First Ministers Health Accords of 2000, 2003, and 2004** represented unprecedented multi-jurisdictional cooperation by the First Ministers on behalf of the federal, provincial, and territorial governments on the renewal of the Canadian health system. In the first meeting in 2000 the Ministers had already selected primary health care as one area which needed concentrated effort; the Primary Health Care Transition Fund was created to this end. Following this, the 2003 Accord on Health Care Renewal set a target that by 2011 at least 50% of residents would have 24/7 access to a primary care provider; when restated in the 2004 Accord it included access to a multi-disciplinary team of providers. The Ministers also agreed that they

⁸ A 6% escalator was set for 2004 - 2017. It has since changed.

⁹ The CST provides funds for post-secondary education, social services, and social assistance support

¹⁰ At the time of the split 62% of the CHST was allocated to CHT and 38% to the CST.

would publicly set out their own objectives on a provincial basis to progress towards accomplishing the agreed upon goal. The 2003 Accord created the Health Reform Fund to give effect to their objectives and secure predictable funding; an additional \$16 billion investment in primary health care, home care and catastrophic drug coverage, which was combined into the Canada Health Transfer two years later. The 2003 Accord promised to use comparable data indicators, develop nationally comparable information for Canadians, and collect good data for quality reporting. Hence, they created the Health Council of Canada to monitor the changes and report progress to the public. The 2004 Accord expanded upon its predecessors and created a narrower and more direct plan termed the 10-year Plan to Strengthen Health Care and provided more funding amounting to \$41.3 billion to be spent from 2004 to 2014, the bulk of which would be provided through the Canada Health Transfer (CHT).

The 2003 First Ministers Health Accord committed a \$16 billion federal investment in the Health Reform Fund, which was targeted to primary health care, home care, and catastrophic drug coverage, and in 2004, the First Ministers established a goal of 50% of Canadians having 24/7 access to multidisciplinary primary health care teams by 2011, and agreed to "accelerate the development and implementation of the electronic health record." – *Health Council*

The overall goal of the Fund is simple, yet formidable: to support the development and implementation of transitional primary health care renewal initiatives by provinces and territories to improve the way primary health care services are delivered across Canada. –

The **Primary Health Care Transition Fund**

(PHCTF) was established with the September 2000 Agreements on Health Renewal and Early Childhood Development. Out of the \$23.4 billion in additional funds dedicated by the federal government \$800

million was pledged to the renewal of primary health care in the provinces and territories over a 6 year period (2000 - 2006). The overall objective of the PHCTF was to fund the costs of a major

transition which would shape the fundamentals of the primary health care systems in the country.

The five common objectives of the PHCTF were:

1. to increase the proportion of the population with access to primary health care organizations which are accountable for the planned provision of comprehensive services to a defined population;
2. to increase the emphasis on health promotion, disease and injury prevention, and chronic disease management;
3. to expand 24/7 access to essential services;
4. to establish multi-disciplinary teams, so that the most appropriate care is provided by the most appropriate provider; and
5. to facilitate coordination with other health services (such as specialists and hospitals). (Government of Canada, n.d.)

In conjunction with the 5 common objectives the PHCTF also had 5 funding envelopes dedicated to the following themes: provincial/territorial, multi-jurisdictional, national, Aboriginal, and official languages minority communities. The Provincial/Territorial envelope received the majority of the funding to support their individual reform efforts. The PHCTF was “an important federal mechanism for the acceleration of primary health care renewal across Canada” (Health Canada, 2007). Importantly, it fueled unprecedented national collaboration, generated leadership in primary health care reform across the country, and spurred the conversation about evaluation and data improvement.

Historically, **Fee-for-Service** has been the principal remuneration model in Canada for family physicians. When family doctors were brought into the Medicare program the pre-existing fee-for-service model, as well as clinical and organizational autonomy were maintained.

Additional barriers include remuneration methods and financial incentives that are rooted strongly in the current physician fee-for-service system. – *Health Council of Canada, 2005, p.18*

The remuneration system pays a single physician for each service rendered per patient, per day. It rewards productivity as it relates to volume of patients seen. In Canada patients have the freedom to choose their health

care provider, and change their mind when they like. It is argued this creates a sense of

accountability for family physicians; if patients are displeased they will go elsewhere. Fee-for-service is frequently identified as an *institution* which acts as a barrier to many of the ideas of the reform period. For instance, in a fee-for-service model, a private physician would have to compensate the labour of other professionals when building a multi-disciplinary primary care team as well as absorb costs related to administration, educational activities, and additional collaboration. There is also a financial disincentive for physicians to provide the type of lengthy preventative care which emerges as an important *idea* in the reforming of primary health care during this period.

The **Traditional Private Physician-led Family Practice (solo or group)** is a well-entrenched *institution* in Canada. It is closely connected to the above described fee-for-service compensation model. This traditional primary care model is characterized by a physician working alone or with other physicians while maintaining professional autonomy and self-management in a private practice; the clinic operates like a small independent business and is largely compensated through fee-for-service by a public insurance system. There is no guaranteed formal integration mechanism into the other components of the healthcare system and no guarantee to patients of longitudinal continuity of care except for the loyalty of the patient to their physician and vice versa. Although some specialists choose to accept self-referred patients, specialists are not obliged to accept referrals from other primary health care practitioners, the family physician maintains the power to refer beyond primary care and holds the position as the gatekeeper to the wider healthcare system. This *institution*, coupled with fee-

The basic structure of primary care organization, funding and delivery in Canada – private, fee-for-service, solo, and small group practice – has remained intact despite repeated calls for reform at both the national and provincial levels. – Holden & Madore, 2002, p.2

for-service remuneration, is deeply embedded in the Medicare system, it is for this reason that the *idea* of alternative remuneration has become so prevalent during the study period.

3.4.3 Interests (of actors)

Interests (of actors) are “The agenda of stakeholders involved in the policy development process to achieve their objectives”. **Federal Government, Nurses, Other Primary Health Care Providers, Physicians, Provincial Governments, the Public, and the Research Community** appeared as the most important stakeholders in the literature, voicing their agendas and taking part in the policy development.

The role of the **Federal Government** in health care is primarily been one of funding support for the provinces and territories¹¹. As outlined previously in this text the federal

The federal government’s role in relation to hospital and physician services covered under the Canada Health Act primarily involves transferring funds to the provinces and ensuring that the conditions of the Act are met. – *Romanow,*

government provides cash and tax transfers to the provinces and territories through the CHT while ensuring that the CHA conditions are met and has provided targeted funding at various times for specific initiatives such as the PHCTF. The PHCTF was the first time that

the federal government established cash transfers for a specific field in health since block funding began. That the funding is conditional is predicated on the notion that they take responsibility for establishing and upholding national standards of healthcare across the provinces and territories. In essence, their broader *interests* are represented by the conditions of the CHA (public administration, universality, portability, accessibility, and comprehensiveness) and when standards of care are failing they have commissioned inquiries to create new

¹¹ The federal government also provides healthcare to federal citizens, is responsible for public health, and food and environmental issues effecting citizens’ health however for the purposes of this paper these responsibilities will not be explored here.

understandings of the future of health care¹², established the First Ministers Accords to collaborate on the goals of reform, and increased federal cash transfers as well as created targeted federal transfers. The federal government collaboratively worked with the provinces and territories to formulate the priorities of health care renewal, agreeing alongside the provinces and territories on the goals for primary health care reform.

The **Provincial Governments** have the primary responsibility for the organization and delivery of health care services, including primary health care. The focal *interest* of the provinces in this regard is to meet

According to the provincial premiers, an effective reform of health care can take place only when an adequate level of funding has been secured. – *Madore, 2003.*

the healthcare needs of its citizens through its publicly administered health system while maintaining a balanced budget. Although they receive federal funding, a large remainder of the

Provinces and territories are committed to the development and continuance of a health system responsive to population health needs within the fiscal resources available to the provinces/territories. – *Provincial and Territorial Ministers of Health,*

healthcare budget comes from their own finances, a source of perpetual tension between the levels of government. The provinces must balance the budgets of health care costs, which

is not predictable. In the early millennium, when funding was at a low and demands on the system were growing, the premiers wrote to the federal government calling for funding increases. All the provinces acknowledged the need for improvement to primary care and agreed to the goals set by the Health Accords for improving access. They were responsible for creating the policies which directly affect achieving those aims. A significant responsibility of the provinces is the remuneration of physicians along with negotiations with physician associations relating to fee schedules and accountability arrangements.

¹² Such as the Kirby Reports and Romanow Commission.

Physicians, specifically family physicians or general practitioners, are the main providers

Every Canadian should have a personal family physician.
– *CFPC, 2007, p.2*

of primary care in Canada. “In Canada, family physicians provide diagnosis and medical treatment; health protection, and promotion; coordination of care; advocacy on behalf of patients; and office-based care, as well as care in hospitals, homes, nursing homes, and community facilities. They provide not only first-line medical services, but also a substantial amount of secondary and tertiary care in all communities, particularly in rural and remote settings” (CFPC, 2000, p.4). They and the professional bodies which represent them also play an important role in primary care reform. Their delivery of primary care, when performed outside a hospital setting has been paid by a public insurance agency since the introduction of the Medical Care Act (1966). The practice of family medicine has changed since the introduction of the Act. Notably, younger physicians have a different view of their practice compared to their predecessors. They generally prefer less of a workload, and they are providing different services: over time there has been a retraction of some services (such as delivering babies) and they are being asked to provide new services such as psychosocial counselling. More than half of new graduates choose to specialize over choosing family medicine. All this to say, during the era under study, much of the literature pointed to a growing need for more family physicians. Given their self-regulation status, physicians are represented by a few important professional bodies in Canada. Provincial organizations and associations are responsible for maintaining standards of medical practice and ethics, training, registration and licensing, and representing their members in the negotiation of fee schedules with the provinces as well as alternate funding agreements where they exist. These tasks are not shared by the same organizations, for instance training standards is a national responsibility of the Royal College of Physicians and Surgeons Canada for specialists and the College of Family

Physicians Canada (CFPC) for family doctors and provincial organizations are responsible for fee negotiations. The national organizations which represent family physicians and have appeared frequently in the literature surrounding primary care reform are the Canadian Medical Association (CMA)¹³ and the CFPC¹⁴. The CMA makes policy recommendations on behalf of their members and the patients, such as campaigning for EMR funding from governments, advocating that every Canadian has access to a family physician, and that physicians be appropriately compensated for caring for patients with chronic conditions. The CMA has been vigilant in advocating the role of the physician as the central provider and coordinator of access to publicly-funded primary care services. They are not opposed to working in multidisciplinary teams but are concerned about accountability if physicians would not maintain the central role as the primary care provider. The CFPC is the representative voice of family medicine in Canada and has been active in the deliberations on primary care reform both at the federal and provincial levels. Some of the policies advocated for by the CFPC which specifically speak to primary care reform include: support for collaborative team-based care with physicians placed at the centre¹⁵, support for primary health care renewal instead of reform, and support for alternative remuneration schemes to better achieve the primary care renewal goals.

¹³ The CMA is a voluntary professional organization representing the majority of Canada's physicians which performs a wide variety of functions such as "advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery" (CMA, 2010, p.ii).

¹⁴ The CFPC is the collective voice of family medicine in Canada and represents more than 37,000 members across the country; it is "responsible for establishing standards for the training, certification and lifelong education of family physicians and for advocating on behalf of the specialty of family medicine, family physicians and their patients. The CFPC accredits postgraduate family medicine training in Canada's 17 medical schools." (CFPC, 2018)

¹⁵ This was first advocated for as the Family Practice Network in 2000 and then as the Patient Medical Home in 2009.

Nurses play an integral role in the primary health care system as health care providers and

A transformed health-care system recognizes RNs, NPs and other health professionals as entry points to the system — one that increases access to home and community care, improves chronic disease prevention and management, and helps families care for ailing loved ones. – *CNA, 2011,*

as advocates for the advancement of the primary health care system. Nurses deliver primary care in nurse-led clinics (often in rural and remote locations), in primary care

clinics with other health professionals such as physicians, and as nurse practitioners. Nurse practitioners have advanced training that enables them to provide additional primary care services; they are licensed as autonomous professionals and can offer many of the same services as a family physician. During the period under study, nurse practitioners became more common however the provinces are at various stages in terms of incorporating them into the primary health care system and they still provide a tiny proportion of PC in Canada. According to the Canadian Nurse Association (CNA), nurses have always advocated for a broader understanding of primary health care as was articulated in the Kirby Reports and the Romanow Commission. They have a broader sense of what it means to offer primary health care, and do not necessarily see that a physician must take the central role in providing that care. The CNA has also worked together with the CFPC to harmonize their ideas for collaborative practice, and offer team-based primary care which includes health professionals who have a superior understanding for each provider's role.

There are many **Other Primary Health Care Providers** whose associations voiced their

Physiotherapy, or physical therapy, is a health care discipline well positioned to take on an increased role in primary health care. – *Fricke, 2005, p.ii*

support and recommendations for primary care reform during this period. Other primary health care providers includes the health professionals beyond the two most

common primary health care providers mentioned above such as physicians assistants, dietitians,

occupational therapists, physiotherapists, mental health workers, and dental hygienists. Although the gray literature from these professional associations came from a diverse group there were notable similarities in their publications. The sources supported the principles of primary health care which were being promoted by the Accords and they called for better coordination between interprofessional health services; improved usage of EMR systems which would include using the specialized components according to their specialties; reformed remuneration policies for other health professionals working in multi-disciplinary primary health care teams; and more inclusive management structures in primary health care teams. In essence, the associations advocated for collaborative multi-disciplinary primary health care and the role their profession would play in expanded teams. Many of the documents outlined direct plans as to how they can be involved, or what kind of services they might provide. The Canadian Mental Health Organization wrote extensively about the integration of mental health services with primary health care, given that, with few exceptions, out-patient mental health services are not paid by the provinces.

The fundamental *interests* of the **Research Community** are to produce evidence and

Canadian Institute for Health Information (CIHI), the Canadian Institutes of Health Research (CIHR), and the Canadian Health Services Research Foundation (CHSRF) are increasingly focusing their data-gathering and research activities to support improvements in primary health care delivery. – *Health Council of Canada,*

knowledge which contributes to the ongoing understanding of what primary health care is and how it should be delivered. Researchers also measure the ongoing progress of the primary health care reform. During this period, evaluation

and data (evidence production) increasingly became a priority¹⁶. This, in conjunction with more data and information becoming available via EMR systems has meant a growing role for the

¹⁶ See *Ideas* above: Evaluation and Data

research community. The research community is made up of academic researchers, think tanks, research units in university departments of family medicine, quality improvement researchers and formal research bodies such as the national research associations: Canadian Institute for Health Information (CIHI), the Canadian Institutes of Health Research (CIHR), the Canadian Foundation for Healthcare Improvement (CFHI)¹⁷, and Statistics Canada. During this period there were substantial gains in terms of collaborative work done in the research community towards measuring and comparing primary health care performance across the country. This included the creation of 105 pan-Canadian primary health care indicators created through an extensive consensus building process led by CIHI which included many stakeholders across the country¹⁸. During the study period the Health Council of Canada measured and reported on the progress of the primary health care reforms and advocated for the Canadian public interest as part of the goals set out by the Accords.

Lastly, the **Public** received mention throughout the literature under study however it was never directly from their perspective; many of the publications advocated for the public good and at times referenced a patient perspective study however due to the nature of the methodology of this study it

Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. – *Romanow, 2002, p. xvi*

People in this country are increasingly anxious about their ability to get in to see the right health professional at the right time. – *Address by Prime Minister Paul Martin at the First Ministers' Meeting, September 13, 2004*

is not surprising that none of the documents were written from a patient perspective. Therefore, it is difficult to say what kind of a role the public plays in the primary health care reform era without a proper examination of, for

¹⁷ During the majority of the period under study was named the Canadian Health Services Research Foundation (CHSRF), which changed in 2012.

¹⁸ They were first created in 2005 and later updated in 2012 given clinical guidelines continue to evolve.

example, the media coverage during the time. A few themes were consistently expounded from the view of the Canadian public. The literature pointed out that Canadians valued having a personal family physician, they continued to support a publically funded health care system although they recognized that the system was in need of reform and that primary health care specifically needed reforming, and that the health care system meet the needs of all Canadians – in other words that the system be equitably accessible to all.

3.5 Discussion

The Pan-Canadian results of the documentary analysis highlight the factors which have played a role in shaping primary care reform as *ideas, institutions* and *interests*. Although insightful at a macro level by gaining an understanding of the national conversation and federal policies, it is necessary to illustrate how the factors play out at a provincial level given provincial policies more directly affect the public and their access to primary care. In this discussion two provinces, Ontario and Manitoba, will be used as examples to highlight how the 3Is of primary care reform have interacted and shaped the policies and change which has occurred at the provincial level. Ontario, as the province with the best access to primary care according to the results of the first phase of this study and Manitoba which demonstrated poorer access more typical of other provinces.

3.5.1 Ontario

At the onset of primary health care reform 15 years ago Ontario adopted a **primary care as foundational** notion of improving the overall healthcare system: “Ontario – stands out in terms of the provincial government’s single-minded focus on primary care” (Marchildron & Hutchison, 2016, p. 733). The **provincial government** provided the political will and support early on, possibly owing to the 1999 report by the Ontario Health Services Restructuring

Commission which had already recommended the creation of primary care models with multidisciplinary teams and 24/7 access (Aggarwal, 2009). Hon. Elizabeth Witmer (Minister of Health and Long-Term Care) makes mention of this commitment: “that had been a priority for this government since 1995, in order to ensure that people could have access to 24-hour-a-day, seven-day-a-week care by doctors, nurses and nurse practitioners” (Hansard, 4 April 2000 col 1450).

The political will coupled with financial support from the **PHCTF** resulted in early experimentation with different models. The 2000 – 2001 Business Plan of the Ministry of Health and Long-Term Care (OMHLT) claimed “waiting for the results of the federal Commission on the Future of Health Care in Canada, due in November 2002, is far too long to wait.” The Plan set out the goal to have 80% of family physicians working in Family Health Network (one of their earliest new primary care models) by 2004, and they provided significant financial support for reorganization and EMRs to achieve this end. With the added funding from the Health Reform Fund provided in the **2003 & 2004 Accords** and a change in government in 2003 the Ontario government further “launched a number of primary care models to increase access and improve the quality and delivery of primary care services” (ibid, p. 733).

The models pursued by Ontario were aimed at changing the **traditional private physician-led practice** centered on **fee-for-service** payment. Incentivizing through the use of **alternative remuneration** was the main policy lever of the province to promote new primary care models, increase patient enrollment, and support the creation of **teams** (Hutchison & Glazier, 2012).¹⁹ The models ranged from providing a combination of fee-for-service with blended targeted incentives and bonuses, capitation, blended capitation, and salary. Offering **24/7**

¹⁹ See Marchildron and Hutchison (2016) for a review of each of the primary care models pursued in Ontario

universal access was a clear priority given that rostering (formal enrollment of patients) was a requirement for all models as well as after-hours provision of care (with the exception of the Nurse Practitioner-Led Clinics). The success of shifting primary care provision from traditional private physician-led practice centered purely on fee-for-service to alternative models is clear: in 2002, 94% of family doctors were remunerated through fee-for-service and by 2015 less than 25% were, more than half of which offered specialized services (Marchildron & Hutchison, 2016).

The earliest models were focused on supporting and expanding the role of family physicians, in 2005 and 2007 multi-disciplinary teams and Nurse Practitioner-led clinics were also championed. Family Health Teams is the multi-disciplinary team-based model heavily supported and promoted by the province. Other primary care providers such as social workers, psychologists, dieticians and pharmacists are salaried to work in the clinic with family physicians. As of 2016, 22.1% of family physicians were working in a Family Health Team and 97 fulltime equivalent nurse practitioners were working in Nurse Practitioner-Led Clinics.

Collaboration at a meso level between the province and the provincial medical association was necessary to introduce the new primary care models, given that their formation were based on **alternative remuneration**. Since 1991, the Ontario Medical Association (OMA) has held the exclusive bargaining rights for all physicians in Ontario. This governance power has had the result of an obligatory partnership between the province and the association to achieve the reform goals, however OMA's role has also meant that the options available for policy reform have maintained the status quo of physicians. "The Ministry of Health and Long-Term Care worked closely with major stakeholders, including physician groups such as the Ontario Medical Association, to develop diverse primary care models that were voluntary for both providers and

patients” (Hutchison & Glazier, p.696, 2012). The new primary care models have maintained physician professional autonomy while simultaneously boosting income, improving infrastructure and working environment, and supporting **EMRs**.

Ontario stands out as one of the provinces which has gone the furthest to reform their primary health care system. The results of the first part of this study reflect better attachment to primary care providers when compared with the other provinces. Ontario has had great success in shifting the types of primary care models family physicians are working in and has appropriately been celebrated for achieving reform through incremental changes made possible by way of strong provincial will, financial support, and buy in by professional associations and other stakeholders (Hutchison et al., 2011). On the other hand, the association’s interest in maintaining the status quo of family physicians and governance structures has meant that whether or not the **system level change** has been achieved or even pursued in Ontario is still in question. Aggarwal claims that the new primary care reforms in Ontario “have not fundamentally altered the underlying institutional and structural relationships that characterize the primary care sector” (2009, p.iii).

In her study, Aggarwal argued that non-fee-for-service remuneration is seen as a risk and a threat to physicians; it takes power and political autonomy from the professional association by giving the government more bureaucratic and governance authority over the primary care system (2009). At the time of her writing the considerable shift of physicians to alternative remuneration had not yet been achieved. The promises of the new primary care models have been enough to achieve this conversion despite the potential loss of autonomy. The Family Health Team model has been well received by family physicians with 22% of Ontario’s family physicians working in one (as of 2015). Physicians working in the FHTs have received a 30% increase in income since

introduction of the new model (Glazier et al., 2009). Included were 200 inter-professional FHTs providing services to 2 million provincial residents (Marchildron & Hutchison, 2016).

More recently, and outside the time frame of this study, the Ontario government has taken primary care reform a step closer towards **system level change**. The provincial government unilaterally decided to cut back physician wages by 7% in 2015, due to increasing fiscal pressures and a belief that the evidence has not reflected an improvement worthy of such a large investment (Marchildon & Hutchison, 2016). OMA reacted with a court challenge in opposition to the decision under the Canadian Charter of Rights and Freedoms with support from the Coalition of Ontario Doctors. Governance issues and tension between the province and the associations have further emerged with the passing of Bill 41, The Patients First Act (2016). Bill 41 originally demonstrated a radical shift in the way that the primary care system would be governed by moving power over to the Local Health Integration Network (LHIN) for health planning and policy. Since its original introduction, feedback from stakeholders such as the Ontario College of Family Physicians resulted in some major amendments before it was passed into law in 2016. The struggle between the province and the associations is ongoing as the province decides how to implement The Patient First Act.

Ontario demonstrates how political will, collaboration, and extra financial support (from the federal government) worked to shape and modify pre-existing *institutions* with the *ideas* coming out to the national conversation, as long as the province's *interests* accommodated those of the physicians. The province now sees that wrenching more control away from physicians is necessary for further reform (and budgetary control) and has run into legal difficulties and significant push back.

3.5.2 Manitoba

Efforts to improve primary care in Manitoba at the start of the study period were directed at building and opening clinics, Access Centres, operated by the Regional Health Authorities (RHAs) with the funds provided by the **PHCTF** (Kreindler et al., 2018 May 30). Although named primary care centres, the Access Centres deliver primary healthcare by salaried or contracted **physicians** and **nurse practitioners**, alongside other health or social service professionals (Government of Manitoba, 2018). Eight centres were opened from 2004 – 2015. The centres exemplify *ideas* of **micro collaboration**, **alternative remuneration**, **EMR**, **evaluation and data**, and **primary care as foundational** (given they offer primary healthcare with a broad-based population health/public health scope). Although some of the clinics offer after hours care, **24/7 universal access** is not available in any of the clinics (WRHA, 2018).

A program created to build **collaboration** between family physicians and mental health professionals began in 2003 titled *Shared Care*. “The goal of this collaborative model is to assist individuals with mental health difficulties to access mental health services in a timely manner and to provide that care within the familiarity of their Family Physician’s office” (WRHA, n.d., p.1). Shared Care employs mental health professionals (**other primary care providers**) who work in a **fee-for-service** physician-led clinic. The program further demonstrates an early acceptance of **primary care as foundational** notion as well as support for team-based care (**micro collaboration**). By 2009, approximately 100 **physicians** and 10 **nurse practitioners** were working with this model (WRHA, 2012).

Access Centers, although innovative and reflective of the goals for primary care reform at a national level, were clearly not going to take the place of the embedded institution of **traditional private physician-led family practices** across the province (Kreindler et al., 2018

May 30). The province began their foray into greater primary care renewal by engaging **fee-for-service** physicians, with a program called Physician Integrated Network (PIN) in 2006. PIN has four main objectives:

- To improve your access to primary care;
- To improve primary care providers' access to and use of information;
- To improve the work life of all primary care providers;
- To demonstrate high-quality primary care, with a focus on chronic disease (Manitoba PIN website, 2018).

With financial aid and support from the province, the participating clinics tailored their own strategies to achieve the PIN objectives: they integrated **EMRs**, tracked quality care indicators, created a multi-disciplinary team-based practice (**collaboration**), and were involved in ongoing feedback to the province. In addition to the regular fee-for-service remuneration the clinics also received quality-based incentive funding to improve chronic disease management. Thirteen clinics (approximately 13% of fee-for-service physicians) in Manitoba participated. Through a **meso level of collaboration** between the province and physicians there has been an excellent use of **data** by way of evaluations at the clinic and program levels, thereby supporting evidence-based decision making and informing future policy making²⁰. The evaluations and feedback derived from this program were used to inform provincial policy development and strategies for primary care improvement in Manitoba (Government of Manitoba, n.d.). Overall, the project maintained a comfortable level of autonomy for **physicians**: it was voluntary, physicians could tailor their plan to meet the objectives, fee-for-service remuneration was not fundamentally changed rather expanded by adding the QBIF. Conversely, the program required additional labour from participating physicians, an unprecedented involvement in governance, and sharing data from their EMR systems.

²⁰ A complete list of PIN reports can be found on the province's website at <http://www.gov.mb.ca/health/primarycare/providers/pin/index.html>.

More all-encompassing changes to the primary care system in Manitoba fell behind the timeline of many other provinces. According to Kreindler et al., by 2010 the provincial and regional stakeholders demonstrated an increased political will to implement widespread changes (2018, May 30). Greater reform officially began with clear political will from the **provincial government**; the Premier at the time, Greg Selinger, made an election promise that by 2015 all residents would have access to a family physician (Government of Manitoba, 2010). To achieve this end an unprecedented amount of resources was poured into improving primary care access in Manitoba. Policies and programs were initiated to attach residents to family physicians by increasing the supply of primary care providers, promoting EMR acquisition, introducing new tariffs to encourage chronic disease management and continuity, opening urgent care/walk-in clinics and mobile clinics, financing interprofessional providers to work in fee-for-service clinics and creating “health teams” or groups of physicians.

Programs which were implemented during the 2011-15 “doc for all” strategy augmented and supported the existing structure of family physicians as the centre of primary care. The family doctor finder connects residents searching for a family physician with one. The program does not have requirements of the physician to work in a specific model type and neither the physician nor the patient have any obligations to take the appointment or maintain the clinical relationship if it is not to their liking. The program has been well received and successful: according to the province by March 2018 approximately 95% (over 93,000 people) of Manitobans without a provider who registered with the program had been matched (Government of Manitoba, n.d.).

Before the 2011 promise there were supply side efforts to boost health and human resources for primary care providers in the province, support for these policies continued during

the 2011 – 2015 strategy period. The policies consisted of recruiting more residents to family medicine training programs, incentives for rural placements, increasing spaces in medical training at the university and increased remuneration (Government of Manitoba, 2011; Government of Manitoba, 2010). There were also efforts to increase the supply of nurse practitioners (Government of Manitoba, 2012).

The province heavily subsidized the cost of adopting one of its chosen **EMR** systems during this period. Canada Health Infoway, a federally funded program to increase EMR adoption, was contributory to the success of the program; by 2015 there was an 80% adoption rate. The program required data extraction and sharing to Manitoba Health, Healthy Living and Seniors, has been ongoing and successful; in return clinics receive reports regarding their overall patient roster, and analysis about on chronic disease population (**data and evaluation**) (Government of Manitoba, 2018).

New tariffs were introduced by the **provincial government** to incentivize and support physicians to provide continuous, comprehensive and coordinated care for patients with chronic diseases. The tariff recognizes that these patients require more complex care. The first tariff introduced was in 2012, the chronic disease (CDM), and the second, the comprehensive care management (CCM) was effective as of 2017. Some of the significant differences between the two are that the CCM requires the provider has an EMR system, and one of its overall goals is to have physicians establish themselves as Home Clinics²¹. One tariff can be claimed per patient in a year. Although slightly different, their goal is the same: to incentivize physicians to provide comprehensive and continuous care for patients with complex needs. Notably, these tariffs are not available to other primary care providers such as nurse practitioners.

²¹Home Clinic is a patient centered primary care clinic where a patient receives their regular care. They will not be examined here given they fall outside the purview of this study.

The *idea* of providing **24/7 universal access** to primary care was supported by the province with the opening of QuickCare and Mobile Clinics. QuickCare Clinics are primary care clinics; their purpose is to offer urgent care when a regular provider is not available. From 2012 - 2017 approximately 8 clinics were opened. They are staffed by salaried nurse practitioners and run by the RHAs²². Mobile clinics were opened right outside the scope of this study in 2014; they are also staffed by nurse practitioners and registered nurses to “provide on the spot primary care for people living in some of Manitoba’s smaller, underserved communities.” (Government of Manitoba, 2018). The QuickCare and Mobile Clinics aim to decrease pressures on emergency rooms by providing walk-in style primary care when people do not have or cannot access their regular provider. The creation of these clinics demonstrates the provinces support for nurse practitioners and **nurses** providing primary care which at the time of its announcement was unprecedented (El-Jardali & Lavis, 2011).

At the tail end of the scope of this study (2013) two other initiatives were enacted. The Interprofessional Team Demonstration Initiative (ITDI) and My Health Teams (MyHTs). Informed by the PIN project, ITDI provided financial aid to fee-for-service clinics to take on a nurse practitioner, nurse or physician assistant. MyHTs provide funding to fee-for-service clinics which agree formally to deliver care to a specific geographic region as a group. Typically, the funding has been used to hire other primary healthcare providers whose labour is shared between the clinics. The goals of MyHTs are:

1. Improving access to primary care for all Manitobans.
2. Demonstrating quality and safety in Primary Care
3. Increasing the focus on the patient and patient-centred primary care.
4. Connecting care providers within and across geographic boundaries to provide seamless transitions in care.
5. Enhancing efficiency in primary care and supporting sustainability of the

²² After a change in the provincial government in 2015 many have been closed and their services transferred to the Access centres. Currently two are in operation: one in Selkirk and one in Steinbach.

health system. (Government of Manitoba, 2018)

Although the program had not yet been formally evaluated, according to Kreindler et al. (2018, May 30) it was not well received by Manitoba physicians; both those who participated and those who did not had negative views on the program as of 2015. She argued that “the acceptability of MyHTs to the overall physician population did not appear sufficient to facilitate their establishment as a dominant model” (ibid).

The overall attitude toward primary care reform in Manitoba has been that more indicative of *renewal* – as explained earlier in this paper, the CFPC was intentional in using the word *renewal* instead of *reform* as it better reflected their expectations for what was necessary for primary care system improvement: enhancements but not a system overhaul. This is correspondingly evident in the language used by Manitoba Health, Seniors and Active Living and found on their website (Government of Manitoba, 2018x). The majority of efforts were to bring additional funding and support to fee-for-service physicians to improve the care they are able to provide while also improving their working conditions and increase the supply of available physicians practicing in Manitoba. Through this process physicians have maintained autonomy and a fee-for-service remuneration model as well as their ability to opt in or out of the new models/tariffs.

The support by the province for nurses and nurse practitioners connects to the *idea* of **increasing efficiencies**. The Hon. Erin Selby spoke of this in Assembly: “maximizing the role of nurse practitioners, physician assistants and, of course, all health-care professionals, as we bring together teams of caregivers to ensure that people get the right care from the right provider at the right time” (Hansard, March 18, 2014, 14:40). The WRHA launched a campaign in 2013 title *My Right Care* with a website by the same name (2013). The purpose of the campaign was to take pressure off of emergency rooms by informing residents of the alternative places to go for

immediate medical care, to connect people seeking care to most appropriate place (WRHA, 2018).

The political resolve for primary care reform in Ontario was mobilized years ahead of that of Manitoba; many of the Manitoba initiatives described began at the tail end of this study. It is possible that this is one of the more important factors influencing the superior access to a family physician in Ontario. Ontario has taken further steps than Manitoba to introduce alternative remuneration and to change the institution of traditional private physician-led family practice predicated on fee-for-service compensation. This difference between the provinces is also reflected in the language which is used: Ontario writes of primary care reform and Manitoba of primary care renewal.

Ontario and Manitoba have made investments to incentivize and support physician practices for the purpose of introducing change. According to Aggarwal, “the structural relationship that exists between the OMA and the provincial government has been one of accommodation in the PC [primary care] sector, with the end result being the adoption of models that reflect the interests of physicians” (2009, p.172). In Manitoba, the associations were less involved in the “top-down” decision-making of primary care reform, however there was little to no push back given that the initiatives engaged, supported and augmented fee-for-service practices to achieve primary care renewal. There was little to no threat to their professional autonomy.

Both provinces demonstrate the need for strong political will and large investments to enact reform. This is made especially clear in their attempts to incentivize change in the way that fee-for-service physicians practice. Over the past two decades this has been made possible given increasing flows of funding from the federal government, much of which has been earmarked for

primary care reform. The incentives have resulted in terrific collaboration with physician stakeholders and provincial governments. The question arises whether or not the initiatives are sustainable in the face of potential funding retrenchment due to economic recession or a change of government. We have already seen this in Ontario, where the province has unilaterally decided to scale back remuneration and pass the *Patient's First* law, resulting in push back from professional bodies and a potential risk to the change which has occurred there.

3.6 Limitations

There are some important limitations to this study which need to be taken into consideration while interpreting the findings. First, the data collection is affected by low retrievability. Access to all potentially insightful documents is not possible; publicly available documents do not necessarily reveal the background dialogue, emails and candid discussions which have occurred outside of drafting of the documents, which may result in skewed outcomes. Some interesting and relevant themes may be missing. Second, the documents inevitably provide insufficient detail where the research question is concerned. The documents were created for a purpose other than the research question and will naturally not address the study question head on in the way that an interview would. Third, there is the issue of biased selectivity from the available documents: an incomplete search of documents may reflect an unintended bias due to the search algorithms using Google Advanced. Finally, owing to the nature of a Master's thesis, triangulation between researchers in the coding process was not possible and would have otherwise been ideal.

4.0 Conclusions and Recommendations

4.1 Ethical Consideration

Ethical approval for this project was obtained through the University of Manitoba Research Ethics Board on February 22, 2016 (H2016:057 (HS19447)). This project was also approved through the Social Sciences and Humanities Research Council (SSHRC) for access to the master file of the CCHS 2013-2014 at the Research Data Centre (RDC) which is operated under the provisions of the Statistics Act in accordance to Statistics Canada and upholds strict data confidentiality standards, such as suppressing cell counts under five, and output vetting by the data analyst.

The ethical considerations for the second half of this analysis are unique. Although all documents were obtained from a public source and meant for publication there is a danger that they are misappropriated and poorly represent the view of the author(s) (Sixsmith & Murray, 2001). Where whole quotes of the data can be presented, providing proper context this can be minimized. This precaution has been taken.

4.2 Future Research

There are several avenues which warrant further consideration for future research. First, an exploration of the media's *interest* as through a discourse analysis of the media coverage would bring about a better understanding of their agenda and influence during the policy reform era. During the period under study there was an increase in media attention on the issue of healthcare across the country; an investigation into the conversation would also bring to light the way that the policy reforms were understood and framed, and criticized or praised by the general public.

Second, it would be prudent to conduct a study which compares access to a regular family physician across points of time during the period under study, while comparing the provinces.

The quantitative phase of this study compared provinces at one point in time which lends an understanding as to how the provinces are different but does not measure how they have or have not changed since the beginning of the period under study. This would offer baseline measures and subsequent measures to see how progress is going and at what pace. It is possible that a significant time lag is necessary to observe progress given the complexity of primary health care. As was pointed out by the Health Council of Canada each province began primary health care policy reform at a different time and in a unique way (2013).

Third, a thorough cross-provincial comparison of how the themes of the 3Is played out at a provincial level for each province would bring more depth to the analysis. In this study Ontario and Manitoba were examined to illustrate how the factors play out, however it would be interesting to see how all the provinces are similar or different.

Finally, a next-step study to follow in the wake of this project would be to further delve into the qualitative phase. Taking the study one step beyond what was done I would use the results of phase 2 to formulate semi-structured interview questions to interview groups of actors who were involved in the policy formulating process. In this study, the final versions of published papers have been analyzed. Interviews with stakeholders would not only gain a more in-depth understanding of how primary health care policy reform took place, but also highlight themes which may have been missed or ideas which were dropped and therefore never surfaced in the published papers.

4.3 Conclusion

This mixed-methods study has utilized a logistic regression analysis and a documentary analysis to illuminate the factors which have contributed to reform for the improvement of access to primary care in Canada from 2000 – 2013. Differences in accessibility to a regular family

physician between the provinces were observed, suggesting that provincial primary care policies directly affect residents' access to primary care and therefore, differences in primary care reform across the provinces will also produce differences, despite national level collective goals and stimulus. Of the provinces, Ontario emerged with the best accessibility to primary care, and Quebec with the least.

Although this study has not ranked the importance of some factors over others it is clear that **collaboration** between various *interests* emerged as one of the *ideas* vital to the achievement of primary care reform. Collaborative intergovernmental politics are important owing to Canada's federalist system; the national standardization of universal health care is a federal responsibility although provincial governments are responsible for health care delivery. The significance of meso collaboration can be seen in the Ontario example where the province and professional associations endeavored to work together to achieve significant primary care reform. Collaboration was vital to achieving any successes in healthcare renewal between provincial associations and the province

The *ideas*, *institutions* and *interests* identified in the documentary analysis have combined to produce in some ways similar and in some ways different outcomes for primary care reform in the provinces, as illuminated by the examples of Ontario and Manitoba. This may or may not account for the differences in access observed in the first part of this study. The *ideas* which emerged from the literature at a national level were championed to rework embedded *institutions*; some of the ideas were embraced more successfully than others depending on how the *interests* (of actors) came to influence them. For instance, where provincial governments and physician stakeholders supported an *idea* such as the adoption of EMRs it was eventually endorsed and embedded in the way that primary care is practiced more widely. Given their wide

acceptability, EMRs could now be understood as an *institution* of primary care. With the wide use of EMR systems a surge in new data and evaluations is possible, which feeds into the next wave of *idea* formation. Accordingly, the question arises as to how the newly created *institutions* will affect the future of primary care and primary care reform policies.

References

- Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health services research*, 9(3), 208.
- Ahmad, F., Shik, A., Vanza, R., Cheung, A., George, U., & Stewart, D. E. (2004). Popular health promotion strategies among Chinese and East Indian immigrant women. *Women & health*, 40(1), 21-40.
- Alberta Health. (2017). *Primary Care Networks*. Retrieved from <http://www.health.alberta.ca/services/primary-care-networks.html> on December 12, 2017.
- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of health and social behavior*, 1-10.
- Anderson, R. M., Rice, T. H., & Kominski, G. F. (2001). *Changing the US Health Care System: Key Issues in Health Services. Policy, and Management*. San Francisco: Jossey-Bass Publishers.
- Andersen, R. M. (2008). National health surveys and the behavioral model of health services use. *Medical care*, 46(7), 647-653.
- Andersen, R. & Davidson P. (2011). Improving Access to Care in America. In Andersen, R, Rice, T & Kominski G. (Eds.), *Changing the US Health Care System: Key Issues in Health Services Policy & Management 3rd edition* (pp. 3-32). San Francisco, CA: John Wiley & Sons.
- Ansari, Z. (2007). The concept and usefulness of ambulatory care sensitive conditions as indicators of quality and access to primary health care. *Australian Journal of Primary Health*, 13(3), 91-110.

- Arnett, M. J., Thorpe, R. J., Gaskin, D. J., Bowie, J. V., & LaVeist, T. A. (2016). Race, medical mistrust, and segregation in primary care as usual source of care: findings from the exploring health disparities in integrated communities study. *Journal of Urban Health, 93*(3), 456-467.
- Asanin, J., & Wilson, K. (2008). "I spent nine years looking for a doctor": exploring access to health care among immigrants in Mississauga, Ontario, Canada. *Social science & medicine, 66*(6), 1271-1283.
- Babitsch B, Gohl D, von Lengerke T. Re-revisiting Andersen's Behavioral Model of Health Services Use: a systematic review of studies from 1998–2011. *GMS Psycho-Social-Medicine.*
- Beaulieu, M. D., Haggerty, J., Tousignant, P., Barnsley, J., Hogg, W., Geneau, R., ... & Del Grande, C. (2013). Characteristics of primary care practices associated with high quality of care. *Canadian Medical Association Journal, 185*(12), E590-E596. Liddy, C., Singh, J., Hogg, W., Dahrouge, S., & Taljaard, M. (2011). Comparison of primary care models in the prevention of cardiovascular disease—a cross sectional study. *BMC family practice, 12*(1), 114.
- Bertakis, K. D., Azari, R., Helms, L. J., Callahan, E. J., & Robbins, J. A. (2000). Gender differences in the utilization of health care services. *Journal of family practice, 49*(2), 147-147.
- Blyth, M. (2009). An Approach to Comparative Analysis or a Subfield Within a Subfield? Political Economy. *Comparative Politics: Rationality, Culture, and Structure*, 193.
- Bissonnette, L., Wilson, K., Bell, S., & Shah, T. I. (2012). Neighbourhoods and potential access to health care: The role of spatial and aspatial factors. *Health & place, 18*(4), 841-853.

- Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative research journal*, 9(2), 27-40.
- Bowels S., Edwards R., & Roosevelt F. (2005). *Understanding Capitalism: Competition, Command, and Change*. Third edition. Oxford University Press: New York.
- Breton, M., Lévesque, J. F., Pineault, R., & Hogg, W. (2011). Primary care reform: can Quebec's family medicine group model benefit from the experience of Ontario's family health teams?. *Healthcare Policy*, 7(2), e122-135.
- Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O'Neil, J. (2011). Access to primary care from the perspective of Aboriginal patients at an urban emergency department. *Qualitative Health Research*, 21(3), 333-348.
- Buse, K. (2008). Addressing the theoretical, practical and ethical challenges inherent in prospective health policy analysis. *Health policy and planning*, 23(5), 351-360.
- Campbell, J. L. (1998). Institutional analysis and the role of ideas in political economy. *Theory and society*, 27(3), 377-409.
- Campbell, J. L., Ramsay, J., & Green, J. (2001). Age, gender, socioeconomic, and ethnic differences in patients' assessments of primary health care. *Quality and Safety in Health Care*, 10(2), 90-95.
- Canada Health Act. Revised Statutes of Canada (1985, c. C-6). Retrieved from the Justice Laws website: <http://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html#h-1>.
- Canada. Parliament. Library of Parliament. (2002, December). *Rural Canada: Access to Health Care. (Report PRB 02-45E)*. Retrieved from <http://www.res.parl.gc.ca/Content/LOP/ResearchPublicationsArchive/bp1000/prb0245-e.asp> on May 31, 2017.

- Canadian Institute for Health Information. (2006). *Pan-Canadian Primary Health Care Indicators: Pan-Canadian Primary Health Care Indicator Development Project. Report 1, Volume 2*. Retrieved from https://secure.cihi.ca/free_products/PHC_Indicator_Report_1-Volume_2_Final_E.pdf on September 15, 2015.
- Canadian Institute of Health Information. (2011). *Seniors and the Health Care System: What Is the Impact of Multiple Chronic Conditions?* Retrieved from https://secure.cihi.ca/free_products/air-chronic_disease_aib_en.pdf on October 20, 2017.
- Canadian Institute for Health Information. (2012a). *Disparities in Primary Health Care Experiences Among Canadians with Ambulatory Care Sensitive Conditions*. Ottawa (ON). Retrieved from https://secure.cihi.ca/free_products/PHC_Experiences_AiB2012_E.pdf on October 8, 2015
- Canadian Institute for Health Information. (2012b). *Health Care in Canada, 2012: A Focus on Wait Times*. Retrieved from https://secure.cihi.ca/free_products/HCIC2012-FullReport-ENweb.pdf on November 2, 2015.
- Canadian Institute for Health Information. (2012c). *Pan-Canadian Primary Health Care Indicator Update Report*. Retrieved from https://secure.cihi.ca/free_products/PanCanadian_PHC_Indicator_Update_Report_en_web.pdf on September 15, 2015.
- Canadian Institute for Health Information. (2013). *OurHealthSystem.ca*. Retrieved from [http://ourhealthsystem.ca/#!/indicators/001/people-who-report-they-have-a-regular-medical-doctor/?province46;trend\(1,59,24\);/](http://ourhealthsystem.ca/#!/indicators/001/people-who-report-they-have-a-regular-medical-doctor/?province46;trend(1,59,24);/) on September 3, 2015.

Canadian Institute of Health Information. (2015). *Trends in Income-Related Health Inequalities in Canada. Summary Report*. Retrieved from <https://yourhealthsystem.cihi.ca> on May 31, 2018.

Canadian Institute of Health Information. (2016). *Regulated Nurses*. Ottawa, ON: CIHI. Retrieved from https://secure.cihi.ca/free_products/Nursing_Report_2015_en.pdf on May 31, 2018.

Canadian Institute of Health Information. (2017). *Your Health System: Have a Regular Doctor*. Retrieved from <https://yourhealthsystem.cihi.ca> on November 17, 2017.

Canadian Institute for Health Research. (2012). *ResearchNet*. Retrieved from <https://www.researchnet-recherchenet.ca/rnr16/vwOpprtntyDtls.do?prog=1568&view=currentOpps&org=CIHR&type=AND&resultCount=25&sort=program&all=1&masterList=true> on August 21, 2015.

Canadian Institutes of Health Research. (2013). *Canadian Institutes of Health Research Annual Report 2012–13: Innovative, Strategic, Current*. Retrieved from <http://www.cihr-irsc.gc.ca/e/47321.html> on June 1, 2018.

Canadian Medical Association. (2018). *About CMA & CMA Companies*. Retrieved from https://www.cma.ca/en/Pages/cma_default.aspx on May 31, 2018.

Carter, R., Quesnel-Vallée, A., Plante, C., Gamache, P., & Lévesque, J. F. (2016). Effect of family medicine groups on visits to the emergency department among diabetic patients in Quebec between 2000 and 2011: a population-based segmented regression analysis. *BMC family practice, 17*(1), 23.

Cleary, P. D., Mechanic, D., & Greenley, J. R. (1982). Sex differences in medical care utilization: an empirical investigation. *Journal of Health and Social Behavior, 106-119*.

- The College of Family Physicians Canada. (2018). *About CFPC*. Retrieved from <http://www.cfpc.ca/AboutUs/> on April 16, 2018.
- Collins, T. (2005). Health policy analysis: a simple tool for policy makers. *Public Health, 119*(3), 192-196.
- Commonwealth Fund. (2001). *Canadian Adults' Health Care System Views and Experiences, 2001: Findings from the Commonwealth Fund 2001 International Health Policy Survey*. Retrieved from http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2002/May/Canadian%20Adults%20Health%20Care%20System%20Views%20and%20Experiences%20202001/can_sb_552%20pdf.pdf on December 1, 2015.
- Commonwealth Fund. (2013). *International profiles of health care systems, 2013: Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*. Retrieved from http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf on December 1, 2015.
- Coyle, N., Strumpf, E., Fiset-Laniel, J., Tousignant, P., & Roy, Y. (2014). Characteristics of physicians and patients who join team-based primary care practices: Evidence from Quebec's Family Medicine Groups. *Health Policy, 116*(2), 264-272.
- Da Silva, R. B., Contandriopoulos, A. P., Pineault, R., & Tousignant, P. (2011). A global approach to evaluation of health services utilization: concepts and measures. *Healthcare Policy, 6*(4), 106.

- Dagnone, T. (2009, October). *For Patients' Sake: Patient First Review Commissioner's Report to the Saskatchewan Minister of Health*. Retrieved from <https://www.saskatchewan.ca/> on May 31, 2018.
- Davis, J. B. (1999). Canada's health system. *Croatian medical journal*, 40: 280-286.
- Devlin, R. A., & Rudolph-Zbarsky, J. (2014). Social networks and the probability of having a regular family doctor. *Social Science & Medicine*, 115, 21-28.
- Devlin, R. A., & Sarma, S. (2008). Do physician remuneration schemes matter? The case of Canadian family physicians. *Journal of health economics*, 27(5), 1168-1181.
- Dunlop, S., Coyte, P. C., & McIsaac, W. (2000). Socio-economic status and the utilisation of physicians' services: results from the Canadian National Population Health Survey. *Social science & medicine*, 51(1), 123-133.
- El-Jardali F, Lavis JN. (2011, July 6) Issue Brief: Addressing the Integration of Nurse Practitioners in Primary Healthcare Settings in Canada. Hamilton, Canada: McMaster Health Forum. Retrieved from <https://www.mcmasterforum.org/docs/default-source/product-documents/issue-briefs/nurse-practitioners-in-primary-healthcare-in-canada-ib.pdf?sfvrsn=2> on May 22, 2018
- Fooks, C. (2004). *Implementing Primary Care Reform in Canada: Barriers and Facilitators*. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.502.6522&rep=rep1&type=pdf> on May 31, 2018.
- Gauvin, F. P. (2014). *Understanding Policy Developments and Choices Through the "3-i" Framework: Interests, Ideas and Institutions*. F. Benoit, & M. Jacques (Eds.).

- Gerster, J. (2017, September 27). Doctors flocking to rural Manitoba: Interlake-Eastern attracting physicians to rural areas without financial enticements. *The Winnipeg Free Press*. Retrieved from <http://www.winnipegfreepress.com>.
- Gerster, J. (2017, September 28). More doctors in province but it's no 'mission accomplished'. *The Winnipeg Free Press*. Retrieved from <http://www.winnipegfreepress.com>.
- Gilson, L., Buse, K., Murray, S. F., & Dickinson, C. (2008). Future directions for health policy analysis: a tribute to the work of Professor Gill Walt. *Health policy and planning*, 23(5), 291-293.
- Glazier, R. H., Agha, M. M., Moineddin, R., & Sibley, L. M. (2009). Universal health insurance and equity in primary care and specialist office visits: a population-based study. *The Annals of Family Medicine*, 7(5), 396-405.
- Glazier, R. H., Creatore, M. I., Cortinois, A. A., Agha, M. M., & Moineddin, R. (2004). Neighbourhood recent immigration and hospitalization in Toronto, Canada. *Canadian Journal of Public Health*, 95(3), I30.
- Glazier, R. H., Klein-Geltink, J., Kopp, A., & Sibley, L. M. (2009). Capitation and enhanced fee-for-service models for primary care reform: a population-based evaluation. *Canadian Medical Association Journal*, 180(11), E72-E81.
- Government of Canada. (2011). *What Determines Health?* Retrieved from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html#key_determinants on April 10, 2018.
- Government of Canada. (2012). *Primary Health care*. Retrieved from <https://www.canada.ca/en/health-canada/services/primary-health-care/about-primary-health-care.html> on May 31, 2018.

Government of Manitoba. (2010, November 10). *Province announces first steps toward a family doctor for every Manitoban by 2015*. [News Release]. Retrieved from <http://news.gov.mb.ca/news/?item=10187&posted=2010-11-17> on May 24, 2018.

Government of Manitoba. (2010, December 10). *Manitoba to fully cover medical school costs of students who agree to work where they are needed most*. [News Release]. Retrieved from <http://news.gov.mb.ca/news/index.html?item=10336> on May 24, 2018.

Government of Manitoba. (2011, October 7). *Doctors ratify new four-year agreement with Manitoba Government*. [Press Release] Retrieved from <http://news.gov.mb.ca/news/index.html?archive=&item=12388> on May 22, 2018.

Government of Manitoba. (2012, June 13). *Government making progress toward ensuring all Manitobans have access to family doctors by 2015: Premier*. [News Release]. Retrieved from <http://news.gov.mb.ca/news/?item=14572&posted=2012-06-13>

Government of Manitoba. (2018a). Health Seniors, and Active Living. *Chronic Disease: Self-Management*. Retrieved from <https://www.gov.mb.ca/health/primarycare/public/access/mobile.html> on May 15, 2018.

Government of Manitoba. (2018b). Health Seniors, and Active Living. *Mobile Clinics*. Retrieved from http://www.gov.mb.ca/health/primarycare/providers/chronicdisease/self_management.html

Government of Manitoba. (2018c). Health Seniors, and Active Living. *Access Centres*. Retrieved from <https://www.gov.mb.ca/health/primarycare/public/access/access.html>

Government of Manitoba. (n.d.). Health Seniors, and Active Living. *Physician Integrated Network (PIN)*. Retrieved from <http://www.gov.mb.ca/health/primarycare/providers/pin/index.html> on May 22, 2015

- Government of Saskatchewan. (2012). *Patient Centred, Community Designed, Team Delivered: a Framework for Achieving a High Performing Primary Health Care System in Saskatchewan*. Retrieved from <http://publications.gov.sk.ca/documents/13/81547-primary-care-framework.pdf> on May 31, 2018.
- Haggerty J., Pineault R., Beaulieu M-D., Brunelle Y. (2004). *Accessibility and Continuity of Primary Care in Quebec*. Ottawa: Canadian Health Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/OGC/haggerty_final.pdf on Oct 1, 2015.
- Hall, P. A. 1986. *Governing the Economy: The Politics of State Intervention in Britain and France*. New York: Oxford University Press.
- Hall, P. A. (1997). The role of interests, institutions, and ideas in the comparative political economy of the industrialized nations. *Comparative politics: Rationality, culture, and structure*, 174-207.
- Hall, P. A., & Taylor, R. C. (1996). Political science and the three new institutionalisms. *Political studies*, 44(5), 936-957.
- Health Canada. (2003). *2003 First Ministers' Accord on Health Care Renewal*. Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php#fnb1> on November 1, 2015.
- Health Canada. (2004). *First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care*. Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php> on November 1, 2015.

Health Canada. (2007). *Primary Health Care Transition Fund: Evaluation and Evidence*.

Retrieved from http://publications.gc.ca/collections/collection_2011/sc-hc/H21-286-3-2007-eng.pdf on May 31, 2017.

Health Council of Canada. (2005). *Health Care Renewal in Canada: Accelerating Change*.

Retrieved from www.healthcouncilcanada.ca on May 31, 2017.

Health Canada. (2007). *Primary Health Transition Fund: Summary of Initiatives: Final Edition*.

Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/pubs/prim/2007-initiatives/index-eng.php> on August 2, 2015.

Health Council of Canada. (2007). *Health Care Renewal in Canada: Measuring Up?* Toronto:

Health Council of Canada. Retrieved from www.healthcouncilcanada.ca on May 31, 2017.

Health Council of Canada. (2011a). *How Engaged Are Canadians in their Primary Care?*

Results from the 2010 Commonwealth Fund International Health Policy Survey. Canadian Health Care Matters, Bulletin 5. Toronto: Health Council of Canada. Retrieved from www.healthcouncilcanada.ca on May 31, 2017.

Health Council of Canada. (2011b). *Progress Report 2011: Health Care Renewal in Canada*.

Appendix : Provincial and Territorial Profiles. Retrieved from https://healthcouncilcanada.ca/files/2.45.1-2011Progress_app_ENG.pdf on May 31, 2017.

Health Council of Canada. (2013). *Progress Report 2013: Health care Renewal in Canada*.

Retrieved from http://healthcouncilcanada.ca/rpt_det.php?id=481 on December 3, 2015.

Health Council of Canada. (2014a). *Health Innovation Portal: Archive of Innovative Practices*.

Theme: Health Policies and Governance. Toronto, ON: Health Council of Canada.

Retrieved from healthcouncilcanada.ca on May 31, 2017.

- Health Council of Canada. (2014b). *Progress timeline 2003 – 2013: Highlights of health care reform*. Toronto, ON: Health Council of Canada. Retrieved from healthcouncilcanada.ca on May 31, 2017.
- Hibbard, J. H., & Pope, C. R. (1983). Gender roles, illness orientation and use of medical services. *Social Science & Medicine*, 17(3), 129-137.
- Hollander, M. J., & Tessaro, A. (2011). *Final Report on the Relationship Between Billing for Incentive Payments and Majority Source of Care Patients per GP: Fiscal 2009/10*. British Columbia Ministry of Health Services and the General Practice Services Committee. Retrieved from http://www.gpsc.bc.ca/sites/default/files/Incentives_and_MSOC_Final%20_2011-07-12.pdf on May 31, 2017.
- Hogg, W., Rowan, M., Russell, G., Geneau, R., & Muldoon, L. (2008). Framework for primary care organizations: the importance of a structural domain. *International Journal for Quality in Health Care*, 20(5), 308-313.
- Hutchison, B., & Glazier, R. (2013). Ontario's primary care reforms have transformed the local care landscape, but a plan is needed for ongoing improvement. *Health Affairs*, 32(4), 695-703.
- Hutchison, B., Levesque, J. -, Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: Systems in motion. *Milbank Quarterly*, 89(2), 256-288. Retrieved from doi:10.1111/j.1468-0009.2011.00628.x on December 1, 2015.
- Hwang, J., Guilcher, S. J., McIsaac, K. E., Matheson, F. I., Glazier, R., & O'Campo, P. (2017). An examination of perceived health care availability and unmet health care need in the

- City of Toronto, Ontario, Canada. *Can J Public Health*, 108(1), 7-13.
- John, P. (2012). *Analyzing Public Policy (2nd Edition)*. Routledge Textbooks in Policy Studies.
- Katz, A., Herpai, N., Smith, G., Aubrey-Bassler, K., Breton, M., Boivin, A., ... & Wong, S. T. (2017). Alignment of Canadian Primary Care with the Patient Medical Home Model: A QUALICO-PC Study. *The Annals of Family Medicine*, 15(3), 230-236.
- Katz, S. J., Hofer, T. P., & Manning, W. G. (1996). Physician use in Ontario and the United States: The impact of socioeconomic status and health status. *American Journal of Public Health*, 86(4), 520-524.
- Khandor, E., Mason, K., Chambers, C., Rossiter, K., Cowan, L., & Hwang, S. W. (2011). Access to primary health care among homeless adults in Toronto, Canada: results from the Street Health survey. *Open Medicine*, 5(2), e94.
- Kiran, T., Victor, J. C., Kopp, A., Shah, B. R., & Glazier, R. H. (2014). The relationship between primary care models and processes of diabetes care in Ontario. *Canadian journal of diabetes*, 38(3), 172-178.
- Kirby, M. J. L. (2002). The health of Canadians and the federal role, final report of the state of the health care system in Canada. Ottawa (ON): Standing Senate Committee on Social Affairs. *Science and Technology*, 188.
- Kitts, J., Cook, C., Frank, C., Kendel, D., Moffatt, M., Ramsden M., ... Cooper B. (2013). *Progress Report: 2013: Health care renewal in Canada*. Retrieved from http://publications.gc.ca/collections/collection_2013/ccs-hcc/H171-3-2013-eng.pdf on November 17, 2017.
- Kreindler, S., Struthers, A., Metge, C.J., Charette, C., Bapuji, S.B., Harlos, K., Francois, J., & Zinnick, S. (2018, May 30). *Why Is Soft Integration So Hard? Assessing System-Level*

Strategies for Primary Care Renewal in Manitoba. Oral presentation at the Canadian Association for Health Services and Policy Research (CAHSPR) conference. Lecture conducted from Montreal, Quebec.

Kringos, D. S., Boerma, W. G., Hutchinson, A., van der Zee, J., & Groenewegen, P. P. (2010).

The breadth of primary care: a systematic literature review of its core dimensions. *BMC health services research*, 10(1), 65.

Kulig, J. (2001, May 31). *Consortium for Rural Health Research, Evidence before the Standing Senate Committee on Social Affairs, Science and Technology*, 17.

Laporte, A., Nauenberg, E., & Shen, L. (2008). Aging, social capital, and health care utilization in Canada. *Health Economics, Policy and Law*, 3(4), 393-411.

Laroche, M. (2000). Health status and health services utilization of Canada's immigrant and non-immigrant populations. *Canadian Public Policy Analyse de Politiques*, 51-75.

Lavergne, M. R., Peterson, S., McKendry, R., Sivananthan, S., & McGrail, K. (2014). Full-service family practice in British Columbia: policy interventions and trends in practice, 1991–2010. *Healthcare Policy*, 9(4), 32.

Lavis J. (1998). Ideas, Policy Learning and Policy Change: The Determinants-of-Health Synthesis in Canada and the United Kingdom, *McMaster University Centre for Health Economics and Policy Analysis Working Paper Series 98-6*, June 1998.

Lazar, H. (2009). A cross-provincial comparison of health care reform in Canada: Building blocks and some preliminary results. *Canadian Political Science Review*, 3(4), 1-14.

- Lazar, H., Lavis, J., Forest, P. G., & Church, J. (Eds.). (2013). *Paradigm freeze: Why it is so hard to reform health-care policy in Canada*. McGill-Queen's University Press: Montreal & Kingston, London, Ithaca.
- Lebrun, L. A., & Shi, L. (2011). Nativity status and access to care in Canada and the US: factoring in the roles of race/ethnicity and socioeconomic status. *Journal of health care for the poor and underserved*, 22(3), 1075-1100.
- Leibowitz R., Day S. & Dunt D. (2003). A Systematic Review of the Effect of Different Models of After-Hours Primary Medical Care Services on Clinical Outcome, Medical Workload and Patient and GP Satisfaction. *Family Practice*, 20(3), 311–317.
- Levesque, J. F., Haggerty, J. L., Hogg, W., Burge, F., Wong, S. T., Katz, A., ... & Pineault, R. (2015). Barriers and Facilitators for Primary Care Reform in Canada: Results from a Deliberative Synthesis across Five Provinces. *Healthcare policy*, 11(2), 44-57.
- Liddy, C., Singh, J., Hogg, W., Dahrouge, S., & Taljaard, M. (2011). Comparison of primary care models in the prevention of cardiovascular disease-a cross sectional study. *BMC family practice*, 12(1), 114.
- Lieu, T. A., Newacheck, P. W., & McManus, M. A. (1993). Race, ethnicity, and access to ambulatory care among US adolescents. *American Journal of Public Health*, 83(7), 960-965.
- Manitoba eHealth. (2018). *EMR Adoption Program*. Retrieved from <http://www.manitoba-ehealth.ca/emr-pcis-adopt.html> on May 22, 2018.
- Manns, B. J., Tonelli, M., Zhang, J., Campbell, D. J., Sargious, P., Ayyalasomayajula, B., ... & McBrien, K. (2011). Enrolment in primary care networks: impact on outcomes and

- processes of care for patients with diabetes. *Canadian Medical Association Journal*, 190(23), 1-9.
- Marchildon, G. P., & Hutchison, B. (2016). Primary care in Ontario, Canada: New proposals after 15 years of reform. *Health Policy*, 120(7), 732-738.
- Marshall, E.G. (2015). *MAAP: Model & Access Atlas to Primary Care in Nova Scotia & PEI*. Presentation October 2, 2015. Retrieved from <https://pei.cfpc.ca/wp-content/uploads/2016/02/MAAP-NS-and-PEI-introduction-Oct-2-2015.pdf> on December 1, 2017.
- Mayberry, R. M., Mili, F., & Ofili, E. (2000). Racial and ethnic differences in access to medical care. *Medical Care Research and Review*, 57(1), 108-145.
- McIssac, W.J., Fuller-Thomson, E., Talbot, Y.. (2001). Does having regular care by a family physician improve preventive care? *Can. Fam. Physician* 47, 70 -76.
- McIsaac, W.J., Goel, V., & Naylor, D. (1997). Socio-economic status and visits to physicians by adults in Ontario, Canada. *Journal of Health Services Research*, 2(2), 94-102.
- McMaster University Maps, Data and GIS Centre. (2016). *Statistics Canada Canadian Community Health Survey, 2013-2014: Annual Component Study Documentation*. Retrieved from <http://gsg.uottawa.ca/data/open/csi/cchs-82M0013-E-2013-2014-Annual-component.pdf> on October 16, 2017.
- Misener, R. M., MacLeod, M. L., Banks, K., Morton, A. M., Vogt, C., & Bentham, D. (2008). There's Rural, and Then There's Rural?: advice from nurses providing primary healthcare in northern remote communities. *Canadian Journal of Nursing Leadership*, 21(3), 54-63.

- Moore, D. G., Wilson, D. R., Cave, A. J., Lyons, S. C. W., & Donoff, M. G. (2007). Improving the Quality and Capacity of Canada's Health Services: Primary Care Physician Perspectives. *Healthcare Policy*, 3(2).
- Muggah, E., Dahrouge, S., & Hogg, W. (2012). Access to primary health care for immigrants: results of a patient survey conducted in 137 primary care practices in Ontario, Canada. *BMC family practice*, 13(1), 128.
- Newbold, K. B., & Danforth, J. (2003). Health status and Canada's immigrant population. *Social science & medicine*, 57(10), 1981-1995.
- Newfoundland and Labrador Medical Association. (2010) *Fact Sheet- Primary Care*. Retrieved from <http://www.nlma.nl.ca/Advocacy/Public-Info-Sessions/Family-Medicine> on December 1, 2017.
- Noone, J. H., & Stephens, C. (2008). Men, masculine identities, and health care utilisation. *Sociology of health & illness*, 30(5), 711-725.
- North, D. C. (1990). *Institutions, institutional change and economic performance*. Cambridge: Cambridge University Press.
- Olah, M. E., Gaisano, G., & Hwang, S. W. (2013). The effect of socioeconomic status on access to primary care: an audit study. *Canadian Medical Association Journal*, 185(6), 263-269.
- Ontario Ministry of Health and Long-Term Care. (2002). *Ministry of Health and Long-Term Care: 2002-2003 Business Plan*. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/plans/bplan_2002_03.pdf on April 30, 2018.
- Ontario Ministry of Health and Long-Term Care. (2000). *Ministry of Health and Long-Term Care: 2001-2002 Business Plan*. Retrieved from

http://www.health.gov.on.ca/en/common/ministry/publications/plans/bplan_2001_02.pdf
on April 30, 2018.

Osborn, R., Moulds, D., Squires, D., Doty, M. M., & Anderson, C. (2014). International survey of older adults finds shortcomings in access, coordination, and patient-centered care. *Health Affairs*, 33(12), 2247-2255.

Ouimet, M. J., Pineault, R., Prud'homme, A., Provost, S., Fournier, M., & Levesque, J. F. (2015). The impact of primary healthcare reform on equity of utilization of services in the province of Quebec: a 2003–2010 follow-up. *International journal for equity in health*, 14(1), 139.

Pompey, M. P., Morgan, S., Church, J., Forest, P. G., Lavis, J. N., McIntosh, T., Smith N., Petrela J., Martin E., & Dobson, S. (2010). Do provincial drug benefit initiatives create an effective policy lab? The evidence from Canada. *Journal of health politics, policy and law*, 35(5), 705-742.

Premji, K., Ryan, B. L., Hogg, W. E., & Wodchis, W. P. (2018). Patients' perceptions of access to primary care: Analysis of the QUALICOPC Patient Experiences Survey. *Canadian Family Physician*, 64(3), 212-220.

Provincial and Territorial Ministers of Health. (2000, June). *Understanding Canada's Health Care Costs: Interim Report*. Retrieved from <http://www.scics.gc.ca/CMFiles/Conferences/850080012e.pdf> on May 31, 2017.

Redondo-Sendino, Á., Guallar-Castillón, P., Banegas, J. R., & Rodríguez-Artalejo, F. (2006). Gender differences in the utilization of health-care services among the older adult population of Spain. *BMC Public Health*, 6(1), 155.

- Romanow, R. (2002). *Building on Values: The Future of Health Care in Canada – Final Report*. Commission on the Future of Health Care in Canada. Retrieved from <http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf> on November 2, 2015.
- Roos, L. L., & Walld, R. (2007). Neighbourhood, family and health care. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, 54-61.
- Rosser, W. W., Colwill, J. M., Kasperski, J., & Wilson, L. (2011). Progress of Ontario's family health team model: a patient-centered medical home. *The Annals of Family Medicine*, 9(2), 165-171.
- Salisbury C., & Munro J. (2002). Walk-In Centres in Primary Care: A Review of the International Literature. *British Journal of General Practice*. Vol 53: 53–59.
- Sanmartin, C., Gendron, F., Berthelot, J.M., Murphy, K., (2004). *Access to Health Care Services in Canada. Statistics Canada Cat. no. 82-575-XIE*. Retrieved from <http://publications.gc.ca/collections/Collection/Statcan/82-575-X/82-575-XIE2006001.pdf> on June 21, 2018.
- Sanmartin, C., & Ross, N. (2006). Experiencing difficulties accessing first-contact health services in Canada: Canadians without regular doctors and recent immigrants have difficulties accessing first-contact healthcare services. Reports of difficulties in accessing care vary by age, sex and region. *Healthcare Policy*, 1(2), 103.
- Sans-Corrales M., Pujol-Ribera E., Gene-Badia J., Pasarín-Rua M. I., Iglesias-Pérez B., & Casajuana-Brunet J. (2006). Family medicine attributes related to satisfaction, health and costs. *Family Practice*, 23(3), 308-316.
- Sarma, S., Devlin, R. A., & Hogg, W. (2010). Physician's production of primary care in Ontario, Canada. *Health Economics*, 19(1), 14-30.

- Selby, E. (2014, Mar. 18). "Budget Debate". Manitoba. Legislative. *Edited Hansard* 40th 3rd session. Retrieved from http://gov.mb.ca/legislature/hansard/40th_3rd/vol_31/h31.html on May 31, 2018.
- Setia, M. S., Quesnel-Vallee, A., Abrahamowicz, M., Tousignant, P., & Lynch, J. (2011). Access to health-care in Canadian immigrants: a longitudinal study of the National Population Health Survey. *Health & social care in the community*, 19(1), 70-79.
- Schoen, C., Osborn, R., Squires, D., Doty, M. M., Pierson, R., & Applebaum, S. (2010). How health insurance design affects access to care and costs, by income, in eleven countries. *Health Affairs*, 29(12), 2323-2334.
- Shah, B. R., Gunraj, N., & Hux, J. E. (2003). Markers of access to and quality of primary care for aboriginal people in Ontario, Canada. *American journal of public health*, 93(5), 798-802.
- Shi, L., Chen, C. C., Nie, X., Zhu, J., & Hu, R. (2014). Racial and socioeconomic disparities in access to primary care among people with chronic conditions. *The Journal of the American Board of Family Medicine*, 27(2), 189-198.
- Sibley, L. M., & Glazier, R. H. (2009). Reasons for self-reported unmet healthcare needs in Canada: a population-based provincial comparison. *Healthcare Policy*, 5(1), 87.
- Sibley, L. M., & Weiner, J. P. (2011). An evaluation of access to health care services along the rural-urban continuum in Canada. *BMC Health Services Research*, 11(1), 20.
- Smith, K. B., Humphreys, J. S., & Wilson, M. G. (2008). Addressing the health disadvantage of rural populations: how does epidemiological evidence inform rural health policies and research? *Australian Journal of Rural Health*, 16(2), 56-66.

- Smith, N., Mitton, C., Davidson, A., & Williams, I. (2014). A politics of priority setting: Ideas, interests and institutions in healthcare resource allocation. *Public Policy and Administration, 29*(4), 331-347.
- Shields, M., & Shooshtari, S. (2001). Determinants of self-perceived health. *Health reports, 13*(1), 35.
- Sixsmith, J., & Murray, C. D. (2001). Ethical issues in the documentary data analysis of Internet posts and archives. *Qualitative Health Research, 11*(3), 423-432.
- Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly, Vol 83*(3):457-502.
- Statistics Canada. (2015a). *Canadian Community Health Survey*. Retrieved from <http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3226> on November 18, 2015.
- Statistics Canada. (2015b). *Access to a regular medical doctor, 2014*. Retrieved from <https://www.statcan.gc.ca> on November 17, 2017.
- Statistics Canada. (2015, June). *Canadian Community Health Survey (CCHS): Annual Component, 2013-2014: Common Content: Derived Variable (DV) Specifications*.
- Stevens, G. D., & Shi, L. (2003). Racial and ethnic disparities in the primary care experiences of children: a review of the literature. *Medical Care Research and Review, 60*(1), 3-30.
- Strumpf, E., Ammi, M., Diop, M., Fiset-Laniel, J., & Tousignant, P. (2016). The Impact of Team-Based Primary Care on Health Care Services Utilization and Costs: Quebec's Family Medicine Groups.
- Strumpf, E., Levesque, J. F., Coyle, N., Hutchison, B., Barnes, M., & Wedel, R. J. (2012). Innovative and diverse strategies toward primary health care reform: lessons learned from

- the Canadian experience. *The Journal of the American Board of Family Medicine*, 25(1), 27-33.
- Suter, E., Misfeldt, R., Mallinson, S., Wilhelm, A., Boakye, O., Marchildon, G., Kendel, D., Nasmith, L., Wong, S., & Lai, D. (2014). *Comparative Review of the Policy Landscape of Team-based Primary Health Care Service Delivery in Western Canada*. Retrieved from <https://www.albertahealthservices.ca/assets/info/res/if-res-wre-policy-final-report-2014.pdf> on May 31, 2018.
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics: Fifth Edition*. Boston, MA: Allyn and Bacon.
- Talbot, Y., Fuller-Thomson, E., Tudiver, F., Habib, Y., & McIsaac, W. J. (2001). Canadians without regular medical doctors. Who are they?. *Canadian Family Physician*, 47(1), 58-64.
- Tang, S., & Browne, A. J. (2008). 'Race' matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity & Health*, 13(2), 109-127. doi:10.1080/13557850701830307.
- Tepper, J. (2004). *The Evolving Role of Canada's Family Physicians: 1992 – 2001*. CIHI: Ottawa Retrieved from https://secure.cihi.ca/free_products/PhysiciansREPORT_eng.pdf on March 3, 2018.
- Thompson, A. E., Anisimowicz, Y., Miedema, B., Hogg, W., Wodchis, W. P., & Aubrey-Bassler, K. (2016). The influence of gender and other patient characteristics on health care-seeking behaviour: a QUALICOPC study. *BMC Family Practice*, 17(1), 38.
- Tourigny, A., Aubin, M., Haggerty, J., Bonin, L., Morin, D., Reinharz, D., ... & Benounissa, Z. (2010). Patients' perceptions of the quality of care after primary care reform: Family medicine groups in Quebec. *Canadian Family Physician*, 56(7), 273-282.

- Tregillus, V., & Cavers, W. (2011). General practice services committee: improving primary care for BC physicians and patients. *Healthcare Quarterly*, 14, 1-6.
- Tuohy, C. (1999). The Dynamics of Change in Health Care Arena in the United States, Britain, and Canada. *Accidental Logics*. New York: Oxford University Press.
- Tuohy, C. H. (2012). Reform and the politics of hybridization in mature health care states. *Journal of Health Politics, Policy and Law*, 37(4), 611-632.
- Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health*. San Francisco, CA: JosseyBass.
- Veugelers, P. J., Yip, A. M., & Elliott, D. C. (2003). Geographic variation in health services use in Nova Scotia. *Chronic Diseases and Injuries in Canada*, 24(4), 116.
- Walt, G. (1994). *Health policy: an introduction to process and power*. Zed Books.
- Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*. Vol 9(4): 353-370.
- Walt, G., Shiffman, J., Schneider, H., Murray, S. F., Brugha, R., & Gilson, L. (2008). 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning*. Vol 23(5): 308-317.
- Wang, L., Rosenberg, M., & Lo, L. (2008). Ethnicity and utilization of family physicians: A case study of Mainland Chinese immigrants in Toronto, Canada. *Social Science & Medicine*, 67(9), 1410-1422.
- Watson, D., Broemeling, A. M., & Wong, S.. (2009). A results-based logic model for primary healthcare: a conceptual foundation for population-based information systems. *Healthcare Policy*. Vol 5: 33-46.

- Watson, D. E., Katz, A., Reid, R. J., Bogdanovic, B., Roos, N., & Heppner, P. (2004). Family physician workloads and access to care in Winnipeg: 1991 to 2001. *Canadian Medical Association Journal*, 171(4), 339-342.
- Weaver, R. G., Manns, B. J., Tonelli, M., Sanmartin, C., Campbell, D. J., Ronksley, P. E., ... & Hemmelgarn, B. R. (2014). Access to primary care and other health care use among western Canadians with chronic conditions: a population-based survey. *Canadian Medical Association Open Access Journal*, 2(1), 27-34.
- Wilson, K., & Rosenberg, M. W. (2004). Accessibility and the Canadian health care system: squaring perceptions and realities. *Health Policy*, 67(2), 137-148.
- Winnipeg Regional Health Authority. (2012). *Shared Mental Health Care Program: Evaluation Report*. Retrieved from http://www.wrha.mb.ca/staff/familyphysicians/files/SC_Eval_May5-2012.pdf on May 22, 2018.
- Winnipeg Regional Health Authority. (2013). *Getting the right care*. Retrieved from <http://www.wrha.mb.ca/wave/2013/07/letter-from-whr.php> on May 25, 2018.
- Winnipeg Regional Health Authority. (2018). *MyRightCare.ca*. Retrieved from <http://www.myrightcare.ca/> on May 22, 2018.
- Winnipeg Regional Health Authority. (n.d). *Community Mental Health Program: Shared Mental Health Care – Fact Sheet*. Retrieved from <http://www.wrha.mb.ca/prog/mentalhealth/files/SharedCareFactSheet.pdf> on May 22, 2018.

- Witmer, E. (2000, Apr. 4). "Health Care." Ontario. Legislative Assembly. *Edited Hansard col 1450*. Retrieved from the Government of Ontario website: <http://hansardindex.ontla.on.ca/hansardeissue/37-1/1035.htm>.
- Wong, S. T., Chau, L. W., Hogg, W., Teare, G. F., Miedema, B., Breton, M., ... & Cooke, T. (2015). An international cross-sectional survey on the Quality and Costs of Primary Care (QUALICO-PC): recruitment and data collection of places delivering primary care across Canada. *BMC family practice, 16*(1), 20.
- Wong, S. & Regan, S. (2009). Patient perspectives on primary health care in rural communities: effects of geography on access, continuity and efficiency. *Rural and Remote Health*. Retrieved from <https://open.library.ubc.ca/cIRcle/collections/> on November 13, 2017.
- Wong, S. T., Watson, D. E., Young, E., & Regan, S. (2008). What do people think is important about primary healthcare?. *Healthcare Policy, 3*(3), 89.
- Wood-Ritsatakis, A., & Makara, P. (2009). *Gaining health: analysis of policy development in European countries for tackling noncommunicable diseases*. WHO Regional Office Europe.
- World Health Organization (1978). Alma Ata Declaration. *Geneva: World Health Organization*.
- Wranik, D. W., & Durier-Copp, M. (2010). Physician remuneration methods for family physicians in Canada: expected outcomes and lessons learned. *Health Care Analysis, 18*(1), 35-59.
- Wu Z, Penning MJ, Schimmele CM. (2005). Immigrant status and unmet health care needs. *Canadian Journal of Public Health, 96*, 369–373.