



Coordinating primary care services: A case of policy layering

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ARTICLE INFO

Article history:

Received 4 April 2018

Received in revised form 4 November 2018

Accepted 8 December 2018

Keywords:

Policy change

Policy reform

Policy layering

Primary care

Care coordination

ABSTRACT

In this paper, we discuss the processes of policy layering as they relate to health care reform. We focus on efforts to achieve systems of coordinated primary care, and demonstrate that material change can be achieved through processes of incremental policy layering. Such processes also have a high potential for unintended consequences. Thus, we propose new principles of 'smart' policy layering to guide decision-makers to do incrementalism better. We then apply these principles to recent primary care reforms in Ontario, Canada. This paper conceptualizes 'smart' policy layering as a mechanism to achieve productive policy change in contexts with strong institutional barriers to reform.

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1. Introduction

The coordination of primary care services has been a decades-long policy pursuit for high-income countries [1]. Coordination of care lies in the middle ground between service "linkage" among organizations and "full integration" of health and social care sectors [2]. It is a pragmatic approach to improving care that can work within existing systems and structures with the addition of designated individuals to coordinate patient services, share clinical information, and manage transitions between settings. Coordination is most critical in fragmented health care systems and for patients with complex health and social needs that require the timely flow of people and information.

Coordinated health systems require a strong primary care foundation. For many populations, primary care is their most frequent point of contact with the health care system [3] and in some jurisdictions, performs a gatekeeping function for other sectors. General practitioners (GPs) most often deliver primary care services, and historically, GPs have been siloed and focused on delivering episodic care. More recently, international organizations [4,5], commissions [6], and scholars [7–10] have called for

a strengthening and reorientation of primary care systems away from this episodic and siloed care toward a population health focus that involves the coordination of health and social services, and the implementation of team-based models. To support this reorientation, policy interventions have focused on improving coordination through targeted interventions to increase access to broad inter-professional teams that include health and social services; patient rostering to ensure consistency of care; and requiring primary care providers to coordinate care for their patients across the continuum [11,12]. The patient-centred medical home has emerged as a prominent example of how a team of primary care providers, including physicians, nurses and other interdisciplinary providers, can support coordinated care [3].

Although much attention has been given to care coordination and primary care reform more generally, some have noted the slow pace at which it has been achieved [13]. Institutional barriers maintain the status quo and impede the implementation of interventions that promote coordinated primary care [14–16]. In Canada, progress toward coordinated primary care has also been plodding. In their seminal paper, Hutchison et al. discuss how during the formation of Canadian Medicare, a bargain between provincial governments and the medical profession institutionalized private physician practice as the dominant model of health care delivery [13,17]. This is a model where physicians own and operate their own practices, but are publicly funded using fee-for-

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service (FFS) payments. Hutchison et al. suggest that this policy legacy started a path-dependent process of failed reforms in the decades that followed [13]. Hinings et al. explain that physicians have been resistant to “rational planning processes and managerial structures” that aim to bring about greater coordination and reduce fragmentation [18]. Fragmentation of primary care services is a byproduct of private delivery. Physicians can set up shop where they like, and with no formal obligations or connections to other providers within and outside of the primary care sector.

In the face of these institutional barriers, incremental change has been the dominant feature of primary care reform in Canada [13,19,20]. Although, incremental policy change often ameliorates immediate policy problems, broader strategic policy objectives can be overlooked [21]. However, there are a number of advantages to incrementalism, such as the simplicity of considering a limited range of policy alternatives, and the political expediency of building from existing policies and structures. Like Lindblom before them [22], Hutchison et al. [13] suggested that the persistence of strong institutional barriers made incrementalism the most promising way forward for primary care reform.

In this paper, we expand our understanding of incremental processes of reform by discussing how incremental changes develop, their potential for unintended consequences, and the lessons we can learn from previous attempts at incrementalism to advance policy objectives. To accomplish this, we utilize the concept of *policy layering*. This is a form of incrementalism that recognizes the unintended consequences produced by interactions between new reforms and existing policies and structures. We use *policy layering* as a tool to examine several phases of reform in Ontario, Canada that have been implemented over the last twenty years to improve the coordination of care. These reforms include alternative payment schemes for physicians; the creation of interprofessional team-based primary care models; a regionally-based planning initiative called Health Links; and, legislative changes that altered the governance arrangements for team-based primary care. These policy layers were assembled upon the foundation of Canadian Medicare, which included the public funding and private delivery of siloed physician services.

In summary, we find that the addition of new policy layers has led to some progress in care coordination, but also unintended consequences. We use the findings from this analysis and build upon layering and incrementalism to develop a concept that we call *smart layering*. This is an alternative approach to incremental reform intended to guide decision-makers in their future efforts to achieve difficult and long-standing policy objectives. In our discussion, we present *smart layering* as a potential way forward.

2. Materials and methods

2.1. Policy layering

Policy layering is a mechanism of policy change [24,28,29]; it involves the introduction of new policies without dismantling existing ones. Over time (sometimes decades or more), layers are added to address new and potentially competing policy problems, resulting in a complex policy-mix [23–27]. Wellstead et al. [30] explain:

‘Layering’ is especially problematic as incremental changes in the mixture of policy elements... can create a situation where the elements can fail to be mutually supportive, incorporating contradictory goals or instruments whose combination creates perverse incentives that frustrate policy goals. When these problems are identified, they set the stage for further rounds of tinkering that may temporarily solve the problems or may make them worse.

The layering of conflicting policies can create instability and incoherence between policy layers. This process is referred to as “tense layering” [24,30]. In the presence of tense layering, we may observe continuous incremental policy change that attempts to ameliorate conflicts between layers [24,27]. The conflict and incoherence that develops from layering is often unpredictable, and in the processes of addressing these conflicts, other unintended consequences can arise.

2.2. ‘Smart’ policy layering

Incremental reform is often contrasted with the rational comprehensive method to decision-making [21]. Following suit, we juxtapose these concepts in Table 1. Where the rational comprehensive method attempts to consider all possible avenues to achieve a policy objective, incrementalism is more pragmatic. The benefits of incrementalism are well documented [21,22,31,32]. Effective incremental reform learns from past failings in a process of trial and error and retrial [22]. It can achieve large-scale change through a series of “small wins” [32]. It also does not necessarily mean slow change, as lower barriers to implementation mean incremental reforms can happen rapidly [22,33]. Incremental reform is usually the most viable option in any context with strong institutional barriers, a large degree of uncertainty regarding the implementation or outcomes of policy decisions, and where there is a lack of evidence about what works [13]. However, the potential for unintended consequences is a strong rationale for developing ways to do incremental policies more effectively in order to minimize their occurrence.

There is a growing literature focused on the ‘smart’ design of policy mixes, and the purposeful use of layering [30,34]. Wellstead and colleagues suggest that ‘one-off’ layers in the form of policy patches can be an effective way to resolve tensions in the policy-mix [30]. Such incremental change may be the most promising avenue for advancement of policy objectives, particularly if combined with processes for policy evaluation and continuous improvement.

Inspired by this literature, we propose that *smart layering* has the following three features (see Table 1). First, the design and implementation of new layers acknowledges the existing policy-mix [34,35]. The policy mix consists of an amalgamation of past decisions and implementation processes that may not necessarily be in alignment. The challenge is to implement policies that take this existing context into account in order to minimize further conflict and incoherence. Second, new policy layers are evaluated in terms of their “goodness of fit” with existing governance and organizational structures [34,36], including the existing capacity for implementation [34]. Third, new policies aim to *patch* new and existing elements of the policy-mix by reducing or avoiding incoherence, inconsistencies, and redundancies [30,34]. In the following sections, we apply the principles of *smart layering* to evaluate efforts in primary care reform in Ontario.

3. Results

3.1. Layering of primary care reforms in Ontario

In Canada, the federal government shares responsibility for the funding of health care services with cash transfers to the provinces and territories. Meanwhile, each of the thirteen provinces and territories manages its own health care system. Under the *Canada Health Act*, each provincial is responsible for ensuring access to medically necessary physician and hospital services, free at the point of access. Beyond this requirement, each province and territorial government can take a different approach to the funding and delivery of health care services.

Table 1
Description of the different approaches to reform.

Approach to reform	Description	Key features
Rational Comprehensive Model	Introduction of fundamentally new policies with clearly identified policy objectives	<ul style="list-style-type: none"> - Starts with clear objectives and policy outcomes. - Can require dismantling of past policies to start anew. - Theory driven decision-making process that assesses all possible policy options. - Select the option that has the most promise to achieve the desired objective(s). - Comprehensive analysis of all policy alternatives is impractical for complex problems.
Incrementalism	<i>Layering</i>	Introduction of new policies without dismantling old ones. <ul style="list-style-type: none"> - Consideration of limited set of alternatives, largely based on past approaches. - May lead to unintended consequences when new layers conflict with existing policies and structures. - New policies address immediate policy challenges, and attempt to mitigate unintended consequences, rather than address broader policy objectives.
	<i>Smart Layering</i>	Policy layering that acknowledges past layers, including existing policies and structures. <ul style="list-style-type: none"> - New layers acknowledge the existing policy-mix and governance context. - Evaluate and revise new policy layers to maximize “goodness of fit” with existing policy-mix and governance context. - New policies aim to patch new and existing elements of the policy-mix by reducing or avoiding incoherence, inconsistencies, and redundancies.

In developing their health systems, layering and incrementalism have been prominent features of reform in all Canadian jurisdictions. For nearly two decades in Ontario (Canada's most populous province of approximately 14 million residents), the provincial government pursued a number of policy objectives for primary care delivery. Among the most prominent was a desire for new primary care models to achieve far better coordination of care for enrolled patients across a broad continuum of health [13,37]. In the 1970s in Ontario, the first tranche of 10 Community Health Centres (CHCs) were implemented as an alternative to the traditional physician-led, solo-practice, fee-for-service (FFS) model. CHCs are community-governed, and involve interprofessional teams responsible for delivering health and social care to underserved communities. However, the implementation of these models was limited (just 56 CHCs have been implemented) [38]. At the time, they did not represent a material overhaul of the dominant physician-led model.

In the late 1990s and early 2000s, further change in primary care ensued. There was growing consensus around the benefits of interprofessional and coordinated care [39,40], and a dissatisfaction with the traditional FFS physician-led model. FFS payment, in particular, was seen to encourage over-service provision (and unpredictable costs), and discourage coordination of care [6,41]. As support for the traditional physician-led FFS model waned, ideas for reform emerged from a number of sources [42].

Between 1999 and 2008, several alternative primary care payment and practice models were implemented across the province. These models introduced incentives for team-based care, 24/7 access, and patient rostering. Between 1999 and 2008, the Ontario government worked collaboratively with the medical profession to establish a variety of payment schemes. The most prominent of these comprised different combinations of FFS, capitation and salaried payment (the details of these models have been discussed elsewhere) [16,20,37,43]. As with the CHC model, these reforms were layered on top of the pre-existing model of privately operated, physician-led practices. Entry into these new models of care was voluntary. Initial attempts to entice physicians out of fee-for-service never met expectations, and further layering occurred through the recalibration of payment reforms to match the objections of the medical profession [44]. In implementing these recalibrations of payment and practice models, decision-makers recognized the barrier of siloed physician practice and increasingly adapted the mix of incentives and practice arrangements to entice physicians to accept change. These alternative payment models were eventually quite successful at attracting physicians and their patients to alternative models of care. Table 2

shows the enrollment of patients in the various payment models as of the end of the 2015/16 fiscal year. The Family Health Organization – a capitation-based model – became the most popular model between 2008 and 2011. The majority of the patients in Ontario followed their doctors out of solo-physician practice. As of March 2016, 85% of Ontarians were enrolled with a physician in an alternative payment model (see Table 2).

The design of these payment reforms relied on the introduction of patient rostering. Rostering was intended to encourage providers to take responsibility for a defined patient population and ensure continuity of care, which is a necessary condition for a coordinated system of care. Providers were encouraged to participate in patient rostering through generous financial incentives, and those who did were obligated to roster a defined number of patients [43].

Payment reform and the establishment of defined patient populations also supported the creation of new team-based models of care. The Family Health Team (FHT) and Nurse-Practitioner Led-Clinic were inspired by the patient-centred medical home, where physicians and a team of interprofessional health care providers are co-located and are responsible for caring for a defined patient population. The FHT was a combination of interprofessional teams and mixed-capitation physician group practices. Unlike the CHC model, which is community-led, FHTs were (and still are) physician-led. The Nurse-Practitioner Led Clinic model, introduced in 2006/07, was inspired by the FHT. The model allowed a nurse practitioner rather than a GP to perform the role of clinical lead.

Evidence regarding the contribution of primary care reform to care coordination is mixed. Access to team-based care improved with the introduction of FHTs and the expansion of the CHC model. However, by 2016, this access remained limited to a minority of Ontario residents; only 25 percent were enrolled in a primary care practice that offered services from an interprofessional team (see Table 2). Outside of these team-based models, primary care practices remain geographically and administratively disconnected from other sectors of the health care system. In addition, evidence suggests that the implementation of group physician practice and alternative payment have had little impact on continuity of care [45,46]. Continuity of care was an objective of primary health care reform in Ontario, and is an important facet of effective coordination.

3.2. ‘Smart’ layering & unintended consequences

In many ways, primary care reform is an example of *smart layering* (see Table 3). The layering of payment and practice models on top of the existing physician-dominated systems resulted in mate-

Table 2
Number of patients enrolled in primary care reform models (As of March 31, 2016).

Primary care reform model	Number of patients	Column %
Family Health Network (FHN) / Family Health Organization (FHO)	3,976,179	28.94%
Family Health Group (FHG)	3,719,992	27.07%
Family Health Team (FHT)	3,415,709	24.86%
Comprehensive Care Model (CCM)	478,423	3.48%
Other group practice	105,688	0.77%
Not rostered to group physician (solo physician)	1,011,733	7.36%
No physician	1,032,511	7.51%
Overall	13,740,235	100%

Source: Author's analysis of administrative health data at the ICES in Ontario, Canada

Table 3
Health care reform in Ontario.

Reforms	Elements of <i>smart layering</i>		
	New layers acknowledge existing policy mix	Ensure “goodness-of-fit” with existing policy mix	Patch conflicts between existing layers
Primary health care reform (1999 - 2008)	Voluntary physician enrollment in alternative payment and practices models recognized the existing institutional structure of public pay and private delivery [16,67].	Reforms developed via collaboration between Ontario government and medical profession [37]. Iterative process of reform and revisions to existing payment and practice models offered a mix of alternatives to attract physicians [19,20,44].	Attempted to patch the inconsistency between coordinated primary care and solo-physician practice model [20]. Conflict between private delivery and coordinated primary care remained. Voluntary physician participation in reforms led to unintended consequences.
Primary health care reform (2009 - 2018)	Period of relative policy stasis in primary health care reform in Ontario. Existing institutional structures remain unaffected.	Relationship between Ontario government and medical profession became acrimonious. Ontario government engaged in unilateral cuts to physician payment [16].	Managed entry into alternative payment models attempts to address unintended consequences of previous reforms [68]. These efforts do not directly address conflict between private delivery and coordinated primary care.
Health Links (2012 - present)	Multiple sectors (acute, primary, home and community) brought together to achieve coordination across care settings, including primary care [69]. Role of provider organizations expanded to take on regional leadership and coordination responsibilities [57,58]. Initiative did not recognize the loose organizational ties between sectors, or the imbalance in capacity between institutional and community provider organizations [57,58].	Duplicated efforts of regional governance structures (LHINs, CCACs). Expanded role imposed by Health Links did not recognize capacity of primary care sector to participate. Solo and group physician practices lack resources to meaningfully engage [57].	Underlying conflict between private delivery and coordination of care remained intact.
Bill 41 - <i>Patients First Act</i> (2016)	Existing regional governance structures were expanded to include interdisciplinary primary care practices [70]. Did not include previous policy layers: alternative physician payment and Health Links.	Salaried interdisciplinary primary care providers are compensated through the LHINs existing funding mechanisms. LHINs were not provided with authority over physician payment [71].	The majority of solo and group physician practices were excluded [70].

rial changes to the way primary care physicians were paid and how they practiced. To some extent these changes were achieved by recognizing the dominance of siloed-physician practice, and tinkering with reforms until a mix was achieved that made change palatable to a majority of physicians. The new models aligned with and complemented existing governance and organizational structures [44]. Physicians were directly involved in the development of reforms, new payment models were designed to complement existing FFS payment structures, and physician self-governance was maintained [37]. Meanwhile, physicians were made accountable to government for patient rostering, 24/7 access, and interdisciplinary care.

However, these reforms also had a number of unintended consequences. Voluntary physician participation in the reform models enabled a process of physician self-selection. Physicians with healthier patients disproportionately switched from FFS to capitation payment [47,48], and as a result, saw their incomes rise due to increased payments for healthier patients [49]. Risings costs

conflicted with an increasing focus on fiscal restraint following the economic downturn in the mid-late 2000s [50]. At the same time, evidence emerged that Ontario's primary health care reform efforts were having a mixed impact on patient outcomes [51,52].

FHT practices were particularly subject to physician self-selection. Physicians who opened FHT practices tended to see healthier patients than physicians in FFS-based practices [48]. Despite the existence of FHTs, sicker patients were more likely to receive care from solo or group fee-for-service physicians, without access to interprofessional teams [47].

In response to these policy problems, the provincial government limited entry into capitation-based payment models in 2012 through a policy called “managed entry”. In addition, it unilaterally cut payments to physicians in 2015, leading to an acrimonious relationship between the government and the medical profession [16]. While these efforts may have been successful in curbing rising costs, they also conflicted with the objectives of coordinated primary care by slowing the adoption of alternative payment models

and FHTs [53]. While the Ontario government announced the addition of 50 new FHTs in 2008/09 (to be implemented by 2011/12) to address capacity in rural and underserved communities, there has been no further expansion of the model. In addition, without the medical profession's participation, introducing new primary care reforms became increasingly challenging [54].

3.3. Health Links

In recent years, the Ontario government has continued with its incremental approach to reform. In 2012, the provincial government released its *Action Plan for Health* [55]. The policy goals of this plan included access to faster and more convenient care (e.g., after hours care), and improved integration of services at the local level.

Also launched in 2012, the Health Links initiative was implemented as a “low rules” and decentralized planning initiative, financially supported by the Ministry of Health and Long-Term Care, but organized, designed, and led by voluntarily partnering independent health and social care delivery organizations (e.g., hospitals, primary care, social service organizations, emergency response) [56]. The objective was to improve the coordination of care for seniors and people living with multiple chronic conditions and complex health and social needs by connecting providers from multiple sectors to develop care plans for enrolled patients. Each Health Link has a lead or a co-lead organization, mainly hospitals or primary care practices, but also regional home care agencies or community services organizations. The primary care sector was identified as a key player in this initiative; the Ministry of Health and Long-Term Care stipulated a minimum of 65 percent of primary care providers in each region be a part of Health Links [56]. However, they have fallen far short of this goal, and Health Links are facing challenges engaging and maintaining commitment from primary care providers [57,58].

The Health Links approach is an attempt at incremental reform that leverages existing elements of the policy-mix. Health Links bring together multiple sectors, including acute, primary, and home and community care, to engage in planning activities for patients with complex health and social needs. However, Health Links is not an example of *smart layering* (see Table 3). First, Health Links' mandate overlaps with that of the existing Community Care Access Centres (CCACs) – organizations that have been charged with coordinating community and home care in Ontario (of note, in 2017, the CCACs merged with the Local Health Integration Networks (LHINs) – regional bodies responsible for the funding and oversight of regional health service providers). Rather than streamline and improve existing processes, Health Links added a level of complexity to the coordination of care. Health Links failed both to strengthen connections between organizations and to “rebalance” the hospital, community, and primary care sectors [59]. If the existing CCAC structure was seen as inadequate to achieve coordination for seniors and people living with complex conditions, then policy-makers should look to replace or enhance that structure, or determine how responsibilities are demarcated.

Second, and perhaps more importantly, Health Links did not take into account the capacity of the primary or community care sectors to participate. Solo and even group physician practices lack the capacity and resources to engage in the time-intensive work required by Health Links, and have limited access to support or managerial staff (for help with administration and coordination activities). Recent studies have highlighted that there is poor awareness of Health Links in the broader primary care community [57,60], however, Health Links have been successful in engaging FHTs and CHCs. This is presumably due to these organizations' greater capacity to engage in the regional coordination activities that Health Links require. This has implications for the success of Health Links, as those segments of the population already

benefiting from interprofessional teams receive further support, while those receiving care from solo and group physician practices remain on the outside [57]. While no studies have evaluated the degree of care coordination within Health Links, systems-level improvements to care coordination have not been realized [58]. In fact, a study of the initial implementation of the program in one region found no improvement among Health Links patients in terms of rates of hospital admission, emergency department visits, days in acute care, 30-day readmissions, and 7 day post discharge follow up [61].

Health Links is an incremental attempt to reorient the health-care system by stretching the role of existing primary care structures. However, physicians' limited capacity to participate has so far impeded the success of Health Links [57,60]. This also points to a larger issue: Health Links do not patch existing conflicts within the existing policy-mix; in particular, they do not reduce tensions between the legacy of siloed community and physician practice and the objective of coordinated care.

The provincial government and the Ontario Medical Association have maintained their one-to-one negotiation process since it was established in 1991 [37]. Yet, the government has also made efforts to move the planning of health care services to the local level. These efforts include the establishment of the LHINs and Health Links [62]. None of these structures has been able to address the underlying tension created by private and siloed delivery of physician services. As a result, the health system remains largely fragmented, particularly in the delivery of community-based care.

3.4. Regionalization and bill 41

In 2015, the provincial government released its *Patients First* strategy, which included goals for more coordinated care for patients with complex medical conditions [55]. In December 2016, as part of the *Patients First* strategy, the provincial government implemented the *Patients First Act*. The stated goals of this reform were to improve access to primary care; improve local connections between sectors of the health care system, ostensibly by providing LHINs with greater oversight; streamline and reduce administration of the health care system, and enhance accountability [63]. The *Patients First Act* expanded the role of the LHINs to include financial oversight of FHTs and Nurse Practitioner-Led Clinics. Previously, LHINs were only responsible for Community Health Centres.

The *Patients First Act* leverages and complements existing structures by expanding the role of the LHINs, but it does not address the tensions between the earlier primary care policy layers, especially FFS, solo and group physician practices. While a greater proportion of primary care practices are included in the LHIN governance framework (i.e., Community Health Centres, FHTs, and Nurse Practitioner-Led Clinics), the *Patients First Act* may emphasize the disparity between team-based primary care and solo and group physician practices. The included practices will be subject to different requirements for the funding and delivery of care, and will presumably be more involved in regional coordination efforts. The *Patients First Act* also inexplicably excludes the subsequent policy layers of alternative physician payment models and Health Links. As a result, it will continue to be challenging for LHINs to usher in a system of coordinated care without authority over the majority of the primary care sector, payment structures, and with Health Links engaged in a potential duplication of efforts.

4. Discussion

In this paper, we have applied the concept of policy layering to health care reform in Ontario to explain the processes of policy change in the presence of strong institutional barriers. We have also

developed the concept of *smart layering* as an alternative process of incremental change. *Smart layering* recognizes that policy change is slow, and that dramatic overhauls are not always productive or feasible.

When reform efforts reach an impasse, large-scale proposals that aim to rid of existing structures or introduce entirely new ones have some appeal. For example, in 2015, the Primary Health Care Expert Advisory Committee, originally established by the Ontario Ministry of Health and Long-Term Care, recommended enrolling the entire population and all primary care providers into primary care fund holding agencies akin to those established in the United Kingdom [64]. However, recent history suggests that such reforms are difficult to achieve and may not be desirable. In the United Kingdom, large-scale transformation of health care systems have been a costly and largely untested enterprise [65]. We can only speculate as to the reasons why the Ontario government did not accept this proposal, but it is likely that it did not want to worsen an already contentious relationship with organized medicine.

Smart layering builds on the concepts of incrementalism and policy layering to propose a way toward incremental change that avoids (where possible) unintended consequences, and patches conflicts between existing layers in the policy-mix. We identify three features of *smart layering*: (1) new policies acknowledge the existing policy-mix [34,35]; (2) new policy layers are evaluated and revised to maximize “goodness of fit” [34,36]; and, (3) new policies aim to patch existing elements of the policy-mix by reducing or avoiding incoherence, inconsistencies, and redundancies [30,34]. Developing these three features offers a deeper understanding of how incremental change may reduce complexities within the policy-mix, and reduce to some extent contradictions and redundancies. For decisions-makers, *smart layering* can be a heuristic device to prompt a recognition of potential conflicts between new policies/programs and the existing mix, to think about “goodness-of-fit”, and identify opportunities to patch conflicts between existing layers.

Being a form of incremental change, *smart layering* does not aim to be a comprehensive review of policy alternatives. It is a pragmatic approach to decision-making that will likely still result in unintended consequences. Decision-makers can never see all ends, even when they are aware of the potential for conflicts in the policy-mix. It is also unclear if building on the existing policy-mix and patching existing conflicts is always the most productive path to achieving policy objectives. *Smart layering* provides no clues to when dramatic change and upheaval is required. However, we suggest that such situations will be rare when it comes to complex policy problems. It may also be impossible to achieve complete coherence within the policy-mix. Meijers and Stead [66] suggest that excessive efforts to eliminate incoherence could result in a loss of flexibility, and perhaps creativity, in the policy-making process. In addition, *smart layering* and evidence-based decision-making are not mutually exclusive [22]. *Smart layering* must embrace the principles of evidence-based decision-making, including policy evaluation and continuous improvement.

5. Conclusion

Ontario’s experience with primary care reform suggests that there is value in building on what is already in place, but also highlights the potential for unintended consequences. The process of primary care reform in Ontario had some elements of *smart layering*, and was able to achieve significant improvements to coordination, particularly access to team-based care. On the other hand, Health Links did not share these elements and faced challenges in improving coordination of care between primary care and other sectors (e.g., hospital, community). Meanwhile, the *Patients First Act* specif-

ically brought primary care practices into the regional governance model (LHINs) to improve coordination with other sectors, but would have needed to include solo and group-physician practices in order to reduce complexity and incoherence between previous layers. The degree to which Bill 41 will improve care coordination remains unclear.

By reviewing the process of policy layering over the past two decades, we highlighted key inconsistencies between layers that currently obstruct progress toward coordinated care. Recent reforms in Ontario failed to patch existing inconsistencies between sectors and within the primary care policy mix, including the conflict between care coordination and the siloed and private delivery of physician services. *Smart layering* would suggest that promising efforts like the *Patients First Act* could go further to patch the inconsistencies by expanding existing governance structures to cover the entire primary care sector. *Smart layering* allows for policy patches that can substitute for large-scale reform when such approaches are not feasible.

Conflict of interest

The authors have no competing interests to declare.

Acknowledgements

This study was supported by ICES, which is funded by an annual grant from the Ontario Ministry of Health and Long-Term Care (MOHLTC). The opinions, results and conclusions reported in this paper are those of the authors and are independent from the funding sources. No endorsement by ICES or the Ontario MOHLTC is intended or should be inferred.

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