

Exploring Context and the Factors Shaping Team-Based Primary Healthcare Policies in Three Canadian Provinces: A Comparative Analysis

Explorer le contexte et les facteurs qui façonnent les
politiques des équipes de soins primaires dans trois
provinces canadiennes : une analyse comparative



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Exploring Context and the Factors Shaping Team-Based Primary Healthcare Policies

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Abstract

This paper discusses findings from a high-level scan of the contextual factors and actors that influenced policies on team-based primary healthcare in three Canadian provinces: British Columbia, Alberta and Saskatchewan. The team searched diverse sources (e.g., news reports, press releases, discussion papers) for contextual information relevant to primary healthcare teams. We also conducted qualitative interviews with key health system informants from the three provinces. Data from documents and interviews were analyzed qualitatively using thematic analysis. We then wrote narrative summaries highlighting pivotal policy and local system events and the influence of actors and context. Our overall findings highlight the value of reviewing the context, relationships and power dynamics, which come together and create “policy windows” at different points in time. We observed physician-centric policy processes with some recent moves to rebalance power and be inclusive of other actors and perspectives. The context review also highlighted the significant influence of changes in political leadership and prioritization in driving policies on team-based care. While this existed in different degrees in the three provinces, the push and pull of political and professional power dynamics shaped Canadian provincial policies governing team-based care. If we are to move team-based primary healthcare forward in Canada, the provinces need to review the external factors and the complex set of relationships and trade-offs that underscore the policy process.

Résumé

Cet article aborde les résultats d'un examen poussé des facteurs contextuels et des acteurs qui influencent les politiques des équipes de soins primaires dans trois provinces canadiennes : la Colombie-Britannique, l'Alberta et la Saskatchewan. L'équipe a étudié plusieurs sources (p. ex., les informations de presse, les communiqués de presse et les documents de travail) pour obtenir de l'information contextuelle pertinente sur les équipes de soins primaires. Nous avons aussi mené des entrevues qualitatives auprès d'informateurs clés des systèmes de santé des trois provinces. Les données provenant des documents et des entrevues ont été analysées qualitativement au moyen d'une analyse thématique. Nous avons ensuite rédigé des résumés qui soulignaient les politiques clés et les événements locaux des systèmes ainsi que l'influence des acteurs et du contexte. Nos conclusions générales soulignent la valeur de la revue du contexte, des relations et des dynamiques de pouvoir, qui s'unissent pour créer des « fenêtres politiques » à divers moments. Nous avons observé des processus politiques centrés sur les médecins dans certaines initiatives récentes visant à rééquilibrer le pouvoir et à être plus inclusives face aux autres acteurs et points de vue. La revue du contexte a aussi permis de souligner l'influence des changements dans le

leadership politique et la priorisation des forces politiques pour les équipes de soins. Bien que cela soit présent à divers degrés dans les trois provinces, les forces politiques et les dynamiques de pouvoir donnent forme aux politiques provinciales canadiennes qui gouvernent les équipes de soins. Si l'on souhaite l'avancement des équipes de soins primaires au Canada, les provinces doivent réviser les facteurs externes et l'ensemble complexe de relations et de compromis qui sous-tendent les processus politiques.

Introduction

Over a decade ago, Canada's First Ministers agreed to make team-based care a central component of healthcare reform. In 2003, they agreed to ensure that Canadians will receive care from multidisciplinary primary healthcare organizations or teams (Health Council of Canada 2005). Teams were defined in the reforms as two or more healthcare providers providing services in a coordinated and integrated manner for the patient's basic healthcare (Health Council of Canada 2009). Substantial resources, via the Primary Care Transition Fund, were allocated to projects piloting multidisciplinary, team-based models of primary care (Herbert 2005; Watson and Wong 2005). These initiatives recognized the potential of creating primary care teams to work together and better address the needs of primary care populations with chronic, complex health conditions.

The growing evidence base suggests that multidisciplinary teams improve care quality and outcomes for patients with complex care needs, job satisfaction among healthcare providers and can improve co-ordination of care and reduce costs (Harris et al. 2016). However, despite Canada's early enthusiasm and investments, team-based primary healthcare was not widely implemented. Instead, team-based primary care remains a patchwork of local reforms and pilot studies (Aggarwal and Hutchison 2012; Hutchison 2008; Levesque et al. 2012).

In Canada, the provinces and territories have jurisdiction over health policy development and implementation, and this includes primary healthcare services. In Canada, team-based care operates under the 1984 *Canada Health Act*, which stipulates that provinces pay for hospital and physician services in return for transfer payments for health services (Deber et al. 2010; Marchildon 2013). The services of many non-physician out-patient healthcare providers (e.g., chiropractors) may be funded or subsidized by the provinces whereby physician private practices for medically necessary care are required to be funded through public funds. Thus, the composition of the "team" and how different members are funded depends on provincial/territorial prioritization. Consequently, different definitions and configurations of team-based primary care have emerged across provincial policies and have varying degrees of successful implementation (Zygmunt and Berge 2014). Given even these high-level issues, the reality is that choices on implementing teams-based services are made within a context of available resources, health human resource capacity and distribution, professional power dynamics, payment models, demographics, geography and the demands and health needs of the public.

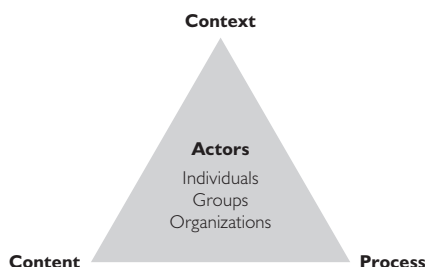
It is therefore reasonable to assume that differences in approach and progress in team-based care have arisen because of differences in provincial context. What we do not know is which elements of context have an important influence on policy development. To support the development of policy options to move team-based care forward, a better understanding of the dynamics between local actors and local policy history is important.

To this end, we conducted a case-study review of policy evolution in three western Canadian provinces – Alberta, British Columbia and Saskatchewan. We aimed to identify and review diverse evidence on the people and events shaping team-based primary health-care alongside formal policies produced and implemented in a particular time period. In this paper, we present the findings from the provincial context reviews and the interviews with key informants about the potential drivers of policy on team-based primary healthcare services. While policy is often the product of complex pressures and myriad influences (see the full report Suter et al. 2014), the focus on actors and context is relatively novel as part of traditional policy analysis and has implications for future cross-provincial policy development initiatives.

Methods

There are several conceptual frameworks for conducting research on policy but for this study we selected the policy triangle framework (Walt and Gilson 1994). The framework (Figure 1) incorporates an analysis of actors and the social, political, economic and cultural contexts in which policy is created (Walt and Gilson 1994).

FIGURE 1. Policy triangle



Source: Walt and Gilson (1994).

Our research was primarily a comparative policy analysis and our key aim was to review and compare existing policy documents in different places. However, our interest in reviewing policies in the light of broader information about the policy landscape in which they had evolved meant we needed to be selective about our study sites. For this reason, we used a case-study approach. Case studies can provide a rich understanding of social phenomena within their own context (Yin 2011). They have been shown to be particularly useful in understanding the factors that shape health policy (Crowe et al. 2010; Gilson 2012). We chose the three Western Canadian provinces – British Columbia, Alberta and Saskatchewan – because they have important differences in how they organize and deliver primary healthcare and their strategic plans.

Using the policy triangle framework, we aimed to compare the policies, considering the context in which they developed and highlight common and divergent themes (Suter et al. 2014). It encouraged us to look beyond the policies themselves and consider underlying relationships and power dynamics (Suter et al. 2014).

To support the work and ensure its relevance to policy makers in the provinces, an advisory team comprising knowledge users and academic researchers was established (Suter et al. 2014). The research and knowledge users who advised us represented a range of perspectives including academics, private consultants, provincial Ministries of Health, health regions and professional organizations. The advisory committee had equitable representation from the three provinces.

The advisory team met with the core research team every one to two months to offer advice on several aspects of the research project including the parameters for the context review, for instance, news stories and documents, the search strategy and our analytical templates. The core research team, who were responsible for data collection and analysis, comprised five researchers from Alberta Health Services (Suter et al. 2014).

Document Review

The members of our advisory team recommended a high-level scan of *Health Edition* (no longer operating), which was a news repository on key health issues from across Canada. We systematically searched the website to identify the social, political and economic dimensions such as political leadership and strategic direction, financial and non-financial resource availability, demographic shifts and professional lobbying that influenced primary healthcare service delivery in the three provinces. We focused our searches on information from 2007 to 2014 to limit the data collection. However, key events that occurred earlier but have impact that extend into our time frame were included – thus enlarging our time frame to 2000. Our inclusion criteria also included documents that were written in English and had a substantial focus on the strategies for primary healthcare reform in Alberta, British Columbia and Saskatchewan and/or the contextual factors that drove policy development (e.g., politics). Any documents identified in the scan (e.g., review papers/briefings, sections from relevant policy documents, peer-reviewed journal articles, media articles, book chapters, editorials and opinion pieces) were also included in our analysis.

We created and used an appraisal tool to judge the relevancy of the documents, the type of document, the focus of the document, the main message and the setting of the document. One researcher filled in the appraisal tool and another researcher validated it. If there was agreement between the researchers, the document was included in the case study review. Any disagreements about the inclusion of documents were resolved at team meetings.

We developed an analytical template to extract and summarize the relevant information on the contextual factors and the role of key actors that set the direction of policy on team-based primary healthcare. Sub-sections of the template included the following: politics, society and culture, economic, service delivery and health profession relationships and values

(Suter et al. 2014). One researcher extracted the information and a second researcher verified the accuracy of the information within the subsection. We settled any disagreements through team meetings. In all, we retrieved 176 news items and source documents (Table 1). We deemed only 119 of these to be relevant to our study. We used these news items and source documents to write succinct two-page narratives of the policy landscapes in each of the three provinces that included a timeline and description of key provincial policies, events and key actors.

TABLE 1. News items captured and screened for relevancy

Province	Number of news items retrieved	Number of news items deemed relevant
British Columbia	41	30
Alberta	85	52
Saskatchewan	50	37
Total	176	119

Key informant interviews

With the help of our advisory team, we identified a purposive sample of key informants who had intimate knowledge of the policy landscape for team-based primary healthcare in their own province. They were invited to participate by e-mail. We sent them participant information, consent forms and the narrative summary of the policy context for their province.

In all, we conducted 30 telephone key informant interviews with provincial stakeholders (Alberta $n = 10$, British Columbia $n = 9$, Saskatchewan $n = 11$). The primary affiliation of the key informants is as follows: Ministries or Departments of Health ($n = 5$), professional colleges or associations ($n = 5$), primary care services ($n = 4$), universities ($n = 5$) and health regions ($n = 8$). Two of the key informants were private healthcare consultants. All of the key informants from the provincial Ministries and Departments of Health, regional health authorities, primary healthcare organizations and provincial professional associations had senior positions within their organizations (e.g., director, registrar, medical director, executive director, president). Although they had primary affiliation with an organization or health region, several ($n = 5$) of the key informants were also practising family physicians. One key informant was also a practising nurse practitioner.

Using the narrative summaries of the policy landscape we had written and an open-ended topic guide, we asked the key informants to consider contextual factors and the key actors influencing primary healthcare policy within their respective provinces. The interviews took approximately 30 minutes to one hour to complete. They were questioned about the direction being taken in their province on team-based primary healthcare including the key drivers and the key actors. The goal was to elicit a more in-depth and enriched account of policy development. We recorded and transcribed the interviews verbatim and then conducted a thematic analysis. This involved an initial reading and independent marking of a sample of transcripts, a discussion within the team to agree to key themes and finally the construction of thematic

tables to summarize relevant data from each interview (Ritchie and Lewis 2003). The final thematic tables included *a priori* themes (e.g., resource availability, key actors, demographics, political leadership) and themes that had emerged from the interviews. Two researchers were responsible for analyzing each province. One team member was responsible for analyzing transcripts in each province and entering data into an analytical template. The second team member also read through the transcripts and checked and validated their thematic analysis summary. Team members were available for discussion of any queries about analysis and any disagreements of interpretation were resolved through team discussion.

We revised our provincial narratives based on the in-depth information provided by the key informants. We also sent the key informants the final analytical paper for their review and validation. The details on our analytical templates are available in our full report (Suter et al. 2013).

Ethics

We obtained ethics approval from the University of Calgary Conjoint Health Research Ethics Board, the University of British Columbia Behavioural Research Ethics Board and the Universities of Regina and Saskatchewan Ethics Boards. We gained operations approval from the different participating health authorities.

Results

Improving access to appropriate care providers, enabling the effective use of available resources and supporting patients with managing their chronic disease is embedded in the primary healthcare policies of all three provinces (Alberta Health 2014; British Columbia Ministry of Health 2007; Saskatchewan Ministry of Health 2012). These principles, while incorporated into provincial policies (Suter et al. 2014), did not necessarily translate into the full spread of team-based care within the provinces. The following narratives for British Columbia, Alberta and Saskatchewan outline several potential explanations for this apparent disconnect between policy intent and practice (see Table 2 on page 87 for a summary). Timelines for these events can be found in our report (Suter et al. 2014).

British Columbia case study

British Columbia (BC) set a provincial vision for team-based primary healthcare within its *Primary Healthcare Charter* (herein referred to as the *Charter*) in 2007 (British Columbia Ministry of Health 2007). However, even with an overarching policy in place early on, this did not lead to a transformative approach to primary healthcare reform or to the systematic implementation of team-based care (Cavers et al. 2010). The consensus from several key informants was that team-based care only existed in pockets across the province (BC02, BC03, BC04).

The key informants gave several potential reasons why team-based primary healthcare may have failed to spread within British Columbia. One issue they raised was that historically the province focused on incentives for full-service family practice that did not include

team-based care. In 2002, the provincial government set up the General Practice Services Committee (GPSC) under a working agreement with the Doctors of BC (then the British Columbia Medical Association) (Tregillus and Cavers 2011). This approach served to mediate the traditional adversarial relationship between the Ministry of Health and the Doctors of BC (Tregillus and Cavers 2011). The GPSC gave physicians access to dedicated funds by the Ministry of Health aimed at improving family physician practice. Several key informants (BC03, BC01, BC08) noted that physicians had regular opportunities to meet with senior government officials through the GPSC, allowing them to influence the direction of primary healthcare reform. Two key informants (BC01, BC2) noted that although the GPSC is not a policy body per se, it was nevertheless influential because dedicated funds flow through it to facilitate the development of primary healthcare. The lack of representation by other providers and stakeholders in decision-making potentially shaped the direction of policy on team-based care. This perspective was expressed by one key informant below:

I think what needs to happen in BC is we need to make sure we really are getting all these stakeholders to the table and that we're giving them a voice and not just the lip service because many of these policies are very much driven by what medicine needs, not what patients need (BC07).

In 2003, the GPSC launched the Full Service Family Practice initiative to provide financial incentives for family physicians to address key health priority areas within their clinical practice (Lavergne et al. 2014). These included services for patients with complex health needs, maternity care, chronic disease management, care of frail elderly and end-of-life care, preventive services and mental health services (Lavergne et al. 2014). One evaluation of the Full Service Family Practice points to a high uptake of these incentives by physicians that translated into improved access to these services (Hollander 2009). The 2014 *Master Agreement* between physicians and the government included funding for “increased multidisciplinary care between General Practitioners and other healthcare providers” (Government of British Columbia 2014). However, this did not translate into incentives for physicians to contract with other providers or to build teams into their practice. The following quote from one key informant typifies this sentiment:

There's a whole kind of network of programs around incentivizing primary care for physicians. And that I think has been really driven through a policy lens that's trying to get physicians to provide broader care, more holistic care, and really for physicians to lead the charge in this way from a physician-led model, not a team-based model (BC03).

In 2007, the province adopted the *Charter* as a means of outlining the existing primary healthcare challenges in the province and a strategic plan to address them (British Columbia

Ministry of Health 2007). Although many stakeholder groups were part of the crafting of the *Charter*, physicians are explicitly stated as the cornerstone of primary healthcare in the *Charter* (British Columbia Ministry of Health 2017). For several key informants, this set the subsequent policies in resource allocation for primary healthcare, including team-based care. According to one key informant, with funding flowing primarily to physicians, other providers (e.g., nurse practitioners) did not receive the same support (BC03). This raised issues for access to primary healthcare services. The key informant stated that: “physicians are the hub of the circle and it’s really expensive and it’s not very effective because in some communities we can’t get physicians” (BC03).

Physicians who wanted to adopt the team-based model in their clinic often faced variability in the availability of funding streams to support the hiring of other providers (BC08). Other providers such as nurse practitioners, were at times funded through the health regions to work in primary healthcare clinics. However, access to funding to support their services (e.g., salaries, clinic overhead and infrastructure) was uneven in the province and there were only pockets of uptake of nurse practitioner services (BC05, BC07, BC08).

In 2008, two key events took place. British Columbia passed an amendment to the *Health Professions Act* to move interprofessional collaboration forward. More specifically, in the *Act*, the province’s health professional regulatory colleges are encouraged to promote and enhance the following: “(ii) interprofessional collaborative practice between its registrants and persons practising another health profession” (Government of British Columbia 1996). Also in 2008, the GPSC launched the Divisions of Family Practice to improve patient care, increase the influence of family physicians on healthcare delivery and policy and enhance professional satisfaction for physicians. Yet the province did not direct resources for the Divisions toward team-based services; rather, resources were allocated for physician incentives. According to one key informant, it was during this time that the model of team-based care began to falter in the province:

I think we saw the implementation of the Divisions of Family Practice, incentives for GPs to provide better care for lack of a better word and we also at the same time saw a fall off of the inter-professional movement in BC. It seemed to fall off the radar screen and it hasn’t really revived since that time (BC07).

While the *Charter* itself was not updated, team-based primary healthcare emerged in recent policies. For example, team-based care was an objective in the Ministry of Health’s 2014 *Service Plan* (British Columbia Ministry of Health 2014). This signalled an incremental move toward embedding team-based primary healthcare in policy during our study period.

Alberta case study

Alberta has a history of implementing primary healthcare teams through the introduction of the Primary Care Networks (PCNs) in 2005. During that period, Alberta’s approach was to

change the structures for delivering team-based services without any overarching policies to guide this process. It was not until 2014 that Alberta introduced their *Primary Healthcare Strategy* (herein referred to as the *Strategy*) to frame primary healthcare reform in the province (Alberta Health 2014). Thus, team-based primary healthcare services existed without an overarching provincial vision.

This lack of a provincial strategy or vision in part shaped how team-based primary health emerged in Alberta. Alberta's approach was to incorporate the First Minister's provincial agreements on promoting team-based care within a new structure. In 2003, the PCNs and the Primary Care Initiative were established through a Master Agreement between the health regions, Alberta Health and the Alberta Medical Association (AMA) (Spenceley et al. 2013). The key aim for PCNs was to improve access and quality of care using primary healthcare teams. Alberta Health allocated funding to PCNs based on patient enrolment, with the expectation that these funds would be used to build teams (Spenceley et al. 2013). Team configuration was set by the mainly physician-led PCN governing boards to reflect local needs (Ludwick 2011). There were exemplars of high functioning team-based care models adopted by PCNs; however, the expectation of team-based care involving a range of providers did not necessarily translate into reality. One key informant described this below:

... have they (PCNs) truly developed inter-professional collaborative practice? I think it's still side by side, working as a team, but in a side by side siloed kind of way, with the physicians for the most part in PCNs (AB05).

Another issue for implementing team-based care is the role of different payment models. For team-based care to flourish in Alberta, physicians needed incentives and explicit expectations for providing services. In the PCN model, for instance, participating PCN clinics were allocated funding for other team members through provincial funding. However, Alberta's family physicians, many of whom worked under the fee-for-service payment model (Canadian Medical Association 2013), needed to first see the patient to be compensated (AB02, AB04, AB07). In other words, even if the appropriate team member was a nurse or mental health therapist, patients were often required to see the physician first.

The key informants wondered whether the lack of a formal policy framework guiding primary healthcare reform might have affected the adoption of team-based primary healthcare. One key informant noted that the PCNs were formed as Alberta's response to the federal funding for team-based care. However, the lack of a coherent vision at the time of PCN implementation led to a "scatter box" approach (AB02). This, in turn, spurred concerns over a lack of accountability for how resources for team-based services were spent by the PCNs. The 2012 Alberta's Auditor General noted significant weaknesses in the accountability structures for the PCNs and recommended that improved structures be in place to create consistent performance management and financial reporting (Auditor General of Alberta 2012).

A number of actions flowed, in part, from the criticisms in the Auditor's report. In 2012, the newly elected premier introduced a new primary care delivery structure to supplement the PCNs, the Family Care Clinics (FCCs), which could be led by nurse practitioners (Alberta Health 2012). Three pilot FCCs were opened in Edmonton, Calgary and Slave Lake, with a second wave of over 80 announced in 2012. Several Alberta key informants argued that the move was the government's response to the Auditor General's report on the PCNs and the need for clear expectations and targets. The strategic plans governing the FCCs emphasized the accountability of the FCC boards to the Ministry of Health and were required to report on performance measurements (Government of Alberta 2013). One key informant noted that: "I think we're now on recalibrate mode and I think FCCs came out as really a very strong pendulum swing toward defining accountability" (AB02).

However, the introduction of the FCCs was not done through a large-scale consultation process and many stakeholders, including physician groups, had issues with the new model. One key informant (AB05) noted that there was a disconnect between those devising the policy and those in the practice or operational arenas. For instance, the FCCs received a lukewarm response from the AMA. The AMA stressed that the FCCs were not new and at best represented an extension of existing care already delivered through PCNs (AMA 2012).

In 2014, Alberta Health introduced the *Strategy* to provide guidance on primary healthcare reform (Alberta Health 2014). A central component of the *Strategy* is team-based care with the actual configuration of teams to be determined by local needs (Alberta Health 2014). There was a range of provider groups involved in the drafting of the *Strategy* through advisory committees including government, the PCNs and community organizations. Nurses and psychologist organizations were also represented on these committees. Compensation models for team-based services are suggested to be flexible, sustainable and provide incentives within the *Strategy*. It also recognizes the FCC model that *may* include physicians, nurses, dietitians, pharmacists, social workers and psychologists in conjunction with the physician-led PCN model (Alberta Health 2014). How these principles translated into the implementation of team-based services in Alberta's primary healthcare services is beyond the time frame of this study.

What we did observe was that political events in 2014 may have created uncertainties about the direction of team-based primary healthcare reform in Alberta. Concurrent with the release of the *Strategy* in the spring of 2014, leadership at the provincial level changed, and the 80 FCCs approved in 2014 were reduced to nine. By the autumn of 2014, Alberta Health announced that the rollout of the FCCs was subject to further review. An explanation for this change in priorities was absent from the public arena at the time.

Saskatchewan case study

Team-based care is a key component of primary healthcare evolution in Saskatchewan. In 2001, the Saskatchewan Commission on Medicare made primary healthcare central to healthcare reform; they invested in “upstream” services that emphasized illness prevention and health promotion (McIntosh and Marchildon 2009). There was also a focus on interdisciplinary teams rather than solo physician practice (McIntosh and Marchildon 2009). The Commission recommended that primary care teams, comprising a variety of primary care providers (e.g., social workers, pharmacists, nurses, mental health workers), work to achieve improved outcomes for patients. The Commission highlighted the traditional fee-for-service model for physicians as a barrier to moving this agenda forward (McIntosh and Marchildon 2009).

In 2002, Saskatchewan released an *Action Plan for Primary Healthcare* (Saskatchewan Ministry of Health 2002). One goal of the *Plan* was to develop an integrated system of health services available on a 24-hour, 7-day-a-week basis through healthcare teams (Saskatchewan Ministry of Health 2002). This prompted the implementation of roughly 40 primary healthcare teams, mainly in rural areas (Hutchison et al. 2011; Marchildon and O’Fee 2007). There is scant information on these teams; however, one key informant (SK10) noted that these teams often comprised solely nurse practitioners and physicians.

There were several drivers noted by the key informants that shaped team-based primary healthcare in the province, including the move toward patient-centred care, supports for chronic disease management and the appropriate use of services (SK02, SK03, SK05, SK09). Yet even with this prioritization, there were issues noted with the system-wide implementation of team-based primary healthcare in Saskatchewan. Team-based care existed in pockets across the province and that team-based care has not been “mobilized successfully across the province” (SK04).

There are several possible reasons for this lack of mobilization; however, these reasons are nuanced for Saskatchewan. The importance of primary healthcare reform in Saskatchewan was highlighted in the *Framework on Primary Healthcare* (herein referred to as the *Framework*) that was released by the Saskatchewan Ministry of Health in 2012 (Saskatchewan Ministry of Health 2012) after an intensive consultation process with a range of stakeholders’ (i.e., facilitated) meetings. Indeed, other providers, patients and community members were actively involved in the development of the *Framework* (SK01, SK03, SK04). The *Framework* provides a high-level strategic plan for implementing primary healthcare services by the regional health authorities. There was general support for the *Framework* among the key informants (SK03, SK04, SK05, SK06, SK08), especially as a key policy for driving team-based primary healthcare forward. For one key informant, the *Framework* signalled the prioritization of primary healthcare reform:

It [the *Framework*] has really brought us all into the spotlight so a lot of the attention ... I think that it’s a great position to be in where we actually can say, this is a provincial priority that needs to be a regional priority and we’re ready (SK03).

Several key informants noted that the *Framework* also focuses on accountability by identifying measures and reporting outcomes (SK08, SK06, SK10). An accountability framework is embedded within the *Framework*, setting up the lines of responsibility between healthcare providers, Regional Health Authorities and the Ministry in meeting several proposed measures of success including access to team-based care (Saskatchewan Ministry of Health 2012).

Historically, primary healthcare did not have as high a priority as acute care. No hard targets were set for primary healthcare whereas other services had clear targets (e.g., surgical wait times) and funding attached to facilitate the change process. One Saskatchewan key informant noted that primary healthcare reform in general was: “not nearly the priority that certain other sectors are ... like wait times for elective surgery” (SK08).

However, even with the degree of prioritization that team-based primary healthcare received, there were some roadblocks to implementation. One of these was the role of physician incentives and payment obstacles in limiting the scale-up of team-based services across the province. For instance, several noted (SK02, SK03, SK05, SK08, SK10) that there was little incentive for physicians to make major changes to their practice and include other providers as team members, especially under the fee-for-service compensation model. One key informant (SK11) noted that the existing policies in Saskatchewan do not allow for the adequate integration of alternative payment models into the healthcare system. The key informant also noted that “... there’s no willingness to consider changing the regulatory framework or specific regulations that would encourage team-based care” in Saskatchewan (SK11). Getting physicians on board with the changes became the focus of the Ministry of Health and health regions and they focused on physician engagement and support – though this did not necessarily come with any changes to existing compensation agreements to support team-based care in physician clinics. For instance, health regions do not have the autonomy to pay physicians alternative compensation models from their budgets.

Even with these challenges, the province moved ahead with implementing team-based services through the establishment of innovation sites in 2012. The innovation sites were the result of partnerships between the communities and First Nations (as applicable) and the regional health authorities to provide team-based care for the local population. The innovation sites received focused investments and supports for the establishment of eight innovation sites for team-based primary healthcare services (Health Council of Canada 2012). Although the key informants (SK04, SK07, SK11) felt that these innovation sites allowed for flexible team configurations based on the needs of the communities, they argued that a strategy for spreading innovation was needed. One key informant noted that, “... there’s way too much focus I think on the innovation sites and not enough focus on supporting the informal innovation and what’s really working out there outside of the innovation sites and spreading that knowledge elsewhere” (SK11).

Exploring Context and the Factors Shaping Team-Based Primary Healthcare Policies

TABLE 2. Summary of contextual drivers and key actors shaping team-based primary healthcare in British Columbia, Alberta and Saskatchewan 2000–2014

Province	Contextual drivers	Key actors
British Columbia	There was little evidence of the prioritization of team-based primary healthcare within the suite of policies. The province focused more on physician incentives for a wider range of primary healthcare services.	Physicians were noted as the “cornerstone” of primary healthcare in the <i>Charter</i> and were pivotal to shaping primary healthcare policies. Resources were earmarked for physician incentives to provide a wide range of primary healthcare services. Other provider groups and community members did not have the same voice when drafting policies or shaping team-based primary healthcare services.
Alberta	Alberta’s direction was to implement physician-led primary healthcare service delivery through the PCNs in the early 2000s. However, there was no overarching provincial framework in place to set out accountabilities. Primary healthcare services became a political issue in the latter years of our study with the introduction of the FCCs in conjunction with the PCNs. While FCCs were listed as an option for team-based primary healthcare services in the <i>Strategy</i> , they were not resourced beyond the three pilots.	The PCNs were physician-led and governed. There was a move to more inclusive policy processes within the <i>Strategy</i> , which had representation from community organizations, nurses, psychologists, government and PCNs. The policies for the FCCs also stressed a role for communities in governance; however, the actual operationalization of this new governance structure is vague.
Saskatchewan	Team-based primary healthcare emerged early in policies in Saskatchewan and was the central tenet of the Framework. Resources were directed to community-designed innovation sites. However, there were some concerns about the prioritization of primary healthcare as compared to more “urgent” health services.	Saskatchewan had a sustained inclusive approach to policy processes with several actors (including community members) at the table when policies were drafted. In the policies, teams must be connected to a family physician; however, team configuration was largely set by local needs and culture (i.e., the inclusion of Aboriginal healers as key team members for some communities). However, there is little information about how these teams emerged across the province.

FCCs = Family Care Clinics; PCNs = Primary Care Networks.

Discussion

Team-based primary healthcare is implemented in a piecemeal manner across Canada. We wanted to understand more about key actors, context, and the evolution of team-based primary healthcare policy. Indeed, primary healthcare reform did not take place in a vacuum. There are several pre-existing limitations on the development of team-based services that require a larger discussion. The provinces are influenced by the tenets of the *Canada Health Act*, which requires public coverage for medically necessary care given by physicians or hospitals (Hutchison 2008). Public payment for other out-patient healthcare providers, such as mental health therapists and physiotherapists, is often determined by a province’s fiscal circumstances, legislation, policies and political priorities and is therefore highly variable across the provinces (Lewis 2015). Any discussion of team-based care needs to be placed within a larger discussion of the role of the complex relationships between social actors. Physician agreements are negotiated between the province and the provincial medical association. Therefore, the provinces build partnerships and negotiate with physicians on primary healthcare reform within their own jurisdiction. For the most part, any changes to the status quo were and are gradually introduced by the provinces to secure physician buy-in and support (Hutchison et al. 2011; Marchildon and Hutchison 2016).

Each province and territory has a set amount of fiscal and human resources, and in some instances, team-based care was introduced to address issues in access to primary healthcare services in some communities – especially those in rural and remote regions. In this respect, nurse-led teams emerged in several Canadian jurisdictions. Team members, however, may also be “add-ons” to clinics to meet the specific needs of the local populations. Thus, the emergence and configuration of team-based care depends largely on what provinces and territories have available. There are a number of pre-existing contextual factors that set the larger stage for if and how team-based services are implemented in Canada.

Our review of context in three case-study provinces mapped the local policy landscape using Walt and Gilson’s policy triangle (Walt and Gilson 1994). Making clear-cut causal statements about the influence of actors and local events is inappropriate given the high-level scan we did, but it gave us insight into the factors that come together and create what Kingdon referred to as “policy windows” (Kingdon 1995). We noted a number of themes that emerged from our document analysis and interviews with key informants. These included: stakeholder relationships, which were felt to be crucial in determining the direction of policy; concern about “who” gets a place at the policy table; and structural issues to moving team-based primary care forward, including historical models of compensation models and a lack of incentive for change.

To an extent, we found the same scenario reported by others (Hutchison et al. 2011; Lavergne et al. 2014). Getting team-based primary healthcare services off the pages of policy and working on the ground was premised on securing the buy-in of physicians. Indeed, the three provinces prioritized relationship building with physician stakeholders (including physician organizations) when designing policies on team-based care, though the degree and type of physician engagement differed. Denis et al. (2013) argued that primary healthcare reform cannot be successful without the support of family physicians, and that they need to be fully engaged in strategies for primary care reform and this was indeed a critical issue for the three provinces.

This physician engagement and relationship building was most visible in BC. Yet there may be some unintended consequences for team-based care. Our BC informants told us that other provider groups such as nurse practitioners did not have the same access to the provincial government and this may limit the discussion about other potential models of primary healthcare service delivery (e.g., nurse practitioner-led teams). In Alberta, the focus was also on physician-led primary care, although there were efforts to expand leadership opportunities to other members of the primary care team. However, Alberta chose to not change the status quo of physician-led primary healthcare services. Even the action taken to ensure inclusive policy making processes in Saskatchewan did not negate the necessity of securing support and buy-in from physicians when it came time to actually implement team-based care.

The implicit linkage between politics and professional power dynamics should prompt Canadian policy makers to reflect on who gets a voice in agenda-setting and policy making. There was a general move toward inclusive policy making. However, it was not clear

to us or to some of the key informants how this worked in practice. For instance, committees were struck in Alberta to draft the *Primary Care Strategy*; however, more needs to be known about what happened within these committees and whether some voices were “louder” than others. Some authors have called for the establishment of mechanisms to ensure representation of all primary health team members on provincial policy committees (DiCenso et al. 2010).

To make team-based healthcare services truly patient-centred, actively engaging patients in policy making is also important because they come with the lived experience of service provision (Lenihan 2012; Mulvale et al. 2015). This requires considerable forethought given the complexity of engagement processes and the resources required. However, truly engaging community members, primary healthcare team members, government and patients will change the dynamics of how we prioritize team-based care and allocate resources (Thurston et al. 2005).

Another key theme that emerged is the need for resources to support team-based services. For instance, a lack of targeted provincial funding can leave physician clinics and health regions care scrambling to resource team-based models of care. We need to have a fulsome discussion about consistent and sustained funding models for team-based services (Clelland 2015). A related issue raised by the key informants is the perpetuation of current compensation models – especially fee-for-service models – and funding streams that do not promote team-based care. Other authors have noted challenges in implementing team-based care when different compensation models and funding streams operate in each province and territory, with no consensus on how this can be reconciled (Reeves 2006; Virini 2012). Interestingly, Alberta’s *Strategy* points to the need for flexibility in compensation models to move team-based care forward (Alberta Health 2014). Yet even with this engrained in policy, changing compensation models (especially fee-for-service) and funding streams are slow to emerge and will require decisive political action. Finally, we noted that a lack of incentives to promote team-based services continues to undermine change efforts. In British Columbia, we observed that resources for team-based services were neglected in favour of physician incentives to provide a wider range of services. When funding for team-based care is directed at physicians, there are limited financial incentives for them to share service provision with other members of the team (Health Council of Canada 2008).

In the end, there are some indications of a lack of spread of high functioning team-based services, with key informants from British Columbia stating that the momentum for team-based services in primary healthcare had effectively stalled in 2014. Alberta and Saskatchewan key informants also noted that there were pockets of excellence in their province, but that successful scale-up had not yet been achieved. The lack of resources may be one. Another may be the need for political action to stimulate policies that move team-based services forward and their effective adoption. This means placing primary healthcare on the political agenda and taking a long-term and sustained approach beyond the short-term political cycles.

Limitations

We heed the cautions set out by Blank and Burau (2013) when they stress that policy development and implementation take place in a highly complex fashion and that understanding the complex interplay between context, actors and policy is challenging. Providing a full and nuanced set of narratives requires careful planning, guidance and resources. Using the policy triangle required considerable thought about the best tools to capture the constant flux of policy development. This is in line with Gilson's (2012) assertion that health policy research be a constant process of conceptualizing and re-conceptualizing. Indeed, we only took a snapshot in time; this limited the extent we were able to analyze the role of the longer-term context that shaped provincial policies (e.g., economic downturns, workforce shortages). Although these issues did not emerge as significant policy drivers in our study, they nevertheless require further exploration.

While we found the framework useful for identifying the high-level issues that require further investigation, we could only tell part of the story about how team-based care emerged in policies. It was very difficult to make explicit connections between events, social actors (along with their motivations and standpoints) and the emergence of policies. Walt et al. (2008) noted the challenges of policy researchers when situated as outsiders to the decision-making process and not being privy to the "behind the scenes" dynamics. They suggest embedding policy researchers within the policy environment to gain access to the meetings and discussions that would provide a more detailed understanding of motivations and intentions and the rationales for policy choices. Finally, policies on team-based care continue to evolve. Our study does not reflect the more recent state of policy drivers in the three provinces.

Conclusion

In the early 2000s, the Canadian provincial/territorial and federal governments agreed to improve access to a multidisciplinary primary healthcare teams (Hutchison 2013). Several authors have argued that Canada still lags behind other countries in reforming primary healthcare (Aggarwal and Hutchison 2012; Hutchison 2013; Johnson and Hogel 2016). Instead, we have a patchwork approach to team-based primary healthcare across the provinces with varying degrees of success. Some of this can be attributed to the provinces designing healthcare systems for their local needs. That said, we observed in our study that there was more at play than the desire to meet local needs. We used the policy triangle to begin disentangling these contextual factors and to identify the key actors who influence policy and resources. Policies on team-based care in the provinces were deeply rooted within pre-existing power dynamics and relationships. The review also highlighted the significant influence of changes in political leadership and prioritization in driving policies on team-based care. Our overall findings highlight the value of reviewing the context, relationships and power dynamics, which come together and create "policy windows" at different points in time. We recommend that policy makers be cognizant of the complex relationships that influence policies governing team-based care to locate possible sticking points in its adoption.

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