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Health Reform Monitor

Primary care reform in Manitoba, Canada, 2011–15: Balancing accountability and acceptability☆

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ABSTRACT

Primary care reform cannot succeed without substantive change on the part of providers. In Canada, these are mostly fee-for-service physicians, who tend to regard themselves as independent professionals and not under managerial sway. Hence, policymakers must balance two conflicting imperatives: ensuring the *acceptability* of renewal efforts to these physicians while enforcing their *accountability* for defined actions or outcomes. In its 2011–15 strategy to improve access to primary care, the province of Manitoba introduced several linked initiatives, each striving to blend acceptability- and accountability-promoting elements. Clearly delimited initiatives that directly promoted a specific observable behaviour (accountability) through financial or non-financial support (acceptability) were most successfully implemented. System-wide initiatives with complicated designs (notably a primary care network model that established formal partnership among clinics and regional health authorities) encountered greater difficulties in recruiting and sustaining physician participation. Although such initiatives offered physicians considerable decision-making latitude (acceptability), many physicians questioned the meaningfulness of opportunities for voice within a predetermined structure (accountability). Moreover, policymakers struggled to enhance the acceptability of such initiatives without sacrificing strong accountability mechanisms. Policymakers must carefully consider how acceptability and accountability elements may interact, and design them in such a way as to minimize the risk of mutual interference.

1. Background

International research attests to the importance of primary care as the foundation of the healthcare system [1]. As populations age and a shift is seen towards chronic and complex conditions, the need for ready access to continuous, comprehensive primary care grows ever more urgent. Over the last 15 years, Canadian policymakers have devoted increasing attention to primary care r̈eformör r̈enewal.R̈eform initiatives have included the promotion of interprofessional teams, group practices and networks, primary health care governance, patient enrolment with a primary care provider, and electronic medical records, as well as financial incentives and blended-payment models [2]. Similar initiatives are underway in other countries [3–5], many of whose efforts are more advanced than Canada's [6].

A major challenge facing policymakers is the lack of structural means to enforce accountability over the high proportion of primary care providers who are non-employees [7]. In many countries, including Canada, the majority of family physicians (or g̈eneral practitioners¨) operate as private businesses, paid on a fee-for-service (FFS) basis, and prize their autonomy [8]. The evolution of physician–system relationships varies by country, and appears highly path-dependent [8,9]. Canada's introduction of universal publicly funded healthcare in the 1960s was made possible by the p̈hysician compact,ẅhereby physicians agreed to cede control over the financing of care in order to maintain control over its delivery [10]. To this day, family physicians tend to regard themselves as independent contractors rather than members of a larger system,

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and as such, are highly resistant to policymakers' agendas for system change [7,10]. Thus, policymakers must balance two conflicting imperatives: ensuring the *acceptability* of renewal efforts to physicians while enforcing their *accountability* for defined actions or outcomes. Recognizing that any attempt to radically reshape delivery would meet with fierce opposition [10], Canadian policymakers have emphasized voluntary physician participation, positive incentives, and relationship-building [11]. The dilemma is to design an approach soft enough to be palatable to physicians yet powerful enough to generate the substantive practice change needed to make reform a reality. Such a dilemma has also been observed in other countries whose physicians cherish their independence (e.g., Australia [12], New Zealand [4], United States [13]).

Healthcare in Canada being a provincial responsibility, each province has attempted to effect this balance in its own way. In terms of promoting reform *implementation*, no particular policy approach has shown its superiority, while the few available studies of *impacts* have reported mixed results [14,15]. Ontario incentivized physicians to join new, predefined models of care; however, most physicians self-selected the model most resembling their existing practice, resulting in a 32% increase in physician incomes with little demonstrated practice change [16]. Alberta invested heavily in Primary Care Networks (geographic physician networks), producing an impressive rate of physician participation; unfortunately, policymakers had little influence over what the networks undertook or accomplished, and belatedly attempted to introduce accountability mechanisms [17]. British Columbia fostered physician networks (Divisions of Family Practice) [18] and offered FFS physicians sizeable financial incentives for such tasks as managing patients with chronic disease and communicating with other care providers; nonetheless patient access, continuity, and coordination of care continued to worsen [19].

Embarking somewhat later on the enterprise of engaging FFS physicians [20], Manitoba had the opportunity to observe that an overemphasis on acceptability, to the detriment of accountability, would limit progress, while overemphasis on accountability could ensue in overwhelming resistance, or ẅaming. Accordingly, policymakers engaged with the issue of *balancing* accountability and acceptability, not only within their overall reform strategy but in the design of each initiative. However, they faced challenges of their own.

From 2011–15, a major strategic effort was implemented to accelerate reform. Focusing on this period, we examine why the sought-after balance remains so elusive. This analysis represents one component of a larger study, whose methods are fully reported elsewhere [21]; these included qualitative interviews with 35 provincial and regional decision-makers and 60 physicians; observation of meetings and engagement events; and review of over 100 documents produced 2000–17, including plans, evaluation/monitoring reports, and communication materials. Unless otherwise noted, facts about initiatives are drawn from internal documents that, for reasons of confidentiality, cannot be cited individually.

2. Manitoba context and history

Manitoba (pop. 1.2 M), like many provinces, has devolved the delivery of health services to regional health authorities, one representing Winnipeg, the provincial capital (pop. 700,000), the other four encompassing smaller cities and large rural areas. Manitoba has approximately 1400 family physicians (average age 50, 39% female) [22]; the majority work in community-based clinics (practices) that are either physician-owned or operated by a health authority or funded agency. About 75% of family physicians are FFS; the fee schedule is negotiated every four years between the government and the provincial physicians' association. Rates of solo and small-group practice (2–4 physicians) can be estimated at ≥25% each [23].

Manitoba's earliest reform efforts (early 2000s) focused on augmenting services directly operated by regional health authorities (see Table 1). However, as policymakers came to accept that the bulk of care would continue to be delivered by FFS physicians, their attention shifted towards engaging those providers. The first province-wide initiative to do so, the Physician Integrated Network (2006–12), encouraged clinics to define and pursue their own improvement activities. Although evaluations demonstrated no significant improvements in access or quality, the very fact that about 13% of the province's FFS family physicians participated was hailed as an important success [24,25]. A subsequent initiative significantly increased the adoption of electronic medical records, using heavy subsidization supplemented by training and communication strategies [26].

3. Designing the 2011–15 strategy

The 2011–15 era reflected two policy goals: to expand the engagement of FFS physicians and to build an integrated primary care system across remuneration models and provider types, using such b̈uilding blocksäs medical homes and primary care networks. In 2011, the Premier's pledge to ensure a "doc for all"[1] Manitobans by 2015 created an unprecedented policy window, promising sustained attention and resources for the long-neglected primary-care sector, and an opportunity for policymakers to press forward with such initiatives. The political promise also created pressure to focus on the specific outcome of patient attachment to a provider (potentially eclipsing others) and to deliver results within a four-year election cycle. Policymakers sought to devise initiatives that would both meet the 2015 deadline and establish a foundation for further reforms promoting access, continuity, and comprehensiveness of care.

Two considerations influenced policymakers to place stronger emphasis on accountability than they had previously. First, awareness of other provinces' disappointing experiences engendered fiscal caution and a strong concern that expenditures be tied to outcomes or d̈eliverables.S̈econd, evaluations of the Physician Integrated Network [24,25] prompted some policymakers to urge the inclusion of stronger accountability mechanisms in subsequent initiatives. However, not all potential accountability mechanisms were on the table. Notably, r̈osteringẅas considered a non-starter with physicians; therefore, physicians were not required to register their patients in order to demonstrate attachment, which was instead assessed via an algorithm (only in 2016 did the province begin to introduce formal, and still voluntary, enrolment).

The Province (Department of Health) was formally responsible for planning and the health authorities for implementation; however, in practice, both groups had involvement in both domains. The design phase featured consultation with physicians and a range of other stakeholders. There appeared to be stakeholder consensus on broad goals and values (access, continuity, comprehensiveness), although not necessarily a shared vision of the desired system or how to achieve it.

4. Content of reforms

Manitoba's 2011–15 strategy encompassed multiple initiatives involving diverse types of providers. However, its most signifi-

[1] While policymakers recognized that both doctors and nurse practitioners could provide primary care, the naming of strategies took into account the fact that the term p̈rimary care providerẅas foreign to the public.

Table 1
Primary Care Reform Initiatives in Manitoba Since 2000.

Prior to 2011–15 Strategy	
Initiative	Description
Directly Operated Primary Care (2000–)	Several regional-health-authority–operated clinics established through Primary Health Care Transition Fund in early 2000s. Access Centres (opened 2004–15) offer multidisciplinary health and social services (7 in Winnipeg, with physicians on contract; 1 in a smaller city, without physicians). Some Community Health Centres have existed since the 1970s, and now operate as funded agencies.
Other Primary Health Care Transition Fund Initiatives (2000–)	The NorthEast Project engaged FFS physicians in one Winnipeg community area and gave them access to interprofessional providers. Uniting Primary Care and Oncology, a collaboration between family medicine and specialists, still exists. No other initiatives involved FFS physicians; most entailed direct service provision or public engagement/education.
Shared care (2003/2008)	Mental health specialist (psychiatrist, psychologist or counsellor) co-located with primary care providers. In Winnipeg and one small urban centre, implemented in regionally operated clinics, then expanded to FFS (1̃00 physicians and 10 nurse practitioners [NPs]).
TeleCare (2005–)	Telephone-based self-management support for patients with certain chronic diseases; expansion on existing Provincial Health Contact Centre. Implemented in two regions, with 186 patients served by 83 physicians; service is ongoing.
Physician Integrated Networks (PIN) (2006–12)	Engaged 13 FFS clinics to identify and implement practice changes that would help achieve 4 goals (improve patient access, information use, worklife; demonstrate high-quality care, with a focus on chronic disease). Included quality-based incentive funding awarded at clinic level for performance on process indicators (intended for improvements like hiring of interprofessional staff).
Advanced access training (2007–)	Extensive training to help primary care clinics re-engineer their scheduling processes to offer same-day appointments. Taken by 50+ clinics (including some FFS).
Efforts to increase supply of primary care providers (2007–)	Ongoing provincial decisions (e.g., increasing the number of spaces in medical school) and targeted regional strategies (e.g., incentivizing physicians to practice in underserved areas) to increase recruitment and retention of family physicians (and other primary care providers, albeit to a much smaller extent). Efforts continued during the 2011–15 strategy. According to data from the Canadian Institute of Health Information (CIHI), the number of family physicians in Manitoba increased 10% from 2005–10 and 14% from 2010–15; however, two regions showed a decrease during the later period.
Bridging generalist/ specialist care / e-referral & consult (2008-2010)	A project to develop referral pathways and embed them in an IT system which would also facilitate communication between the referring physician and specialist. An evaluation of the pilot project found referral pathways were appreciated, but uptake of the IT system was low due to various deficiencies. It was redeveloped into the eReferral & Consultation application, but utilization remained low, and the system was decommissioned in 2015.
Regulated Health Professions Act (2009/2014)	New regulation to replace 21 separate pieces of legislation by establishing which duties can legally be done by which provider. Passed 2009; first profession included in 2014.
Other Regulations (2009–)	Medical Amendment Act (2009) recognized physician assistants (note that military-trained PAs had been working in Manitoba since 1999). Pharmaceutical Act (2013) empowered pharmacists to prescribe certain drugs, give vaccinations, and order/receive diagnostic tests. Some minor extensions to nurses'/NPs' scopes of practice.
Electronic Medical Record Adoption Program (2010–15)	Province reimbursed up to 70% of eligible implementation costs of one of 4 approved Electronic Medical Records (EMRs), plus up to 2 years of eligible operating costs, up to a fixed maximum, funded by Canada Health Infoway. Included highly developed communication and training strategy with specific resource development for FFS clinics. In 2012, target of 1000 applicants (representing 70% of eligible providers, i.e., family physicians and NPs) was achieved.
During 2011–15 Strategy	
Initiative	Description
Chronic disease management tariffs (2012–)	Tariffs billable for providing "comprehensive chronic disease management" to patients with diabetes, asthma, congestive heart failure, coronary artery disease, or hypertension.
QuickCare Clinics (2012—)	Regional-health-authority–run, NP-staffed clinics providing non-emergency urgent care days and evenings, intended to reduce non-emergent visits to Emergency Departments. Planners, concerned that the model might conflict with continuity of care, added a requirement for NPs to (re)connect patients to a regular provider. Total of 8 clinics in 3 regions. In 2017, clinics in Winnipeg were closed and their functions moved to nearby Access centres; 2 clinics remain in other regions.
My Health Teams (MyHTs) (2013–)	Physicians in a geographic area agree to work with regional health authority, each other, and community partners to plan ways to better meet needs of local population. Each MyHT receives an annual amount (rising from $525,000 in Year 1 to $750,000 in Year 4) to spend on augmenting services, typically by hiring allied health providers to be shared among clinics; health authorities are also expected to leverage existing resources. Each MyHT is required to collectively attach 2000 new patients. Planning and major, ongoing engagement efforts began in 2011; the first MyHT became operational in 2014. Most MyHTs, as intended, contained multiple FFS clinics, although a few were formed with only one large FFS clinic. Coverage information in text.
Inter-Professional Team Demonstration Initiative (ITDI) (2013–)	Financially supports FFS clinics to take on an interprofessional provider (this has included nurses, NPs, and physician assistants), who must remain an employee of the public system. Support includes salary, stipend to cover overhead, and variable payment at end of each year based on net attachment; minimum attachment requirement is 500 new patients. Also included capacity-building support in choosing and utilizing interprofessional providers (toolkit, intensive hands-on facilitation in some health authorities). Willingness to join a MyHT is a prerequisite for participation in ITDI.Coverage information in text.
Family Doctor Finder (2013–)	Unattached patients register by phone or online; regional primary care connector seeks to match patients to a suitable, willing provider (physician or nurse practitioner) within 30 days. No financial incentives for attaching patients; instead, the initiative relies on intensive, one-on-one efforts by regional staff to build trusting relationships with physicians. Piloted in 2013 in two regions, rolled out in 2014. Coverage information in text.

Table 1 (*Continued*)

Prior to 2011–15 Strategy	
Initiative	Description
Mobile Clinics (2014–)	Mobile Clinics were designed to meet the primary care needs of Manitobans in small, remote and underserviced communities. They are buses staffed by a nurse practitioner and a registered nurse, providing full service primary care. Operational in three regions.
After 2011–15 Strategy	
Initiative	Description
Home Clinics (2016–)	Clinics that commit to providing continuous, comprehensive care and use an electronic medical record are eligible to register as Home Clinics. Each must develop a formal list of enrolled patients and submit data extracts from their electronic medical record. Effective April, 2017, Comprehensive Care Management tariffs can be claimed only for a Home Clinic's enrolled patients. By the end of 2017, 70% of primary care clinics had registered as a home clinic, with 52% of the Manitoba population enrolled.
Complex Care Management Tariffs (2017–)	These tariffs, applicable to enrolled patients, take account of age and chronic diseases; to claim them, physicians must demonstrate compliance with chronic disease management guidelines.

FFS = fee-for-service; NP = nurse practitioner.
Note: This table covers initiatives launched by the Province or regional health authorities. General physician engagement activities, such as the establishment of physician advisory councils, are not included. Efforts of other bodies, such as physician organizations, are out-of-scope for this paper, but will be examined separately.

cant and novel plank was a trifecta of initiatives that engaged heavily with FFS physicians: Family Doctor Finder, a centralized service to match unattached patients with a primary care provider; the Interprofessional Team Demonstration Initiative (ITDI), which funded interprofessional providers in FFS clinics; and My Health Teams (MyHTs), formerly known as primary care networks. MyHTs, envisioned as a significant, long-term system change, were formal, contractual arrangements among FFS clinics, regional health authorities, and other parties to jointly plan and deliver care to meet local population needs. Each received funding to spend on augmenting services, typically by hiring allied health providers. Both ITDI and MyHTs had an ättachment deliverableïequiring that each clinic or MyHT attach a minimum quota of new patients. Also introduced were tariffs billable for chronic disease management.

While initiative design was informed by a multiplicity of considerations, we find it most edifying to focus on how policymakers responded to the dual imperatives of ensuring *acceptability to* and *accountability from* physicians. Each initiative featured a combination of accountability(-promoting) and acceptability(-promoting) elements. The simplest initiatives targeted a specific behaviour change (*accountability*) through financial or non-financial support (*acceptability*); for example, the Chronic Disease Management Tariffs were financial incentives, while Family Doctor Finder relied on relationship-building. More complicated were initiatives that established a predefined structure and deliverables (*accountability*), then provided opportunities for voice within that structure (*acceptability*). ITDI and MyHTs included major predetermined aspects; having agreed to those conditions, physicians were given access to resources and considerable latitude in how they might use them. In the clinic-specific ITDI, physicians' exercise of voice was a relatively straightforward affair: choosing the most suitable provider and tailoring his/her role to clinic needs. With MyHTs, the matter involved significant complexities: First, to exercise voice, physicians were obliged to participate in a level of governance beyond that of the individual clinic, via committees that also included regional b̈ureaucrats.S̈econd, MyHTs were granted a great deal of freedom to determine the deployment of their resources; while this freedom served as a counterweight to MyHTs' restrictive aspects, it also made it difficult – even for policymakers – to articulate a clear, concrete description of the program.

To implement its new initiatives, provincial and regional decision-makers undertook extensive physician-engagement efforts, both formal (e.g., town halls) and, perhaps more important, informal (i.e., outreach to build relationships with individual physicians/clinics). Other strategies that appeared to play a smaller role included formal communication (e.g., online) and linkage with the Manitoba College of Family Physicians (which helped to spread reform ideas, but could not advocate too strongly for government initiatives lest it lose credibility with physicians).

5. Implementation and impacts

As the initiatives purposely relied on voluntary participation, they attracted no organized resistance. The question was whether they would garner a significant degree of participation, and whether such participation would translate into impact on patient access.

By late 2016, Family Doctor Finder had matched over 64,000 unattached patients to a primary care provider, accomplishing this within 30 days for over 80% of registrants (the major barrier being limited provider supply in some rural areas). This simple, effective model – a contrast to certain other provinces' centralized waiting lists, with their convoluted prioritization schemes and costly incentives – has attracted positive attention from other jurisdictions [27]. Eleven MyHTs were operational (fully covering the Winnipeg and Southern regions and partially covering another), and four were in the planning stages. The proportion of Manitoba's FFS physicians who had joined a MyHT was approximately 19%; some policymakers considered this satisfactory given the timelines of implementation and the fact that MyHTs did not yet cover the whole province, while others thought it disappointingly low. ITDI continued to allocate providers; full allocation of all 45 was anticipated by end 2018. Patient attachment rates are being monitored and evaluation of other outcomes (access, quality, continuity) is planned; however, at the time of data collection, MyHTs and ITDI were deemed too new to show system impacts.

Qualitative research conducted in late 2015 suggested that negative views of MyHTs (and to a lesser extent ITDI) were prevalent among FFS physicians, including some who had joined MyHTs [21,28]. The goal of increasing attachment did not resonate strongly with physicians, who expressed more interest in improving care for their existing patients. Many questioned the authenticity of opportunities for voice within a predefined structure; the slow, bureaucratic nature of decision-making bred frustration and alienation; and the loose, conceptual definition of MyHTs was a source of confusion and even some suspicion. The opportunity to be involved in m̈anagement-typeäctivities beyond the operation of their day-to-day practice was embraced by a few, but perceived by others as more of a burden or even a threat to physician identity. In a separate survey of MyHT participants (an unspecified proportion of whom were physicians), a majority of respondents agreed that their MyHT had improved integration among participating service providers

and helped them optimize their scope of practice to deliver services more efficiently (Prairie Research Associates, unpublished results). Nonetheless, the acceptability of MyHTs to the overall physician population remained a concern. Meanwhile, the definition of the attachment deliverable as a collective (MyHT) rather than an individual (clinic) responsibility helped to make MyHTs acceptable to physicians already managing large patient panels, but also weakened the deliverable's potential as an accountability mechanism.

While comparison among initiatives must be pursued with caution, as all were interlinked, it appears that the initiatives most likely to meet their objectives were those in which acceptability elements directly facilitated physicians' achievement of an outcome for which they were accountable. Such direct, meaningful relatedness between acceptability and accountability was exemplified by initiatives that provided support for a specific, easily observable behaviour, such as electronic medical record adoption or patient attachment through Family Doctor Finder. In contrast, initiatives such as MyHTs featured a collection of oblique measures and corrections: In a complicated set of compromises, acceptability elements (e.g., opportunities for voice), rather than directly supporting outcome achievement, compensated indirectly for the presence of accountability mechanisms; meanwhile, certain accountability elements (e.g., the requirement that interprofessional staff be public employees) were not tied to specific outcomes, but compensated indirectly for the risks associated with acceptability elements (e.g., that decision-makers might lose control of the process). Within such convoluted arrangements, there was significant potential for the two imperatives to work against each other, hindering implementation and outcome achievement.

6. Continuing reforms

System change is difficult precisely because it demands much more than the promotion of simple, observable behaviour changes. However, Manitoba's reform experience raises a provocative possibility: might it be possible to build system change üpwardf̈rom simple initiatives that target specific outcomes, rather than d̈ownwardf̈rom complicated system-level design? Two promising developments (which policymakers view as an evolution of, not a departure from, prior strategies) merit continued investigation.

First, the Home Clinic initiative (based on the p̈atient's medical home,än idea strongly endorsed by the College of Family Physicians of Canada [29]) was launched in November 2016. In its first year, it attracted about two thirds of eligible clinics – many FFS – suggesting high acceptability. With no certification process and few prerequisites for joining, the model does not require physicians to immediately accept strong accountability mechanisms, but rather provides a framework within which accountability elements can later be introduced. Second, while MyHT scale-up efforts continue, policymakers have also taken an increasingly flexible approach to collaborating with clinics, facilitating MyHT-like service-delivery arrangements among clinics that have balked at signing a contract. A locally tailored approach that fosters f̈rontline ownership[̈30] may improve the acceptability of reform to physicians. If this approach also succeeds at improving patient outcomes, it may prove fruitful to reimagine MyHTs not as an entry point but as an *eventual* formalization of informal cooperative arrangements – in other words, to pursue clinical integration before structural integration [31].

7. Broader implications

Manitoba's policymakers adopted an incrementalist approach, taking gradual, politically viable steps and anticipating the necessity of trial-and-error learning. Incrementalism is frequently recommended as a means of coping with human cognitive limitations or political resistance [32,33]. The incrementalist strategy of policy layering – adding new policy elements without removing the old – offers a way to circumvent powerful actors who would veto radical change [34]. However, layering can ensue in a convoluted, incoherent policy mix [35]. Consequently, Rudoler et al. (2019) have called for s̈mart layering,̈in which policymakers introduce each new element to p̈atchä known gap or inconsistency, while taking care to ensure congruence with existing policies and context [36]. The simplest of Manitoba's initiatives (e.g., Family Doctor Finder) did patch a specific gap in this manner. However, complex initiatives like MyHTs sought to address multiple actual and anticipated gaps via elements that were not necessarily congruent with the context, or even with each other. Decision-makers' preferred strategy of layering seemed imperfectly aligned with their vision of MyHTs as a transformative system change. The goals of reform might have been better served by either reconsidering incrementalism (as a few dissident decision-makers advocated) or finding ways to clearly separate policy elements in order to smart-layer them, rather than combine them in a complex package.

One complexity of MyHTs was that they required physicians to both form networks with each other and enter joint governance arrangements with regional decision-makers. Physician networks have proven attractive to physicians elsewhere in Canada [17,18]; indeed, in some countries, general practitioners have spontaneously formed networks (e.g., Independent Practitioner Associations in New Zealand) in order to adapt to other policies [4,37]. Furthermore, a multi-country European survey found that membership in an integrated network of primary care centres was positively associated with professional satisfaction [38]. However, even physicians who embrace networks may resist joint governance, as seen during Australia's short-lived experiment with Medicare Locals [12] and New Zealand's attempt to replace Independent Practitioner Associations with Primary Health Organizations [4]. Both countries subsequently sought to right the accountability–acceptability balance by expanding physicians' role in decision-making [12,39]. Analyzing policies in terms of their accountability and acceptability elements may help policymakers identify (un)promising candidates for layering.

8. Conclusion

Primary care reform demands that accountability mechanisms be embedded in initiatives acceptable to physicians. However, policymakers' vision for system change unavoidably overreaches what can be achieved via simple, outcome-specific initiatives that enable an unproblematic balancing of accountability and acceptability imperatives; and as complexity increases, so does the difficulty of balancing their competing claims. Reformers must strive to design acceptability and accountability elements in such a way as to maximize their potential to synergize, and minimize their potential to clash.

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References

[1] Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. Pediatrics 2004;113(May (5 Suppl)):1493–8.
[2] Hutchison B, Levesque J-F, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. The Milbank Quarterly 2011;89:256–88.
[3] Grundy P, Hagan KR, Hansen JC, Grumbach K. The multi-stakeholder movement for primary care renewal and reform. Health Affairs 2018;29(5):791–8.
[4] Gauld R. Lessons for Australian primary care reform from New Zealand, that great change laboratory. The Medical Journal of Australia 2011;195(4):216–7.
[5] Starfield B. Toward international primary care reform. CMAJ 2009;180(11):1091–2.
[6] Canadian Institute for Health Information. How Canada compares: results from the Commonwealth Fund 2015 international health policy survey of primary care physicians. Ottawa, ON: CIHI; 2016.
[7] Martin D, Miller AP, Quesnel-Vallée A, Caron RN, Vissandjee B, Marchildon GP. Canada's universal health-care system: achieving its potential. Lancet 2018;391(10131):1718–35.
[8] Tenbensel T, Burau V. Contrasting approaches to primary care performance governance in Denmark and New Zealand. Health Policy 2017;121:853–61.
[9] Kirkpatrick I, Jespersen PK, Dent M, Neogy I. Medicine and management in a comparative perspective: the case of Denmark and England. Sociology of Health and Illness 2009;31(5):642–58.
[10] Lazar H, Lavis JN, Forest P-G, Church J. Paradigm freeze: why is it so hard to reform health-care policy in Canada? Montreal/Kingston: McGill-Queen's University Press; 2013.
[11] Kreindler SA, Larson BK, Wu FM, Carluzzo KL, Gbemudu JN, Struthers A, et al. Interpretations of integration in early accountable care organizations. The Milbank Quarterly 2012;90:457–83.
[12] Martin D. Of honey and health policy: the limits of sweet, sticky substances in reforming primary care. Healthcare Papers 2012;12(2):34–9.
[13] Foster M, Henman P, Gable A, Denton M. Population health performance as primary healthcare governance in Australia: professionals and the politics of performance. Policy Studies 2016;37(6):521–34.
[14] Levesque J-F, Pineault R, Grimard D, Burge F, Haggerty J, Hogg W, et al. Looking back to move forward: a synthesis of primary health care reform evaluations in Canada. Montreal, QC: Agence de la santé et des services sociaux de Montréal/Direction de santé publique/ Institut national de santé publique du Québec; 2012.
[15] Carter R, Riverin B, Levesque JF, Gariepy G, Quesnel-Vallée A. The impact of primary care reform on health system performance in Canada: a systematic review. BMC Health Services Research 2016;16:324.
[16] Glazier RH, Klein-Geltink J, Kopp A, Sibley LM. Capitation and enhanced fee-for-service models for primary care reform: a population-based evaluation. CMAJ 2009;180(11):E72–81.
[17] Health Alberta. Primary care networks review. Edmonton, AB: Government of Alberta; 2016.
[18] Wong ST, MacDonald M, Valaitis RK, Kaczorowski J, Munroe V, Blatherwick J. An environmental scan of primary care and public health in the province of British Columbia. Vancouver, BC: Centre for Health Services and Policy Research, University of British Columbia; 2009.
[19] Lavergne MR, Peterson S, McKendry R, Sivananthan S, McGrail K. Full-service family practice in British Columbia: policy interventions and trends in practice, 1991–2010. Healthcare Policy 2014;9(4):32–47.
[20] Hutchison B. From Hall to now: reflections on Canadian medicare from a primary care perspective. Presentation at the Canadian Association of Health Services and Policy Research Conference 2013.
[21] Kreindler SA, Struthers A, Metge CJ, Charette C, Harlos K, Beaudin P, Bapuji SB, Botting I, Francois J. Pushing for partnership: Physician engagement and resistance in primary care renewal. Journal of Health Organization and Management 2019, http://dx.doi.org/10.1108/JHOM-05-2018-0141 (early cite).
[22] Canadian Institute for Health Information. Physicians in Canada, 2017. Ottawa, ON: CIHI; 2019.
[23] College of Physicians and Surgeons Manitoba. Physician directory [Internet]; 2017 [cited 2017 Oct 19]. Available from: www.cpsm.mb.ca.
[24] Prairie Research Associates. Manitoba's Physician Integrated Network (PIN) initiative: a benefits evaluation report. Winnipeg, MB: Government of Manitoba; 2012.
[25] Katz A, Chateau D, Bogdanovic B, Taylor C, McGowan K-L, Rajotte L, et al. Physician integrated network: a second look. Winnipeg: Manitoba Centre for Health Policy; 2014.
[26] Brennan G [cited 2018 May 8]. Available from: Driving EMR adoption: from zero to seventy [Internet]; 2018 www.slideserve.com/rod/driving-emr-adoption-from-zero-to-seventy.
[27] Breton M, Wong ST, Smithman MA, Kreindler S, Jbilou J, Sutherland J, et al. Centralized waiting lists for unattached patients in primary care: learning from an intervention implemented in seven Canadian provinces. Healthcare Policy 2018;13(4):65–82.
[28] Struthers A, Metge C, Charette C, Harlos K, Bapuji S.B, Beaudin P, Botting I, Katz A, Kreindler S.A, Family physician perceptions of primary care renewal strategies in Manitoba. Canadian Family Physician; in press.
[29] College of Family Physicians of Canada [cited 2018 Mar 2] Available from: The patient's medical home [Internet]; 2018 http://www.cfpc.ca/PMH/.
[30] Zimmerman B, Reason P, Rykert L, Gitterman L, Cristian J, Gardam M. Frontline ownership: generating a cure mindset for patient safety. Healthcare Papers 2013;13(1):6–22.
[31] Curry N, Ham C. Clinical and service integration: the route to improved outcomes. London, UK: King's Fund; 2010.
[32] Lindblom CE. The science of "muddling through.". Public Administration Review 1959;19(2):79–88.
[33] Béland D, Powell M. Continuity and change in social policy. Social Policy & Administration 2016;50(2):129–47.
[34] Mahoney J, Thelen K. A theory of gradual institutional change. In: Mahoney J, Thelen K, editors. Explaining institutional change: ambiguity, agency, and power. Cambridge: Cambridge University Press; 2010. p. 1–37.
[35] Rayner J, Howlett M. Introduction: understanding integrated policy strategies and their evolution. Policy and Society 2009;28(2):99–109.
[36] Rudoler D, Peckham A, Grudniewicz A, Marchildon G. Coordinating primary care services: a case of policy layering. Health Policy 2019;123(2):215–21.
[37] Rosen R, Pettigrew LM, Mays N, Kumpunen S, Posaner R. Lessons for "large-scale" general practice provider organisations in England from other inter-organisational healthcare collaborations. Health Policy 2018;123(1):51–61.
[38] Sanchez-Piedra CA, Jaruseviciene L, Prado-Galbarro FJ, Liseckiene I, Sánchez-Alonso F, García-Pérez S, et al. Factors associated with professional satisfaction in primary care: results from EUprimecare project. European Journal of General Practice 2017;23(1):114–20.
[39] Gauld R. Could lessons have been drawn from New Zealand for England's NHS reforms? Commonwealth & Comparative Politics 2016;54(4):518–35.