Health Canada Santé Canada

Primary Health Care Transition Fund

Formative Evaluation Report

Presented to

Health Canada
Departmental Audit and Evaluation Committee

April 2006

Canada

ACTION PLAN IN RESPONSE TO THE PRIMARY HEALTH CARE TRANSITION FUND FORMATIVE EVALUATION REPORT

Management Observations – Undergoing the process of a formative evaluation has been beneficial to the PHCTF in strengthening and improving the performance measurement strategy and a number of improvements have already been made as a result. The PHCTF agrees that it can further strengthen the integration of its performance measurement strategy into its ongoing monitoring and evaluation activities
With regard to timing, the evaluation notes the lack of significant performance measurement information available at the time of data collection (November 2004 to June 2005). Indeed, given the planning and preparation needed for implementation for such large initiatives, the PHCTF is not surprised by these findings. However, as the initiatives have progressed, so has the quality and depth of information provided.

RECOMMENDATION	RESPONSE	ACTION TAKEN AND REQUIRED	LEAD	TIME FRAME
1. The PHCTF management should examine its performance measurement strategy and monitoring activities, initiate planning for the summative evaluation, and ensure that performance information is being collected to inform the assessment of. PHCTF outcomes and results.	The PHCTF accepts the recommendation.	Final report guidelines were developed based on the logic model. The PHCTF has communicated the need for strengthening performance measurement reporting to its recipients, including PTs. Resources have been allocated for 2005-06 for the development of the summative evaluation framework – the work for the 2005-06 year will consist of Terms of Reference between PHCTF and DPED and a work plan outlining how the summative evaluation will proceed in the year 2006-07.	PCHCD PCHCD	Sept – Dec 05 Jan – June 06
More specifically: a) PHCTF should develop a tracking system to document, monitor and publicly report on all progress towards the PHCTF outcomes.	The PHCTF accepts the recommendation.	The PHCTF tracks progress the following ways: • websites and jurisdictions' communications with the public, including news releases; • annual reports; • quarterly financial and progress reports; and • attendance at various meetings, including initiative steering committee meetings and the FPT Advisory Group meetings.	PCHCD PCHCD	Ongoing Ongoing

RECOMMENDATION	RESPONSE	ACTION TAKEN AND REQUIRED	LEAD	TIME FRAME
		The Primary Health Care Policy Unit developed a database in the Spring 2005 for the purpose of tracking information on primary health care in the Canadian health care system, particularly with a view to monitor progress in PHC renewal. It includes, but is not limited to, information on PHCTF-funded initiatives. Information is collected across three categories: governments (i.e., provincial, federal and territorial initiatives in primary health care); national health organizations (i.e., their activities/positions in relation to PHC); and pan-Canadian PHCTF initiatives. Additionally, the PHCTF developed a program database which will provide electronic access to standard data on all PHCTF initiatives (that was collected previously by hand). This will increase efficiency in accessing and consolidating information and in reporting. The program database will also link to the PHCTF website for use in disseminating information on the initiatives, including resources and events. The website will remain accessible after the PHCTF sunsets. Both databases will help facilitate the extraction of information to publicly report on progress towards the PHCTF objectives. The PHCTF has undertaken several actions to ensure appropriate reporting, including: • input to departmental Report on Plans and Priorities; • internal information sharing is facilitated through the PHCTF Departmental Reference Group, established in May 2005 and a Departmental Primary Health Care Network, sponsored by the Policy Unit, to share information and stimulate discussion on issues related to primary health care renewal; • briefing notes; and • input to FMM tracking reports.	PCHCD PCHCD PCHCD	May 05 - ongoing Nov 05 – ongoing Ongoing

RECOMMENDATION	RESPONSE	ACTION TAKEN AND REQUIRED	LEAD	TIME FRAME
b) Monitoring activities should be formally integrated and fully linked with the logic model and the performance measurement strategy of the PHCTF.	The PHCTF accepts the recommendation.	In addition to the databases, the PHCTF has developed final reporting guidelines (see Appendix A) as well as questionnaires (see Appendix B) relating to specific synthesis themes. These tools are based on the program logic model. Consult DPED for advice and recommendations.	PCHCD	Ongoing
c) PHCTF should plan and communicate its summative evaluation strategy with PTs and PHCTF funded initiatives so that relevant performance information is collected in preparation for the summative evaluation.	The PHCTF accepts the recommendation.	The evaluation framework – which incorporates the summative evaluation – was completed in June 2004. More detail about the methodology and timelines will be provided in the summative evaluation work plan. The PHCTF has informed all recipients of the information that will be required through the final report guidelines & synthesis questions. Once the summative evaluation framework is finalized, other information needs may be identified and will be addressed at that time.	PCHCD and DPED PCHCD	Jan – June 2006 Nov 05 - ongoing
2. To enhance communication with stakeholders, it is recommended that PHCTF management plan an enhanced role in the development and dissemination of PHCTF information and results, to ensure sustainability of initiatives, to inform stakeholders of PHCTF progress in a timely manner, and to improve potential linkages among initiatives.	The PHCTF accepts the recommendation.	It is a condition of all contribution agreements that the recipients disseminate materials and products resulting from their initiative. The PHCTF communicates with stakeholders by distributing broadly PHCTF publications to recipients, senior officials, PT officials, parliamentarians, media, and stakeholders, and by making available on the website the following: • PHCTF Pamphlet (produced in 2003-04) • PHCTF Summary of Initiatives (October 2004, revised in May 2005, revised in October 2005) • PHCTF Interim Report (May 2005 and revised October 2005) • PHCTF Tools for Transition and Best Practices Network Calendar of Upcoming Events (produced in Sept 05)	PHCTF PCHCD	Ongoing June 05 - ongoing

RECOMMENDATION	RESPONSE	ACTION TAKEN AND REQUIRED	LEAD	TIME FRAME
		A new and improved website with updated information on every funded initiative is being developed. Fact sheets will be posted on every initiative once they have ended. As well, synthesis reports will be posted on the web toward the end of the program.		
		The PHCTF regularly shares initiative-based information to increase knowledge of, and exposure to, primary health care renewal efforts. This includes senior official participation at initiative events (launches and receptions), facilitated meetings among proponents, and circulating publications (literature reviews, research reports etc.) produced by the PHCTF initiatives, as well as participating at meetings of the PHC Network, FPT Advisory Group, PHCTF Reference Group, and Advisory Committee on Health Delivery and Human Resources.	PCHCD	Ongoing
		A final synthesis and dissemination plan has been completed. The dissemination principles have been posted on the PHCTF website. Work is underway to implement the synthesis and dissemination plan which includes a series of synthesis reports and a final wrap-up conference to be held in Ottawa in February 2007.	PCHCD	Sept 05 - ongoing

Lessons Learned

1. Time limited programs that provide funding to other orders of government should consider whether the use of contribution agreements is the appropriate mechanism to transfer funds.

The Department is aware that contribution agreements may not be the most appropriate mechanism to transfer funds to other orders of government, and requested that Treasury Board introduce a new instrument. PHCTF officials participate on the Department's Interim Steering Committee on Grants & Contributions. A key activity in 2005-06 was to provide input to Treasury Board's new Transfer Payment Policy. The issue of mechanisms for funding other orders of government was raised but an alternative mechanism did not result at that time. The program supports continued efforts to develop an appropriate mechanism.

2. **Performance measurement and evaluation requirements should be formally integrated into the program design. This recommendation entails that common definitions and indicators, data collection tools, reporting templates, and evaluation requirements be developed and communicated to funding recipients at the outset of the program implementation**.

   The PHCTF agrees. With respect to evaluation of primary health care now and in the future, the PHCTF is funding a national process that will seek to develop a framework for evaluation of primary health care renewal, commonly agreed upon indicators and tools and instruments to guide the data collection. These did not exist prior to the PHCTF; one legacy of the PHCTF will be to create that capacity.

3. **If sustainability is relevant to the program, the concept should be defined and implications for funding recipients and program stakeholders should be considered and communicated at the program design stage. Defining concepts that are central to the success of the program at the early stage could ensure a consistent understanding of its implications and improve the chances of its successful application**.

   The PHCTF agrees and would encourage Treasury Board to support the development of tools, concepts and definitions of sustainability at a government-wide level, as this continues to be a requirement for many Gs&Cs programs.

M:\PHC (PCHCD)\1PHCTF\Quality Assurance\Program Evaluation\Mid-Term Evaluation\Final RESPONSE&ACTION PLAN06Feb22.doc

Appendix A

PHCTF FINAL REPORT COVER SHEET
(All Envelopes)

Please provide the following information for your initiative and complete the form electronically.

Name of Initiative:	
PHCTF envelope and sub-envelope, if applicable:	
Contribution agreement #:	
Lead organization (i.e. which managed the initiative on behalf of the partners (usually the signatory to the contribution agreement)):	
PHCTF contribution amount:	
Initiative End Date:	
Report date:	
Partner organizations (i.e. those which collaborated in developing and carrying out the initiative – does not include third-parties who were contracted to undertake work, or organizations which were consulted or targeted by the initiative). If additional space is required, please provide list in full on a separate page.	
Name/Contact Information For Lead Individual Within The Lead Organization	
Individual's name and title:	
Organization:	
Mailing Address:	
Phone:	
Fax	
E-mail	
Name/contact for information Communications contact (if different from initiative lead):	
Initiative website, or website with information on the initiative:	

GUIDELINES FOR PHCTF FINAL REPORTING

Documentation Requirements

All initiatives are required to complete the following documentation:

- cover sheet (Attachment A) – to provide standard information on your initiative;
- objectives checklist (Attachment B) – to explain how your initiative addressed the PHCTF's objectives; and
- final report of activities and results (Attachment C) – to provide a narrative account of your initiative.

In addition, some initiatives may be asked to complete questionnaires relating to certain theme areas, such as information technology or chronic disease management. This information will be used by Health Canada to prepare the PHCTF synthesis reports. Questionnaires pertinent to your initiative are included in this package.

Financial and Administrative Reporting

Information on financial and administrative wrap-up of your initiative will follow under separate cover. In the meantime, please continue to submit your regular financial statements.

Formatting and Delivery Requirements

- Please follow the templates provided for each document.
- Please use Microsoft Word, WordPerfect, or another standard word processing program to prepare your report (please **do not** submit reports in PDF format).
- Please send **one electronic copy** of each document to your designated program officer at the PHCTF.
- Please send five hard copies of all documents to the PHCTF at the following address by the date specified in the cover letter:

  Primary Health Care Transition Fund
  1845B Jeanne Mance Building
  PL 1918B
  Tunney's Pasture, Ottawa, Ontario
  K1A 0K9

  If your initiative has lengthy appendices or other attachments, please consult your program officer regarding submission of hard copies.

Timelines

Reporting deadlines vary with contribution agreement end-dates. Please refer to the cover letter for the due date for your initiative's documentation. In general, the requirements are:

CA end-date	Reporting Requirements	Due Date
March 31, 2006	as described above	June 30, 2006
April 2006 - August 2006	as described above	one month after CA end-date
September 2006	see below	see below

For initiatives ending in September 2006 only:

As was noted in the PHCTF extension guidelines, substantive information is required from extended initiatives in the spring of 2006 in order to support PHCTF program wrap-up and national dissemination activities, notwithstanding that they may be continuing as late as September 30, 2006. Therefore, the reporting requirements will occur in two phases as follows:

- submission of a preliminary final report **by May 31, 2006**, using the attached reporting templates and questionnaires, based on activities and results up to March 31, 2006; and
- submission of a final report by **October 31, 2006 at the latest**. This report will consist of an updated version of Attachment C (final report on activities and results), with changes or additions from the preliminary final report clearly noted (e.g. in text highlighting or "track changes" mode). This report should be submitted in the following formats: one electronic copy showing changes from the May 31, 2006 version; one clean electronic copy; and three hard copies each of the clean and "show changes" versions.

This sequencing and level of information will optimally support the dissemination of PHCTF results. Your collaboration in completing the required documentation in a timely fashion is much appreciated.

PHCTF PROGRAM OBJECTIVES CHECKLIST
(PT Envelope)

Instructions:

- Please fill out the name of your initiative where indicated.
- All initiatives: please complete Section A (PHCTF common objectives).
- Sections B, C: if your initiative addressed any of the objectives of the Aboriginal or OLMC envelopes, please complete where appropriate.
- Please be specific but succinct in highlighting how your initiative addressed the relevant objective(s). You will have an opportunity to elaborate in your report on activities and results.

Name of initiative: _____

SECTION A: PHCTF COMMON OBJECTIVES

Note: Not all initiatives will address all five objectives, and some will address only one.

PHCTF objective	Check if applicable	If yes, please explain
Increase the proportion of the population having access to primary health care organizations (PHCOs) accountable for the planned provision of a defined set of comprehensive services to a defined population		[e.g. how many PHCOs have been created? how many people do they serve?]
Increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases		[e.g. how was this emphasis increased?]
Expand 24/7 access to essential services		[e.g. what services are provided 24/7?]
Establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider		[e.g. number and composition of teams]
Facilitate coordination and integration with other health services, e.g. in institutions and in communities		[e.g. what linkages were established with other parts of the health care system, and how]

SECTION B: ABORIGINAL ENVELOPE

Aboriginal envelope objective	Check if applicable	If yes, please explain
Promoting more productive and cost-effective primary health care service delivery through the integration of existing services and resources.		
Enhancing coordination of service delivery between Health Canada, provincial and territorial governments, and First Nations/Inuit communities and health organizations.		
Enhancing the ability of federal, provincial, and territorial systems to be accountable to each other and to their publics through collaborative information development.		
Improving the quality of services delivered to Aboriginal peoples, including cultural appropriateness.		
Improving linkages between primary health care services and social services.		

SECTION C: OFFICIAL LANGUAGES MINORITIES COMMUNITIES ENVELOPE

OLMC envelope objective	Check if applicable	If yes, please explain
Improving information-sharing and networking among primary health care providers, governments, and official languages minority communities.		
Developing training activities and tools for primary health care providers to improve the effectiveness of services delivered to official languages minority communities.		
Increasing providers'capacity to offer primary health care services to official languages minority communities in Canada.		

PHCTF FINAL REPORT OF ACTIVITIES AND RESULTS
(PT Envelope)

General Instructions

- Please use the following template to prepare your report.
- Please ensure that the report is internally complete, i.e. do not refer to appendices or attachments except to provide additional detail, and not to substitute for substantive responses.
- Please respond as succinctly as is consistent with sufficient detail.
- Remember that valuable lessons may be learned from "failures" as well as "successes" and discuss the former as fully and freely as the latter.
- Please focus throughout on how your initiative supported primary health care renewal, how it was transitional in nature, and how it sought to leverage change in the health care system.
- Please note that final reports, and other relevant resources, created by PHCTF initiatives will be posted on the Health Canada website.

Final Report Template – please follow these headings and guidelines in preparing your report

Title Page
- name of initiative
- lead organization
- initiative lead within lead organization (name and title)
- report author (if different from initiative lead)
- website address for initiative, if applicable
- date of report
- please include the following acknowledgement/disclaimer:
  This project was supported by a financial contribution from the Primary Health Care Transition Fund, Health Canada. The views expressed herein do not necessarily reflect the views of Health Canada.

Table of Contents
- please provide a table of contents according to the headings in this template

Executive Summary
- please provide an executive summary of your report, using the same headings as in the main report

Background and Rationale
- please describe how the initiative arose and the need it was intended to address, focussing on its role in advancing primary health care renewal and leveraging health care system change

Goals and Objectives

- please indicate which of the PHCTF's program objectives your initiative addressed
- include common objectives (all initiatives) and the objectives specific to your PHCTF funding envelope
- refer to Attachment B for the objectives, and ensure that your response is consistent with your feedback for Attachment B
- please describe your initiative's specific goals and objectives
- if the goals and activities changed in the course of the initiative, please discuss how and why

Activities

- describe the activities which you undertook to achieve your goals and objectives
- include activities specifically addressing Aboriginal or OLMC populations, if applicable
- identify challenges and barriers to success, and highlight change management strategies to address them or other facilitators of success
- include a description of your evaluation plan and activities
- include a description of your dissemination plan and activities

Outcomes and Results

- describe the outcomes and results of your initiative, linking to its goals and objectives and including the results of your evaluation activities
- discuss how your initiative advanced primary health care renewal and contributed to health care system change and transition
- include expected and unexpected results, as well as both process and substantive outcomes
- include quantitative results wherever possible
- include information on impact of dissemination activities, if known

Implications

- discuss the importance of the initiative in the context of primary health care renewal and health care system reform, referring to its impact or potential impact beyond its own parameters
- consider implications for both policy and practice, as applicable

Sustainability

- describe the strategies you undertook to support your initiative's sustainability
- discuss how the changes achieved by your initiative will be sustained

Success Stories

- please provide a brief description of notable successes that you wish to highlight

Transferability

- describe how any outcomes and/or products resulting from your initiative may be useful to others

SYNTHESIS TOPIC: CHRONIC DISEASE MANAGEMENT AND HEALTH PROMOTION

Instructions

- You have been asked to complete this questionnaire because your initiative involved chronic disease management and/or health promotion.
- Please complete either or both sections, as applicable. If your initiative involved information management, please complete the questionnaire on that topic also.
- Some responses to this questionnaire may overlap with material in your PHCTF final report. Feel free to refer to your final report in lieu of a response (specific page reference please).

Section A: Chronic Disease Management

1. Did your initiative involve a general strategy which could be applied to various chronic diseases, or did it target specific diseases? If the latter, please identify them.

3. Please describe your initiative's objectives *vis à vis* chronic disease management, and describe the activities which were undertaken to this end.
- Please include efforts to encourage client/patient self-management, if applicable.
- Please include the roles and responsibilities of those involved in client/patient care.

4. Please describe barriers and challenges (anticipated and unexpected) which you encountered, and change management activities which were undertaken to address them. Please highlight factors which facilitated improved chronic disease management.

- Please describe your process outcomes to date (for example, numbers of providers involved and clients/patients served).

- How do you measure the impact of your chronic disease management initiative, and what impact have you measured to date? As applicable, please include information on:
- quality of life;
- number of visits to specialists;
- hospital admissions and length of stay;
- client/patient and provider satisfaction; and
- health outcomes.

Section B: Health Promotion [should this be "Health Promotion/Disease and Injury Prevention"? I used "Health Promotion" mainly to keep the title short, but if we're missing something by leaving out "Disease and Injury Prevention" we should reconsider]

1. Does your initiative involve a general strategy to promote health, or does it target specific issues (such as smoking cessation)? If the latter, please identify them.

2. Do you target specific clients/patients? If so, how did you identify them?

3. Please describe your initiative's objectives *vis à vis* health promotion, and describe the activities which were undertaken to this end.

- Please include efforts to encourage client/patient involvement, if applicable.
- Please include efforts to implement recommended preventive guidelines (i.e. Canadian Task Force on Preventive Health Services), if applicable.
- Please include the roles and responsibilities of those involved in client/patient care.

5. Please describe barriers and challenges (anticipated and unexpected) which you encountered, and change management activities which were undertaken to address them. Please highlight factors which facilitated successful health promotion activities.

8. Please describe your process outcomes to date (i.e. for example, numbers of providers involved and clients/patients served).

- How do you measure the impact of your health promotion initiative, and what impact have you measured to date? As applicable, please include information to date on:
- quality of life;
- health outcomes;
- client/patient and provider satisfaction; and percentage of the recommended preventive guidelines that have been implemented.

SYNTHESIS TOPIC: EVALUATION

Instructions

- You have been asked to complete this questionnaire because your initiative involved building capacity in evaluating primary health care.
- Some responses to this questionnaire may overlap with material in your PHCTF final report. Feel free to refer to your final report in lieu of a response (specific page reference please).

1. Please identify how your initiative sought to improve the evaluation of primary health care – for example, by providing baseline measurements, developing indicators, developing data collection capacity, etc.

2. What elements or features of primary health care did your initiative seek to measure, and how?

3. If you developed specific evaluation tools or instruments, please discuss:
   - how they were disseminated;
   - if they have been implemented, and if so, where and by whom;
   - how they have been incorporated into accountability models and/or are supporting quality improvement initiatives; and
   - what challenges to implementation were encountered, and change management strategies to overcome them.

4. Please comment on data collection issues to support your evaluation goals or products – i.e. is data already available? Are new data collection methods required?

5. Are you aware of any substantive results re primary health care renewal which are available as a result of your initiative (i.e. measurable outcomes produced by tools created by your initiative)?

SYNTHESIS TOPIC: PRIMARY HEALTH CARE TEAMS

Instructions

- You have been asked to complete this questionnaire because your initiative included the creation of primary health care (PHC) teams.
- Please complete Section A, and subsequent sections based on your response to Section A.
- Some responses to this questionnaire may overlap with material in your PHCTF final report. Feel free to refer to your final report in lieu of a response (specific page reference please).

Section A (all initiatives)
Please check the appropriate response to indicate what type of PHC team model your initiative involved (if your initiative involved both types, please check both boxes and provide a separate response for each type):

☐ 1 PHC teams which are responsible for the general PHC needs of their target populations. ***Please complete Sections B and C below.***

☐ 2 PHC teams which are limited to addressing specific conditions or needs (for example, management of a chronic disease). ***Please complete Sections B and D below.***

Section B (all initiatives)
- Please describe your PHC team model in terms of:
- governance and accountability;
- funding mechanism;
- team composition (how many providers, which professions, etc.);
- physical setting (i.e. co-located vs. virtual);
- mechanisms for remuneration of providers;
- range of services provided;
- roles and responsibilities of providers, including individual scopes of practice *vis à vis* collaborative care; and
- access (office hours, after-hours coverage, etc.).

- How are the teams' client/patient populations identified?

- How many teams have been created to date, including: (1) total number of teams; (2) clients/patients served per team; (3) total number of clients/patients served; and (4) geographic distribution (i.e. rural vs. urban settings)?

- How do your PHC teams engage or solicit input from their client/patient populations, and for what purposes (for example, to tailor services or inform planning activities)? How does team composition (i.e. number and mix of providers) reflect community or client/patient needs?

- Please describe barriers and challenges (anticipated and unexpected) which you encountered, and change management activities which were undertaken to address them. Please highlight factors which facilitated teamwork among providers.

- Do your PHC teams emphasize chronic disease management and/or health promotion? If so, please complete the "Chronic Disease Management and Health Promotion" questionnaire.

- Do your PHC teams use information management (for example, telehealth, decision-support software, or electronic medical records) to support their practice? If so, please complete the "Information Management" questionnaire.

- How do your PHC teams engage in quality monitoring and/or improvement initiatives, and how is performance measured (i.e. what indicators do you use)?

- How do you measure the impact of your PHC teams, and what impact have you measured to date? As applicable, please include information on:
- health outcomes;
- levels of success in achieving targets such as optimal rates for immunizations, screening tests, chronic disease management, etc.;
- cost-effectiveness; and
- provider and client/patient satisfaction.

Section C (please complete if you checked Box 1 in Section A)
- How do your PHC teams identify the composition or characteristics of their client/patient populations (for example, demographic characteristics, health status, etc.)?

- How do your PHC teams provide coordination and integration with other parts of the health care system for their clients/patients (for example, hospitals, home care, specialists)?

- Do your PHC teams maintain registries of clients/patients with chronic conditions? If not, how do they identify clients/patients for targeted interventions in chronic disease management?

Section D (please complete if you checked Box 2 in Section A)
- What need is your PHC team model intended to address?

- How do your PHC teams coordinate with other parts of the health care system (for example, hospitals, specialists, home care). If a client/patient's principal PHC provider (usually a family physician) is NOT part of the team, please describe how coordination occurs with him or her.

SYNTHESIS TOPIC: INFORMATION MANAGEMENT

Instructions

- You have been asked to complete this questionnaire because your initiative involved information management in primary health care renewal.
- Please respond as succinctly as is consistent with sufficient detail.
- Please complete Section A (all initiatives), and Section B if your initiative involved telephone advice lines.
- Some responses to this questionnaire may overlap with material in your PHCTF final report. Feel free to refer to your final report in lieu of a response (specific page reference please).

Section A (all initiatives)

1. Please describe:
   i. what type of information management your initiative involved (for example: electronic medical record; telehealth; telephone advice line) (if more than one IT support was involved, please describe each separately);
   ii. what services or activities are supported by information management (for example: clinical decision support; record-keeping; prescribing; ordering tests and receiving results); and
   iii. your objectives in using information management to support PHC delivery, focussing on how it is supporting new or enhanced activities.

2. Please describe barriers and challenges (anticipated and unexpected) which you encountered, and change management activities which were undertaken to address them. Please highlight factors which facilitated uptake and implementation of your information management initiative.

3. Please describe your process outcomes to date (e.g. numbers of technologies installed and providers now using them).

4. How do you measure the impact of your use of information management, and what impact have you measured to date? As applicable, please include information on:
   i. access;
   ii. quality;
   iii. collaboration among providers;
   iv. client/patient and provider satisfaction;
   v. cost-effectiveness;
   vi. self-care;
   vii. continuity of care; and
   viii. integration with other parts of the health care sector (e.g. specialists, hospitals, labs, etc.). With regard to this final point, please comment on interoperability considerations.

Section B (initiatives involving telephone advice lines only, in addition to Section A)

1. Please describe the range of services provided through your telephone advice line.
   - If your initiative does not involve direct service delivery, please describe how it is intended to support telephone advice lines.
   - Do you provide "active" services (for example, outgoing calls to support chronic disease management) in addition to responses to incoming calls?

2. How does your telephone advice service coordinate with the client/patient's principal primary health care provider (usually a family physician)?

3. If not included in your response to Section A, please comment on:
   i. how your telephone advice line has affected access (e.g., number and type of services provided; how clients/patients have been directed; estimated impact on other services such as ER use); and
   ii. cost-effectiveness.

Health Canada Santé Canada

Primary Health Care Transition Fund

FORMATIVE EVALUATION REPORT

September 2005

Departmental Performance Measurement and Evaluation Directorate
Chief Financial Officer Branch

Canada

ACKNOWLEDGEMENTS

We would like to express our appreciation to the many individuals who participated in this evaluation from both Health Canada and outside the Department. Without their cooperation, this evaluation study would not have been possible. In particular, we would like to acknowledge the following individuals.

All of the PHCTF staff, who provided their time and expertise throughout the duration of the study. In particular, from the Primary and Continuing Health Care Division, Health Policy Branch, Health Canada:

- Nancy Milroy-Swainson, Director;
- Cindy Moriarty, Manager;
- Louise Rosborough, A/Manager;
- Sandra Tomkins, Senior Policy Analyst; and
- Georgia Livadiotakis, Policy Analyst.

From the Departmental Performance Measurement and Evaluation Directorate, Information, Analysis and Connectivity Branch, Health Canada:

- Kevin McKenzie, Evaluation Manager;
- Jennifer Cushon, Evaluator;
- Diane Spallin, Administrative Coordinator; and
- Jennifer Taylor, Evaluator.

We would also like to acknowledge the F/P/T Advisory Group on the PHCTF and program stakeholders who participated in the interview component of this study.

Health Canada was assisted by the firms EKOS Research Associates Inc. and Integrity Research Network Inc. for the lines of evidence.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

CONTEXT

On September 11, 2000, First Ministers agreed that "improvements to primary health care are crucial to the renewal of health services" and highlighted the importance of multi-disciplinary teams. In response to these commitments, in 2001, the Government of Canada announced the Primary Health Care Transition Fund (PHCTF or the Fund), an $800 million investment between the years 2001 - 2002 and 2006 - 2007 to support the transitional costs of implementing sustainable, large-scale primary health care renewal initiatives across Canada. The objectives of the Fund are to:

- increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population;
- increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;
- expand 24 hour, 7 day-a-week (24/7) access to essential services;
- establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider; and
- facilitate coordination and integration with other health services.

The PHCTF provides funding through five funding Envelopes: Provincial/Territorial, Multi-Jurisdictional, National, Aboriginal, and Official Languages Minority Communities: the Provincial/Territorial Envelope accounts for the majority of PHCTF funding ($576 million) and is directly supporting provinces and territories in their primary health care renewal activities; the Multi-Jurisdictional Envelope offers the opportunity for collaboration among two or more jurisdictions to realize economies of scale, increase efficiency, and overcome common barriers to primary health care renewal; the National Envelope supports initiatives that create the necessary conditions on a national level to advance primary health care and address common barriers or gaps to primary health care renewal; the Aboriginal Envelope supports initiatives specific to the renewal of primary health care services for Aboriginal peoples (First Nations, Inuit, and Métis) and address the unique needs of Aboriginal communities more generally; and the Official Languages Minority Communities Envelope supports initiatives specific to the needs of French and English-speaking minority communities in Canada. Initiatives funded under all envelopes are intended to complement provincial and territorial activities.

PROGRAM EVALUATION

Health Canada's Departmental Audit and Evaluation Committee designated the current formative evaluation as a key evaluation project and as a result, the Departmental Performance Measurement and Evaluation Directorate, in collaboration with PHCTF management, has managed the evaluation study. The formative evaluation of the PHCTF was conducted to meet the requirements of the 2001 Treasury Board submission as well as to contribute to program management's decision-making, by providing recommendations that could be implemented in the remaining time frame of the Fund as well as lessons learned for future Health Canada programs of a similar nature. The objectives of the formative evaluation are to assess the program design, implementation, reach, and impacts to date of the PHCTF.

Design and Methods

Due to the dynamic environment in which the PHCTF operates, this study employed a pre-post design using the following methods:

- a **literature review**, to examine information on similar primary health care renewal programs and change management in health care systems;
- a **document review**, to assess the Fund's impacts to date;
- **interviews** with 40 program stakeholders, including interviews with Health Canada representatives, provincial and territorial representatives, project proponents from each PHCTF Envelope, non-funded project proponents, provincial/territorial and project evaluators, and researchers and experts in the field of primary health care; and
- a **baseline study comparison**, to assess program impacts to date using 2001 as the reference point.

The design and methods employed for this study are outlined in greater detail in the PHCTF Evaluation Framework, which presents the PHCTF performance measurement and evaluation strategies.

Limitations

While evaluators took every measure to conduct a thorough and methodologically sound study, the following limitations must be considered:

- limited performance management and outcome monitoring;
- extent to which the evaluation questions could be addressed;
- inability to develop valid cause and effect inferences on progress; and
- changing environment in which the PHCTF operates.

FINDINGS

This evaluation study evidenced some weaknesses with respect to the performance measurement and program evaluation context in which the PHCTF operates. While a PHCTF performance measurement strategy is presented in the program's evaluation framework, it has not been fully implemented and as a result, there is insufficient data available to make a thorough assessment of the program's design, implementation, reach, and impacts to date. This does not imply that the PHCTF has not had an impact to date, only that the available data cannot fully assess the PHCTF's effectiveness. As a result, the findings presented in this report are based primarily on the activities and outputs of the Fund and on the opinions of program stakeholders.

Design

The design of the PHCTF and its program objectives were based on formal consultation with the provinces and territories and a number of stakeholder groups and national organizations. The PHCTF objectives are supported by program stakeholders and are consistent with primary health care renewal activities occurring across Canada, which is expected given that a requirement of PHCTF funding was adherence to one or more of the PHCTF objectives.

The evaluation also investigated the appropriateness of the Fund as mechanism to accelerate PHC renewal. In terms of the funding mechanism, Health Canada representatives indicated that the use of Contribution Agreements has facilitated accountability and consistency among initiatives. However, P/T representatives and program stakeholders were more divided on this issue and some cited concerns regarding the length of time between the establishment of the Fund and the approval of Contribution Agreements, the amount of reporting required by the provinces, and the extent to which progress could be made toward the objectives of the Fund given the five year time frame.

Implementation

Evaluation questions regarding the implementation of the Fund addressed the extent to which the Fund has been implemented as intended, the nature of the approval process, the allocation of resources, obstacles encountered in implementation, and the extent of Fund monitoring.

Evaluation results indicate there are several variations in terms of the original PHCTF design and the actual implementation of the Fund. However, these variations are generally consistent with the original substance of the program and reflect the evolving nature of the Fund and the dynamic environment in which primary health care renewal occurs. The main obstacle to

implementation identified by program stakeholders and the document review was the amount of time between the establishment of the Fund and the finalization of the contribution agreements. This delay impacted the level of available data regarding impact of the PHCTF.

The evaluation established that Health Canada has several mechanisms in place to monitor the progress of the PHCTF, including overall monitoring tools, financial management tools, reporting tools, and project closure tools.

Reach

The formative evaluation sought to examine the extent to which the PHCTF fostered collaboration and communication with Fund stakeholders. Available information from the document review and stakeholder interviews indicates that both formal and informal communication mechanisms are being used to communicate with program stakeholders and that these are perceived to be effective.

With respect to partnership development, program stakeholders identified a number of factors that have contributed to partnerships and collaboration, including the existence of the Fund, the range of activities being funded, and the collaboration required for initiatives as contributing factors for partnership development.

Impacts of the Fund

The evaluation sought to assess the impacts of the PHCTF to date. Due to limited performance measurement information available at the time of data collection, the findings focus predominantly on the activities and outputs achieved instead of the outcomes of the Fund.

Program stakeholders believe that the PHCTF has had a positive impact on primary health care renewal in Canada; many respondents identified examples of acceleration of pre-existing renewal efforts and new efforts that are a result of the Fund.

RECOMMENDATIONS

The following recommendations are based on the findings and analysis of multiple lines of evidence that were developed to address the formative evaluation questions related to PHCTF design, implementation, reach, and impacts to date.

This evaluation study found that there were areas in which communication and information sharing amongst stakeholders could be enhanced. Also, weaknesses with respect to the performance management of the PHCTF were identified. An assessment of program impacts

was not possible due to the fact that the PHCTF performance measurement strategy was not implemented. To improve its ongoing communication and performance measurement and ensure that information is being collected in preparation for the summative evaluation, the following recommendations are presented.

1. PHCTF Management should examine its performance measurement strategy and monitoring activities, initiate planning for the summative evaluation, and ensure that performance information is being collected to inform the assessment of PHCTF outcomes and results. More specifically:

    a. PHCTF should develop a tracking system to document, monitor, and publicly report on progress towards the PHCTF outcomes.
    b. Monitoring activities should be formally integrated and fully linked with the logic model and the performance measurement strategy of the PHCTF.
    c. PHCTF should plan and communicate its summative evaluation strategy with P/Ts and PHCTF funded initiatives so that relevant performance information is collected in preparation for the summative evaluation.

2. To enhance communication with stakeholders, it is recommended that PHCTF management play an enhanced role in the development and dissemination of PHCTF information and results, to ensure sustainability of initiatives, to inform stakeholders of PHCTF progress in a timely manner, and to improve potential linkages among initiatives.

LESSONS LEARNED

The intent of the formative evaluation was twofold: first, to make recommendations to PHCTF management that could be implemented in the remaining time frame of the Fund. Second, the evaluation was intended to extrapolate lessons learned that could be applied to future Health Canada programs of a similar nature. The general lessons learned presented below, while based on the findings of the PHCTF evaluation, are not expected to be responded to or implemented by PHCTF management.

Based on the findings of the PHCTF formative evaluation, the following lessons learned are highlighted:

1. Time limited programs that provide funding to other orders of government should consider whether the use of contribution agreements is the appropriate mechanisms to transfer funds.

2. Performance measurement and evaluation requirements should be formally integrated into the program design. This recommendation entails that common definitions and indicators, data collection tools, reporting templates, and evaluation requirements be developed and communicated to funding recipients at the outset of program implementation.

3. If sustainability is relevant to the program, the concept should be defined and implications for funding recipients and program stakeholders should be considered and communicated at the program design stage. Defining concepts that are central to the success of the program at an early stage could ensure a consistent understanding of its implications and improve the chances of its successful application.

INTRODUCTION

This report presents the findings and recommendations of the Primary Health Care Transition Fund (PHCTF or the Fund) formative evaluation. The report consists of five sections and begins with an introduction, which describes the concept of primary health care and the context in which primary health care renewal in Canada is taking place. Following this, the PHCTF is described, including information on program objectives, funding Envelopes, resource profile, and the program logic model. The second section of the report focuses on evaluation methods, including a description of the evaluation issues and questions, evaluation design, methods, and limitations. The next section, which comprises the bulk of the report, presents the findings of the evaluation study, organized by the evaluation issues examined: design, implementation, reach, and impacts to date. The fourth section describes the state of primary health care in Canada at the outset of the Fund and at the time of the present study, in an attempt to characterize any change with respect to primary health care in Canada. The final section presents the recommendations of the evaluation of the PHCTF.

Health Canada's Departmental Audit and Evaluation Committee (DAEC) identified the PHCTF formative evaluation as a key evaluation project for 2004/ 2005 and consequently, the Departmental Performance Measurement and Evaluation Directorate assumed responsibility for managing the evaluation. The PHCTF contribution funding spans the years 2001/2002 - 2005/2006, with an extension of contribution funding until September 2006 for some initiatives; PHCTF operations will continue until March 2007. The purpose of doing a formative evaluation, given the timing of the contribution funding and the length of time taken for program implementation, is threefold:

- to contribute to program management's decision-making by providing recommendations that could be implemented in the remaining time frame of the Fund and to ensure performance information is being collected to inform the summative evaluation;

- to make recommendations that could inform future Health Canada programs of a similar nature; and

- to meet commitments made in the PHCTF Treasury Board submission, which included the development of an evaluation framework (competed in June 2004), the current formative evaluation (2004/2005), and a summative evaluation (2006/2007) to assess the overall impacts of the Fund.

PRIMARY HEALTH CARE RENEWAL IN CANADA

Defining Primary Health Care

Primary health care is not a new idea; in 1978, the World Health Organization's Alma Ata Declaration described primary health care as an integral part of a country's health system, as the first level of contact with the health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.[1] Since that time, primary health care has become a central element of international health system reforms.

To understand the objectives of the PHCTF, it is important to distinguish between two related concepts: primary care and primary health care. Primary care refers to the "diagnosis, treatment, and management of health problems with services delivered primarily by physicians."[2] Primary health care "incorporates primary care, but also recognizes and addresses the broader determinants of health including population health, sickness prevention, and health promotion, with services provided by physicians and other providers often in group practices and multi disciplinary teams."[3] In other words, primary health care refers to an approach to health and a spectrum of services beyond the traditional health care system and includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focusses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury.

While definitions of primary health care are not consistent in the Canadian literature, common themes and characteristics emerge that are relevant to the Canadian context. The level of contact with the health care system is a common component of many primary health care definitions, including the definitions articulated by Alberta, British Columbia, Manitoba, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Saskatchewan, and Health Canada, describing primary health care as the first point of contact for Canadians with the health system. In addition, an analysis of the definitions, restructuring, primary health care models and components across Canada reveals the following common characteristics:

- continuity of services 24 hours a day, 7days a week, in person or by phone;

---

1 World Health Organization. (1978). *Declaration of Alma Ata.* Retrieved on April 22, 2005. http://www.who.dk/AboutWHO/Policy/20010827_1

2 Health Canada. (2000). *Opportunities and Potential: A Review of International Literature on Primary Health Care Reform and Models*. Prepared by: John Marriott and Ann L. Mable. Ottawa, Ontario: p. 1.

3 Ibid.

- development of genuinely interdisciplinary teams of health professionals going beyond the family physician and a nurse;
- ability for patients to choose their primary care provider(s) and, in some cases, the expectation that they will sign up (roster) with their choice for a minimum period of time;
- a focus on wellness and health promotion activities; and
- funding which would be a mixture of capitation arrangements, fee-for-service for specialized services, and program funding.[4]

Health Reform Reports

Considerable efforts have been invested by F/P/T governments into research inquiries on the state of Canada's health care system. National and provincial reports alike placed significant emphasis on primary health care renewal in health system reform. In 2002, the Romanow Report acknowledged the almost universally recognized importance of primary health care, highlighting its benefits such as more coordinated care among different facets of the health care system; improved quality of care via networks of health care providers and agencies sharing responsibility for individuals' care; and a more effective use of resources to prevent illness and save costly hospital care for those who truly need it.[5] Similarly, provincial health reform reports from Alberta, New Brunswick, Ontario, Quebec, and Saskatchewan identified the need to restructure the delivery of primary health care to successfully implement health care reform.

- Alberta's Mazankowski report recommended that health providers explore and implement different approaches to organizing and delivering health care services;[6]
- New Brunswick's report called for the implementation of community health centres to deliver a range of services and the creation of a Health Care Report Card with standards and performance measures;[7]

---

[4] Canadian Policy Research Networks. (2002). *Romanow and Beyond: A Primer on Health Reform Issues in Canada.* Retrieved online. http://www.cprn.com/en/doc.cfm?doc=130

[5] Commission on the Future of Health Care in Canada. (2002). *Building on Values: the Future of Health Care in Canada.* Retrieved online May 20, 2005. p. 115-166. http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf

[6] Premiers Advisory Council on Health for Alberta. (2001). *A Framework for Reform: Report of the Premier's Advisory Council on Health*. Retrieved online May 19, 2005. p. 10. http://www.premiersadvisory.com/pdf/PACH_report_final.pdf

[7] Government of New Brunswick. (2001). *Report of the Premiers Health Quality Council.* Retrieved online January 13, 2005. http://www.gnb.ca/0051/index-e.asp

- Quebec's Clair Commission identified primary health care as the foundation of the health system and called for primary health care networks and family medicine groups, to improve access to front-line services, 24 hours a day, seven days a week;[8] and
- Saskatchewan's Fyke Commission recommended the establishment of primary health service teams that would ensure that comprehensive services are available 24 hours a day, seven days a week.[9]

Primary Health Care and Health System Renewal in Canada

Understanding the roles and responsibilities of federal, provincial, and territorial orders of government is crucial to understanding health care reform and primary health care renewal in Canada. Provincial and territorial governments are responsible for the administration, funding, and delivery of health care services within their respective jurisdictions. The federal government is responsible for administering the Canada Health Act; assisting in the financing of provincial/territorial health care services through fiscal transfers; delivering health care services to specific groups (e.g. First Nations and Inuit and veterans); and providing other health-related functions such as public health and health protection programs and health research.[10]

FMM 2000

The commitment to collaborate that was initiated with the Social Union Framework Agreement continues through the mechanism of First Ministers' Meetings (FMM). On September 11, 2000, First Ministers' of Health agreed on a vision, a set of principles, and an action plan for health system renewal. The action plan agreed to continue to make primary health care renewal a priority and indicated that improvements to primary health care are crucial to the renewal of health services.

In response to commitments made in FMM 2000, in 2001, the Government of Canada announced the Primary Health Care Transition Fund (PHCTF), an $800 million investment between the years 2001 - 2002 and 2006 - 2007 to support the transitional costs of implementing sustainable, large-scale primary health care renewal initiatives across Canada.

---

8 Government of Quebec. (2000). *Emerging Solutions: Report of the Commission of Study for Health and Social Services.* Retrieved online My 19, 2005. *http://www.cessss.gouv.qc.ca*

9 Government of Saskatchewan. (2001). *Caring for Medicare: Sustaining a Quality System*. Retrieved online May 19, 2005. p.15. http://www.health.gov.sk.ca/mc_dp_commission_on_medicare-bw.pdf

10 Health Canada. (2004). *Health Care.* Retrieved on April 22, 2005. http://www.hc-sc.gc.ca/english/care/index.html

FMM 2003

In 2003, the First Ministers' Accord on Health Care Renewal renewed the F/P/T commitment to work in partnership toward health care renewal. Towards this goal, First Ministers agreed to immediately accelerate primary health care initiatives and make significant annual progress so that citizens routinely receive needed care from multi-disciplinary primary health care organizations or teams. The Accord set a target that by 2011 at least 50% of Canadians should have 24/7 access to an appropriate primary health care provider.

FMM 2004

Building on previous renewal efforts, in 2004, First Ministers reiterated the target in the Ten-Year Plan to Strengthen Health Care and agreed to establish a Best Practices Network for information-sharing and collaboration. Foremost on the agenda is the need to ensure that timely access to quality care is a reality for Canadians. These commitment were accompanied by additional federal funding.

Aboriginal Health Transition Fund

In 2004, the Government of Canada announced the funding of $200 million for an Aboriginal Health Transition Fund (AHTF) to enable governments and communities to devise new ways to integrate and adapt existing health services to better meet the needs of Aboriginal people.

Health Council of Canada

The Health Council of Canada, an independent council whose aim is to inform Canadians on health care matters, also views primary health care renewal as a priority. In their 2005 report, the Council emphasized the significance of primary health care, indicating it is the foundation of Canada's health care system.[11] The Council supported the work F/P/T governments have achieved to date and made a series of recommendations aimed at accelerating change, including: the use of common definitions; accelerate new delivery models; remove regulatory barriers; change education and training models; and accelerate the introduction of information technology.[12]

---

[11] Health Council of Canada. (2005). *Health Care Renewal in Canada: Accelerating Change*. Retrieved online April 21, 2005. http://hcc-ccs.com/report/Annual_Report/Accelerating_Change_HCC_2005.pdf

[12] Ibid.

PRIMARY HEALTH CARE TRANSITION FUND

Program Objectives

As outlined in documents used in support of the creation of the PHCTF, based on consultation with provincial and territorial representatives, and consistent with primary health care renewal priorities identified in FMM 2000, the common objectives of the PHCTF are to:

- increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population;
- increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;
- expand 24 hour, 7 day-a-week (24/7) access to essential services;
- establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider; and
- facilitate coordination and integration with other health services, i.e. in institutions and in communities.

Fund Components

The PHCTF provides funding through five funding Envelopes: Provincial/Territorial, Multi-Jurisdictional, National, Aboriginal, and Official Languages Minority Communities. The program objectives mentioned above pertain to all of the five funding Envelopes. In addition, four of the Envelopes have more specific objectives: the Multi-Jurisdictional, National, Aboriginal, and Official Languages Minority Communities.

- **Provincial/Territorial Envelope (P/T)**

The purpose of the P/T Envelope is to assist P/Ts in broadening and accelerating primary health care initiatives by providing funding to support time-limited, transitional costs of introducing systemic primary health care renewal. In the context of the common objectives, the funding supports large-scale implementation initiatives that will lead to fundamental and sustainable changes to the organization, funding, and delivery of primary health care services in each jurisdiction.

❑ Multi-Jurisdictional Envelope (MJ)

The purpose of the MJ Envelope is to support collaborative initiatives undertaken by two or more P/Ts by providing the opportunity for governments to work together on primary health care renewal. The specific objectives of this envelope are to realize economies of scale, encourage the sharing of lessons learned, increase efficiency by avoiding duplication of effort, and overcome common barriers to primary health care renewal.

❑ National Envelope

The purpose of the National Envelope is to support large-scale initiatives of national significance and relevance that will support and complement primary health care renewal activities funded under the P/T Envelope. The objectives of the National Envelope are to:

- enhance sustainability of the primary health care system by engaging stakeholders and the public in dialogue on primary health care renewal;
- educate the public on primary health care renewal;
- maximize synergies and the use of collaborative approaches to renewal by providing fora for information sharing;
- improve availability and quality of information on primary health care nationally;
- create common practical tools to address challenges that arise during the renewal process;
- facilitate collaboration among primary health care professions; and
- facilitate changes to practice patterns for primary health care providers.

The National Envelope supports initiatives through three funding streams:

- National Strategies: for initiatives conducted at the national level, which maximize synergies and cost effectiveness by developing common or collaborative approaches to key areas of primary health care renewal.
- Tools for Transition: offers providers, planners, and administrators the opportunity to share information and experiences on change management as renewal efforts are implemented. Tools for Transition is comprised of a F/P/T component and a Responsive component.
- National Initiatives: for primary health care renewal activities that are national in scope or relevance, but that occur in local or regional settings.

❑ Aboriginal Envelope

The Aboriginal Envelope supports initiatives specific to the renewal of primary health care services for Aboriginal peoples (First Nations, Inuit, and Métis) and will respond to the Aboriginal population's need for access to integrated primary health care by promoting large-scale, sustainable changes to the F/P/T health systems which support Aboriginal health.

The specific objectives of this Envelope are to:

- promote more productive, cost-effective primary health care service delivery to Aboriginal peoples by integrating existing services and resources;
- enhance service delivery co-ordination between Health Canada's First Nations and Inuit Health Branch, provincial/territorial governments, First Nations and Inuit communities and health organizations;
- enhance the ability of provincial/territorial and First Nations and Inuit Health Branch systems to be accountable to each other and their public through collaborative information development;
- improve the quality of primary health care services delivered to Aboriginal peoples, including the cultural appropriateness of services; and
- improve linkages between primary health care services and social services delivered to Aboriginal peoples.

The Aboriginal Envelope supports initiatives through two types of funding:

- Health System Renewal: for large-scale initiatives that will renew entire primary health care delivery systems, not just individual centres, professional practices or delivery sites. Large-scale can refer to a broad geographic area that is affected by renewal, but it can also refer to the depth of renewal; and
- Health System Enhancement: for activities that do not necessarily result in changes to entire health systems, but instead improve the delivery of primary health care in a way that specifically benefits Aboriginal peoples.

In 2003, a Memorandum of Understanding between the PCHCD and FNIHB was developed to transfer $15 million over three years for the Nursing Strategy and Health Integration Initiative. FNIHB manages the funds in accordance with the PHCTF Terms and Conditions and the Treasury Board Transfer Payment Policy and participates in the Fund's reporting framework and program evaluation.

❑ Official Languages Minority Community Envelope (OLMC)

The purpose of the OLMC Envelope is to fund initiatives that support primary health care renewal for French and English speaking minority communities across Canada. The OLMC Envelope seeks to:

- improve information-sharing, networking, and forging of links among providers, governments, and official languages minority communities;
- develop training activities and tools for providers to improve accessibility of primary health care services by official languages minority communities; and
- increase capacity of providers to offer primary health care services to official languages minority communities throughout Canada.

There are two main OLMC Envelope initiatives: English-Speaking Minority Communities and French-Speaking Minority Communities. The Community Health and Social Services Network and Société Santé en français [Francophone Health Society] are the two lead organizations for these initiatives, respectively.

Program Management

The PHCTF is managed by a Secretariat in the Health Care Policy Directorate of the Health Policy Branch. At the time of Fund inception, $30 million in operating funds were allocated to the Primary Health Care Division, which included three units:

- a fund unit to manage the contributions process (funding guidelines, RFPs, reviewing proposals, monitoring agreements etc.)
- a policy unit to both inform the funding decisions under the PHCTF and to be informed by the outcomes of PHCTF funded initiatives within the broader policy context for primary health care renewal; and
- an operations and accountability unit responsible for financial management of contributions funding, and development of accountability tools such as the Results-Based Management and Accountability Framework (RMAF) and Results Based Audit Framework (RBAF).

Since the time of Fund inception, a Directorate realignment resulted in the PHCTF being situated in the Primary and Continuing Health Care Division (PCHCD).

Program Resources

As per the PHCTF RMAF, the original Fund total was $800 million. Since that time, there have been revisions to the budget and resource allocations. Table 1 presents the original and revised PHCTF budget.

Table 1
PHCTF Original and Current Resource Allocations (in millions)

Envelope	Original Allocation	Allocated Funds
Provincial/Territorial Envelope	$576 M	$576 M
Multi-Jurisdictional Envelope	$25 M	$30.2M
National Envelope	$50 M	$64M
Aboriginal Envelope	$20 M	$34.7M
Official Language Minority Communities Envelope	$15 M	$30M
Unassigned Funds	$84 M	-
Contribution Allocation (Subtotal)	**$770 M**	**$734.9**

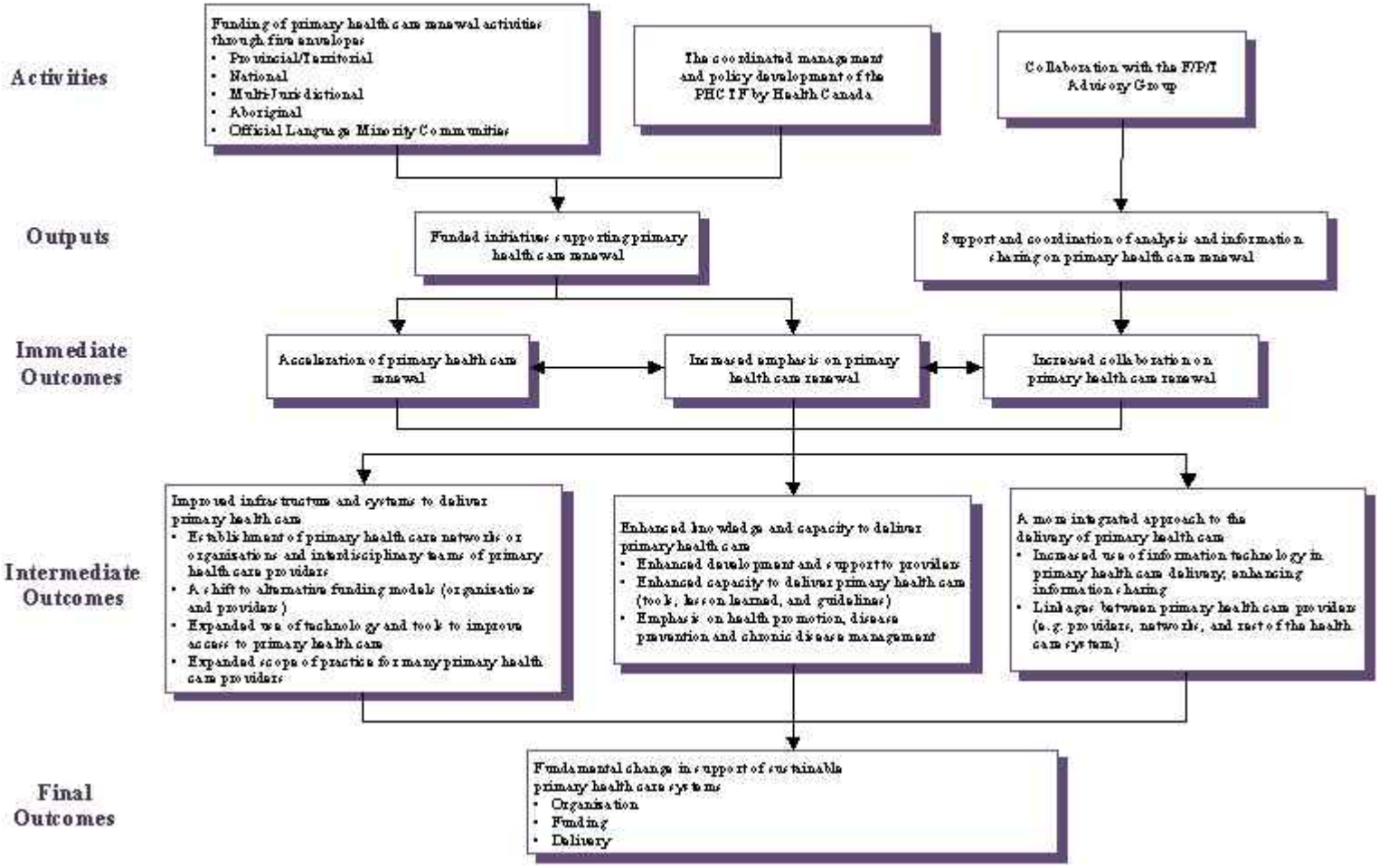
Table 1 PHCTF Original and Current Resource Allocations (in millions)		
Operating dollars (includes PWGSC Accommodation Costs)	$30 M	$29.4
Total Allocation	**$800 M**	**$764.3**
Lapsed Funds ($15.7 M in 2001-02; $2.9 M in 2003-04)		$18.6 M
Departmental Reduction ($16.6 M; $5.9 M in 2004-05; $8.9 M in 2005-06)		$31.4 M
Redirected Lapsing Funds ($3.9 M in 2002-03; $8.7 M in 2003-04)		$12.6 M
Vote Transferred from contributions to O&M 2005-06 ARLU		$4.78M

PHCTF Logic Model

In 2001, a program logic model was developed based on the reality at the time the PHCTF was established. In 2004, the development of the PHCTF Evaluation Framework provided the opportunity to review and revise the program logic, based on the information emanating the various lines of evidence used to inform the framework and a logic model session with participants from the PCHCD and the Departmental Performance Measurement and Evaluation Directorate (DPMED). Presented in Figure 1, the revised PHCTF logic model is a diagram used to describe and communicate the elements of the Fund and provides the focus for the performance measurement strategy and formative evaluation. In addition to describing the main components of the Program, the logic model describes the linkages between the main activities, the outputs, and the immediate, intermediate, and final outcomes.[13]

[13] A narrative description of the PHCTF logic model was also developed but is not included in this report.

Primary Health Care Transition Fund Logic Model



METHODS

Planning for this evaluation began in June 2004, when Terms of Reference were developed between the DPMED and the PHCTF management; data collection was conducted from September 2004 to March 2005; the final report was drafted in May 2005 and completed in July 2005.

EVALUATION ISSUES AND QUESTIONS

The evaluation was national in scope and focussed on addressing four key evaluation issues: design, implementation, reach, and impacts to date. The formative PHCTF formative evaluation questions are presented in Table 2.

Table 2
PHCTF Formative Evaluation Questions

Evaluation Issues	Evaluation Questions	Literature Review	Document Review	Stakeholder Interviews
Design	To what extent has the PHCTF been an appropriate mechanism to accelerate primary health care reform in Canada?	X	X	X
	Are the objectives of the Fund appropriate?	X	X	X
	Were the right stakeholders included in the design process to ensure full buy-in and participation?		X	X
	What are the strengths and weaknesses of the design?		X	X
Implementation	Has the PHCTF been implemented as intended?		X	X
	Was the approval process fair, comprehensive and timely?		X	X
	How were the resources allocated? Were they allocated appropriately?		X	X
	What obstacles were encountered in the implementation?		X	X
	To what extent has the Program been monitoring progress of the PHCTF?		X	X

Table 2 PHCTF Formative Evaluation Questions				
Evaluation Issues	**Evaluation Questions**	**Literature Review**	**Document Review**	**Stakeholder Interviews**
Reach	What communication has been established with partners, stakeholders?		X	X
	What were the conditions required to build trust for partnerships and for collaboration to be successful (between levels of government, among providers)?		X	X
Impacts	To date, what evidence is there of increased emphasis on primary health care renewal as a result of the Fund?	X	X	X
	To date, what factors contributed to collaboration, partnerships?	X	X	X

EVALUATION DESIGN

The context in which the PHCTF operates is complex and presents a host of challenges in terms of program evaluation. The PHCTF is a "non-uniform full coverage program", meaning that while the program is theoretically uniform in terms of having common objectives, implementation varies significantly.[14] The P/Ts and other Envelopes are at different stages of primary health care renewal and have placed emphasis on varying PHCTF objectives.

As in the case of the PHCTF, "Full coverage programs," present significant challenges to program evaluation, as there are no unserved targets available to use as controls.[15] The PHCTF provides funding to all P/Ts who in turn use the funding to support primary health care delivery to their entire population; therefore, the use of a control group is not possible. As a consequence of the PHCTF's design, to make an assessment of program impacts, the only comparison available is between the same group/target, before and after exposure to the program. The essential feature of a "before and after" study design is a comparison of the same target at two points in time, separated by the program intervention.[16] This pre-post design is the foundation on which the PHCTF formative and summative evaluations will be based.

---

[14] Ibid, p. 344.

[15] Rossi, Peter H., Freeman, Howard E., & Lipsey, Mark W. (1999). Evaluation: A Systematic Approach. (Sixth Edition). SGE Publications Inc., p. 263.

[16] Ibid, p. 267.

FORMATIVE EVALUATION METHODS

As outlined in the PHCTF Evaluation Framework, multiple lines of evidence were developed to form the basis of the findings for the formative evaluation; collecting data from multiple sources and different perspectives lends greater credibility to the findings.

Literature Review

For purposes of this evaluation, a literature search was conducted to review information on similar primary health care renewal programs and change management in health care systems. Also, this component reviewed secondary data to make an assessment of program impacts to date, using the baseline study as a reference point. The strategy for the review included searching academic literature, web-based literature, and grey literature from governments and research organizations using key search terms. Once the information was collected, the material was examined and common themes were identified which form the basis of the literature review.

Document Review

A review of program documentation was conducted to seek insight into the specific program being evaluated and to facilitate an assessment of program impacts to date. Documents reviewed include, but were not limited to, the following: the PHCTF Treasury Board submission and RMAF, policy documents, budget and expenditure information, accountability documents, administrative records, and annual progress reports submitted by P/Ts and funded initiatives. A documentation review template was used to facilitate the retrieval and organization of information according to the evaluation questions and performance indicators.

Stakeholder Interviews

Interviews were conducted with program stakeholders to inform the assessment of program design, implementation, and reach. A comprehensive list of program stakeholders was developed by PCHCD and DPMED and selection criteria were then applied to finalize the list of stakeholders to be interviewed; selection criteria included the number of respondents to be interviewed by stakeholder type, where possible, avoidance of duplication with respondents from interviews conducted during the development of the PHCTF Evaluation Framework to minimize interviewee fatigue, and regional representation of respondents.

Prior to scheduling interviews, all potential respondents were contacted and sent an introductory letter outlining the purpose of the interviews and assuring candidates of confidentiality according to the federal government's policies and laws governing

information. Next, in advance of the interview, respondents were provided with a copy of the interview guide that provided background information on the evaluation and the list of interview questions to assist in their preparation.

In total, 40 interviews were conducted with respondents in a number of stakeholder groups as identified in Table 3 below.

Table 3
Distribution of PHCTF Stakeholder Interviews

Category Of Respondents	Number of Interviews Completed
Provincial/Territorial Representatives	8
Health Canada Representatives	10
Project Proponents	10
Non-Funded Project Proponents	1
Researchers/experts/NGOs	5
Project and P/T Evaluators	6
Total	40

Interviews were conducted between November, 2004 and January, 2005 and were a mix of in-person and telephone interviews.[17] Interviews were generally 45 minutes to one hour in length and were conducted in the official language of choice of the respondent. Interviews were tape-recorded and a detailed summary was prepared for each interview; summaries were then submitted to the interview respondent for validation.

Interview results were analysed on three levels: the identification of key themes and messages from each individual interview, in each category of respondents (i.e., common themes and messages across interview respondents in the same category), and across the various categories of interview respondents.

The objective of interviews is to gather the perceptions and opinions of stakeholders. Given the qualitative nature of the data, it is useful to use qualitative descriptors such as "some" or "most" respondents during the data analysis and reporting stage. It should be noted that the strength of response (i.e., number of respondents who share an opinion) is not necessarily a reflection of the importance of the theme or message associated with it. The following parameters were used in applying the descriptors to the interpretation of results:

[17] Due to evaluation budget restraints, interviews were conducted in-person only when the interviewee resided in the National Capital Region and was available to be interviewed in-person.

Table 4 Descriptors Used for Stakeholder Interviews	
Descriptor	**Definition**
some; a few	25 per cent of respondents or less (i.e., 10 respondents or fewer)
many; several	25 per cent to 75 per cent of interview respondents
almost all; a majority	75 per cent or more

Baseline Study Update

In 2004, a baseline study was completed that described the primary health care system in Canada, in each province and territory, and of the target populations funded by PHCTF at the outset of the Funding in 2001/2002. The literature and document reviews attempted to provide similar primary health care information to compare to the baseline study.

Analysis, Integration and Preparation of Final Report

Once the lines of evidence were complete, all individual reports were analysed by DPMED evaluators and synthesized to form the basis for the formative evaluation report. An information capture template was developed to facilitate the retrieval and organization of the findings according to the evaluation issues, questions, and indicators. It should be noted that the data collection phase for the document review was extended beyond the contract time lines so DPMED evaluators could examine additional primary data. Information was incorporated only when it was necessary to effectively characterize the PHCTF and its activities, not so as to be incorporated in the data analysis. Once the information was categorized, evaluators conducted a thematic analysis of the information and reported the findings based on the evaluation questions.

LIMITATIONS

Document Review

Several limitations associated with the document review should be noted. First, due to the nature of the Fund (i.e. the use of contribution agreements for transferring funds), an evaluation must take place to ensure appropriate and fair program spending. However, the level of detail submitted in the annual reports varies from recipient to recipient, and some reported limited performance information. This situation poses a dilemma for the evaluators who are seeking information to tell a thorough story about the Fund. Instead the evaluators must rely on the performance data that is publicly accessible.

Second, during the early years of the Fund, P/Ts were in the planning stage of their initiatives and embarking on some activities that were of a sensitive nature, which may not have been yet communicated to their public or stakeholders. As a result, Health Canada was not in the position to share more broadly all the information that was provided by P/Ts. Therefore, there was limited performance data at the time of the formative evaluation from the P/Ts. As the Fund progresses and the P/Ts are in the implementation stage, the PHCTF is able to share more information with the public.

Third, program documentation is not always produced for the explicit purpose of evaluation and therefore, some information was not relevant to the evaluation and the information that was available was not always consistent, comprehensive or according to program objectives and therefore did not lend easily to making an assessment of program impacts. In addition, because initiatives are funded at different times, at the time of data collection, many projects were still in the planning and implementation stages and therefore did not provide any performance information making it difficult to assess PHCTF's impact to date.

Stakeholder Interviews

There were some limitations associated with the interviews that should be considered. First, while repeated efforts were made to contact the respondents initially selected, some declined to participate, did not respond to the request, or repeatedly rescheduled or did not present themselves at the time of the interview; in these instances, a replacement was chosen at random. Consequently, the perspective that was originally sought might not have been captured. Another limitation is that several respondents were not able to respond to all the questions. The final limitations relate to factors inherent in qualitative research; the number of interviewees selected represent only a proportion of the total PHCTF stakeholders and their views therefore do not necessarily reflect those of all stakeholders. Furthermore, it is important to note that many interview respondents work closely with the PHCTF and/or have received funding from the PHCTF and can therefore be considered to have a vested interest and thus may not be completely impartial in their views.

Literature Review and Baseline Study Update

There are several notable limitations associated with the literature review and baseline update that should be considered when reviewing the information. First, the literature review identified little information in terms of best practices and lessons learned. Second, the primary source of information used to inform this phase of the study was publicly accessible information. This poses several limitations as it was not produced for the explicit purposes of the evaluation and therefore was not always relevant to the objectives of the PHCTF. For instance, the primary source of information for the 2004 data were the F/P/T reports on comparable health indicators, which used information from national data sources provided by Statistics Canada, Health Canada, and the Canadian Institute for Health Information. While these reports are useful in characterizing primary health care in Canada, they do not provide information that is directly related to the PHCTF objectives. The information that was

collected was from multiple data sources at different times and did not always adhere to the same data collection techniques and reporting methods. For instance, the 2004 comparable health indicators reports are not the same as the 2002 reports, as a common core set of indicators were adopted in 2004, excluding some of the previous indicators and adding new indicators in 2004. Furthermore, there are differences in the reporting methods for some of the indicators, as some are reported using age standardization while others are not. Consequently, while every attempt was made to collect information that could be used to make an assessment of PHCTF progress, the information from 2002 and 2004 are not always comparable across time periods and should not be read as such. Due to these limitations, this information is not presented as part of the findings but is in the Appendix B of the report. Appendix B will be used as a reference point and comparison for the summative evaluation.

Extent to which the evaluation questions could be addressed

The evaluation study relied on multiple lines of evidence to produce a balanced and comprehensive assessment of the PHCTF's design, implementation, reach, and impacts to date. The PHCTF provided well-organized and comprehensive documents that were critical to the present study and were willing to accommodate all data collection requirements. However, due to gaps in performance management and ongoing performance measurement, the extent which the evaluation questions could be addressed is limited.

Inability to develop cause and effect inferences on progress

Due to complexity surrounding primary health care renewal in Canada and the broad objectives of the PHCTF, the research design employed in the present study was based on a pre-post design. However, due to the limited ongoing collection of performance information, the only sources of information available at the time of the evaluation were publicly accessible reports on primary health care. The information that was used to inform this study was variable across the country and was not comparable to the information presented in the baseline study nor was it directly applicable to the PHCTF objectives. As a result, this evaluation is not able to develop causal statements in terms of progress or impacts that can be attributed to the PHCTF.

Changing environment in which the PHCTF Operates

The PHCTF operates in a complex and dynamic environment that should be noted when considering the impacts of the PHCTF. Health care renewal involves a range of stakeholders and is comprised of several priority areas, of which primary health care is one. Since the PHCTF was implemented, F/P/T governments have invested resources and implemented initiatives that are likely to influence the environment in which the PHCTF and its funded initiatives are operating. Given the broad coverage and implementation of health care reform commitments, it is difficult to isolate the effects of the PHCTF from these external factors and as such, it is difficult to make an assessment of the PHCTF's progress without considering the impacts of other initiatives that operate along side the Fund.

FINDINGS

In this section, the findings of the PHCTF formative evaluation are reported, and organized by the issues of design, implementation, and reach. As indicated in the methods section, the findings are based on multiple lines of evidence which have been synthesized to form the basis of this report.

DESIGN

The formative evaluation sought to assess the appropriateness of the Fund's design. The evaluation questions related to design explored the Fund's mechanism, objectives, stakeholder involvement, and strengths and weaknesses.

The Fund as a Mechanism to Accelerate Primary Health Care Renewal

There is little performance information found in the document and literature review to assess the effectiveness of the Fund as a mechanism to accelerate primary health care renewal and evidence from the stakeholder interviews is mixed and provides only anecdotal information on this question.

All interview respondents, except provincial and project evaluators, were asked their opinion on the appropriateness of the Fund (contribution agreements) as a mechanism to accelerate PHC renewal. Most Health Canada representatives, project proponents, and researchers agreed that the Fund has been an appropriate mechanism to accelerate PHC renewal in Canada. All Health Canada representatives believed contribution agreements were an effective way to ensure accountability and consistency among funded initiatives with the PHCTF objectives, although a few stated that the time taken to approve contribution agreements may pose a challenge for some initiatives to be completed in the five-year time frame.

Provincial/territorial representatives were more divided on this issue. While some P/T representatives stated the Fund was effective, the majority expressed concerns about the five-year time frame and the length of time required to finalize contribution agreements. A few provincial/territorial respondents felt that the contribution agreement mechanism has been cumbersome to manage and a straight fiscal transfer would have been more effective. A few provincial/territorial representatives also expressed concerns that the transitional nature of the Fund (i.e., the five-year time frame) might make it difficult to attract human resources.

A small number of proponents and researchers expressed specific criticisms about the appropriateness of the Fund, including: some communities may be excluded from funding due to the proposal-based nature of the Fund; the time frame might make it difficult to implement sustainable projects; and one respondent believed that Health Canada did not strive for creativity and innovation with the Fund.

Stakeholder Involvement

Findings from the stakeholder interviews and document review indicate that consultation with stakeholders was part of the PHCTF design process and informed the development of the Fund's objectives. The interview component found that many Health Canada and P/T representatives were unable to comment on stakeholder inclusion at the design stage of the Fund due to lack of involvement at the design stage. Those Health Canada and P/T representatives who were involved indicated that extensive consultation had taken place. The document review also found evidence of several mechanisms through which consultation informed the development of the PHCTF. At the 2000 Annual Conference of Ministers of Health, "A Vision for Primary Health Care Across Canada" (also referred to as the Vision Paper) was discussed and Ministers of Health endorsed the visions, goals, objectives, and framework for primary health care as articulated in the paper; this document outlines many of the themes that were later translated into PHCTF objectives. Following this, a discussion paper on fund design for the PHCTF was developed to foster F/P/T discussion and consensus on the matters specific to the PHCTF. This paper was developed based on P/T consultation, including negotiating aspects of the Fund related to objectives, proposal requirements, proposal development and approval process, eligible costs, and funding envelopes. Finally, the PHCTF RMAF indicates that the Fund's design was informed by the F/P/T Advisory Group on Primary Health Care.

Health Canada representatives also noted that consultations with national organizations (e.g., health care organizations, health provider organizations, Aboriginal organizations) were conducted for the National, Multi-Jurisdictional, and Aboriginal Envelopes. The document review indicated that consultations were also carried out with numerous Aboriginal groups, including FNIHB, the Assembly of First Nations, and various Aboriginal NGOs focussed on health, women, addictions, and mental health.

Fund Objectives

Overall, the PHCTF objectives are supported by evidence in the literature and program stakeholders believe that they are relevant, well-informed, and suitable for the PHCTF. The PHCTF objectives are consistent with primary health care renewal activities in the P/Ts and overall primary health care reform principles. In terms of the appropriateness of objectives, the literature review indicated that the provinces and regional health authorities (RHAs) have been focussing on themes for PHC that are very consistent with the objectives of the Fund. The Access objective was reflected in the literature from the provinces and territories. Kouri

and Winquists' (2004) survey data indicated that new PHC initiatives were focussing on: new methods of care; increasing emphasis on health promotion, disease and injury prevention; and the management of chronic diseases.[18] Furthermore, this study found that 37 of 45 RHAs were involved in inter-sectoral collaboration, which demonstrates support in their jurisdictions for the interdisciplinary health care team objective.[19] The literature review did not find much evidence of the coordination and integration objective being supported in the provinces and territories. However, Kouri and Winquist's results suggested that initiatives in inter-sectoral collaboration will eventually encourage greater coordination and integration.

The document review also found that the objectives are based on extensive consultation with the P/Ts and are based on the common elements of the vision paper and the 2000 FMM agreement. In addition, P/T initiatives support the PHCTF objectives, according to an analysis of elements and themes of P/T projects. In particular, the first and second objectives of the Fund are most clearly supported by the P/T projects. Furthermore, the other objectives are expected to take longer to develop, thus the emphasis on the first objective is logical. It should be noted that the fact that P/T renewal efforts are aligned with PHCTF objectives is expected since a requirement of PHCTF funding is a focus on the objectives.

Strengths and Weaknesses of the Design

Interview respondents, with no significant differences across categories, cited strengths and weaknesses of the design. Strengths identified by respondents included:

- Communication, collaboration and partnership resulting from the Fund.
- Flexibility provided to provinces/territories and other proponents to identify objectives and priorities under the broad objectives of the Fund.
- The monitoring conducted under the Fund, which was described as clear and proactive.
- Funding dedicated to PHC renewal.
- Specific aspects of the Fund allocation, particularly the emphasis on allocation to provinces and territories.
- Use of contribution agreements, allowing HC to monitor projects and ensure that funds are spent according to Fund objectives.
- Health Canada management and staff were described by a few respondents as a strength of the Fund.
- Rigorous assessment process for proposals.

---

[18] Kouri, Denise & Winquist, Brandace. (2004). *Primary Health Care Renewal and Canada's Regional Health Authorities*. Canadian Centre of Analysis and Regionalization and Health. Retrieved on March 28, 2005. http://www.regionalization.org/Publications/Survey_04_PHC.pdf

[19] Ibid.

- Savings realized through the Multi-Jurisdictional Envelope. For example, tele-care in the Atlantic region has accrued savings.
- F/P/T Advisory Group was identified by one researcher/NGO respondent as a strength.

Weaknesses identified by respondents included:

- The five-year time frame of the Fund, with many respondents feeling that the time frame is too short to complete work (as per the PHCTF objectives).
- The length of time between the Fund's establishment and the finalization of contribution agreements, particularly for the National Envelope. As a result of these delays, some projects did not start on schedule. Furthermore, a number of respondents were concerned that the Fund could have benefited from national direction on evaluation under the National Envelope.
- Sheer volume of work given the five-year time frame.
- Concerns about the sustainability of projects and initiatives following the expiry of funds.
- A few respondents were concerned with the timing of the Primary Health Care Awareness Strategy, believing that it started too late in the implementation of the Fund.
- Small number of respondents identified insufficient communication between proponents as a weakness.
- A few HC representatives identified the lack of focus or strategy in some envelopes, particularly the National Envelope. For instance, these respondents stated that most of the initiatives being funded under the National Envelope do not focus on overall system renewal.

Summary

The PHCTF was designed and objectives created based on consultation with the provinces and territories. In addition, a number of Aboriginal groups, health care organizations, and health provider organizations were consulted when the National, Multi-Jurisdictional, and Aboriginal Envelopes were being designed. It should be noted that a few Health Canada representatives felt that consultations with health organizations were limited. PHCTF objectives were found to be consistent with the PHC renewal activities occurring in the provinces and territories.

This section also investigated the perceived appropriateness of the Fund as mechanism to accelerate PHC renewal and some of the Fund's strengths and weaknesses. Almost all HC representatives felt the Fund is an appropriate mechanism for accelerating renewal. However, the P/T representatives were more divided on this issue and cited some specific concerns regarding the length of time taken for approving contribution agreements and the five-year time frame. Furthermore, the sustainability of the renewal efforts supported by the Fund was noted as a weakness. Respondents were consistently concerned about the time-limited nature

of the Fund and this theme is captured in other sections of this report. In terms of strengths, many were cited and they generally focussed on collaboration and partnership, flexibility, the funding itself, and the specific activities funding has supported.

IMPLEMENTATION

This formative evaluation assessed the alignment of Fund objectives with intended outcomes. Evaluation questions in the implementation section addressed the extent to which the Fund has been implemented as intended, the nature of the approval process, the allocation of resources, obstacles encountered in implementation, and the extent of Fund monitoring.

Variation in Implementation

Findings reveal that there are several variations in terms of the original PHCTF design and the actual implementation of the Fund; the main variations in implementation include changes to the PHCTF Terms and conditions, refinements to the objectives of the targeted envelopes, changes in PHCTF resources allocation and administration, changes in management of the OLMC Envelope, and initiative-level changes.

In 2001/2002, considerable progress was made on fund implementation, including the development of detailed processes related to PHCTF implementation and the evolution in Fund nomenclature. To reflect the reality of the Fund after a year of operation, several changes were made to the PHCTF Terms and Conditions in 2002; these changes include the allocation of supplementary funds to smaller jurisdictions; additional details related to the P/T envelope; the eligibility of proposal development funding for all envelopes; an extension of the time frame for the development of the PHCTF evaluation framework; and revisions to the PHCTF nomenclature and conceptualization of funding envelopes. For example, the funding was originally conceived as a 70% - 30% split between the P/T and National envelopes; however, the program description was changed to consist of five funding envelopes. As implementation continued, additional changes were made to the Fund's nomenclature. As described in the introduction, the original objectives of the targeted envelopes (M/J, National, Aboriginal, and OLMC) were further articulated since the original design of the Fund and the priorities of each envelope were established.

Another considerable variation in implementation that has been ongoing is changes to both the overall PHCTF budget and within specific funding envelopes; overall PHCTF budget changes occurred for several reasons, including changes to the Terms and Conditions, lapsed funds, departmental reductions, and unassigned funds; while changes to Envelope allocations occurred, there is little program documentation available at the time of data collection to explain these changes other than the fact that there were unassigned funds at the outset of the program.

Furthermore, there were changes in the administration of the Fund. When the PHCTF was established, the policy unit focussed on the PHCTF and primary health care. In 2002 - 2003, a realignment of the Health Policy Directorate resulted in an expanded role for the Division and its name was changed to the Primary and Continuing Health Care Division, to reflect the additional responsibilities for Home and Continuing Care and Palliative and End-of-Life Care. In addition, the operations and accountability unit were disbanded and some functions (and the associated resources) were centralised in the Director General's office.

Generally, interview respondents (F/P/T representatives) believed there have not been major variations in the implementation of the Fund and that implementation has mainly been consistent with objectives and plans. A few respondents indicated additions or changes to the Fund, including:

- increase in the OLMC Envelope due to the "Action Plan on Official Languages" (Dion report);
- increase in funding to the Aboriginal envelope due to the allocation of funds to FNIHB;
- delays in implementation were cited by a few as representing a variation. Delays in implementation were also noted in the document review and this will be discussed in the next section; and
- additional funding allocated to smaller jurisdictions.

A change in the implementation of the Fund that surfaced in the interviews and was substantiated by the document review was the change in management of the OLMC funding envelope. In July 2004, a Memorandum of Understanding was developed to transfer the OLMC Envelope to Health Canada's Official Languages Community Development Bureau (OLCDB). The impetus behind this relocation was the decision that official languages contribution funding programs should be consolidated in one branch to facilitate a coordinated approach to accessing programs and to minimize risk. For example, the risk of stacking assistance and/or duplication of efforts. The OLCDB has been given responsibility for managing the OLMC Envelope, including commitments incurred and contribution agreements signed prior to the transfer. The Bureau manages the funds in accordance with the PHCTF Terms and Conditions and the Treasury Board Transfer Payment Policy, and participates in the Fund's reporting framework.

There also were changes in the implementation of some PHCTF initiatives. For instance, the document review found that the National Evaluation Strategy (NES), funded under the National Envelope, has undergone some changes since the advent of the Fund. The focus of the National Evaluation Strategy is on creating information, evidence, and tools to support PHC reform. Originally, CIHI and Health Quality Council were responsible for developing a proposal for the National Evaluation Strategy, however, this proposal was terminated. According to the document review, some of the reasons for termination were: the scaling back of Health Quality Council's participation; concerns about feasibility given the time available; concerns from F/P/T officials about how well the draft proposal responded to P/T needs; and a

funding cut in the Fund. The original objectives and approach of the NES have remained the same, although the extent to which these will be achieved have been reconsidered because of less funding and time. At the time of data collection, two projects had been initiated to create PHC indicators and a toolkit for PHC evaluation.

Obstacles to Implementation

Based on findings from the document review and stakeholder interviews, the main obstacle to implementation identified was the amount of time between the establishment of the Fund and the signing of the contribution agreements; while the evaluation was not able to determine the cause, it was found that the length of time between the proposal being received and the funding announcements varied considerably among jurisdictions/initiatives. According to the document review, a major challenge to initiative-level implementation has been a delay of several months for approving and allocating funds to projects under the National, Multi-Jurisdictional, Aboriginal, and OLMC Envelopes. According to annual progress reports, these delays have resulted in compressed time frames and challenges for initiatives. For instance, some activities had to be eliminated by certain projects and workloads have been increased to make up for lost time.

At the project level, the document review found that the most frequently-cited barrier to implementation has been physician resistance to participation in new primary health care models. Numerous projects also cited human resource issues, such as hiring processes taking longer than expected and turnover, as a barrier to project-level implementation. Projects in Northern and remote areas frequently mentioned difficulties with finding qualified candidates for vacant positions.

Resource Allocation

The original Fund totalled $800 million, however, revisions have been made to the budget since that time due to changes to the PHCTF Terms and Conditions, unassigned funds (these changes did not affect overall budget) as well as lapsed funds and departmental reductions, which resulted in changes to the overall budget. In terms of actual PHCTF allocations, the funds in the Envelopes have been disbursed as follows:

- Provincial/Territorial Envelope: 13 Contribution Agreements signed, Envelope complete;
- Multi-Jurisdictional Envelope: 5 Contribution Agreements signed, Envelope complete;
- National Envelope: 15 Contribution Agreements signed;
- Aboriginal Envelope: 6 Contribution Agreements and one Memorandum of Understanding with FNIHB signed, Envelope complete; and
- Official Language Minority Communities Envelope: 1 Contribution Agreement signed and a number of proposals in the process of being negotiated under both components.

Please refer to Appendix A for a detailed listing of PHCTF initiatives, allocations, and partners.

Approval Process

Based on available information, the PHCTF funding approval process followed a series of stages and varied by funding envelope. For the proposal development process, the PHCTF provided proposal development funding to the P/Ts and some other stakeholders to aid in the development of sound proposals. Furthermore, a letter of intent (LOI) process for the National and Aboriginal Envelopes allowed the Fund to review ideas, identify potential gaps and identify potential areas for collaboration.

For the provincial/territorial proposals, proposals were negotiated on a bilateral basis with each jurisdiction. In terms of the review, a minimum of three people reviewed each proposal and Health Canada staff were invited to review proposals based on subject expertise. Multi-jurisdictional proposals were reviewed by the project officer, regional analysts, and other Health Canada staff. In some instances, reviewers from outside the division were involved, depending on the content of the proposal. National Envelope LOIs were grouped according to theme and then reviewed by Health Canada officials with expertise in the area. Requests for proposals were then sent to those who were deemed appropriate through the LOI process. Health Canada staff then reviewed the proposals based on their area of expertise. Aboriginal LOIs were reviewed exclusively by the PHCTF as Health Canada (FNIHB) was allowed to apply for funding under this Envelope. Aboriginal people with expertise in health service delivery, regional analysts, Health Canada staff with expertise and program officers also reviewed these proposals. For the OLMC envelope, proposals were reviewed by appropriate Health Canada staff.

To be approved for PHCTF funding, all initiatives were assessed against a set of criteria that included: context; funding; goals and objectives; consistency with PHCTF objectives; progress indicators; transitional nature; global budget for each fiscal year and detailed budget for first fiscal year and feasibility; sustainability; and recommendations. After Health Canada officials reviewed the proposals against the criteria, feedback was provided to each P/T or initiative and revisions were made as necessary. Final versions of the proposals were forwarded to the Minister's Office for approval and then joint funding announcements were made. Once funding was approved, the Program Officer responsible for the file notified the recipient and a Contribution Agreement was drafted.

Provincial/territorial representatives were asked to comment on the approval process used in their jurisdiction. According to responses, the approval process varied from jurisdiction to jurisdiction. Almost all respondents believed that the approval process was comprehensive and fair, although concerns were noted in terms of timeliness; many respondents felt the

approval process was too time consuming and resulted in delays to the initiatives. Furthermore, delays were encountered in obtaining Health Canada approval and provincial/territorial approval.

Performance Monitoring

The interviews and document review found that Health Canada has several mechanisms in place to monitor the progress of the PHCTF, including quarterly financial reports, annual progress reports, annual risk assessments, site visits and FPT meetings. In addition, program officers maintain regular contact with funded initiatives and monitor progress of their activities. These reporting mechanisms are required so the federal government can assess progress, track initiatives as they are implemented, and support aggregate PHCTF financial planning and performance reporting. At this point in time, the performance information captured from these monitoring activities is limited, mainly due to the delay in establishing contribution agreements which in turn delayed the start of the initiatives.

Progress reports revealed that a challenge to monitoring is the variation in reports. A template for progress reports has been developed, but not every project has strictly adhered to the template. For example, while a range of initiatives are being funded, P/Ts and funded initiatives are expected to report on how their initiative (PHCTF funding) supports the achievement of the Fund's common objectives. However, very few annual reports include this type of information and this challenge will be discussed in greater detail below.

According to the document review, monitoring of the PHCTF follows the guidelines established by Health Canada, which are detailed in the Program Monitoring Guidelines document. Monitoring of the Contribution Agreements is the responsibility of the Program Officer under the guidance of the Program Coordinator/Manager. Program officers monitor a recipient's progress with respect to clearly defined activities, outputs, and outcomes as stated in the recipient's work plan.

The document review also indicated that budget submissions are to be made on an annual basis to Health Canada or when there has been a change in funding allocation. In addition to ongoing reporting, each P/T and funding recipient is required to evaluate the implementation and impact of the project within the context of the five objectives and to provide a report on these evaluation activities by June 2006.

Program officers have a number of monitoring tools at their disposal to ensure programmatic and financial compliance. Categories of tools are:

- overall monitoring tools (i.e., file management; project monitoring checklist; conversation record; site visit report form; project assessment and levels of involvement guide);
- financial management tools (i.e., quarterly cashflow forecast and record of expenditures form and guide; quarterly cash flow reports checklist);

- reporting tools (i.e., annual progress report guidelines; checklist for annual progress report); and
- project closure tools (i.e., project closure checklist; project closure communications).

In addition, Health Canada has developed guidelines and frameworks for risk assessment and for audits of contribution recipients under the Fund.

According to the interviews of provincial/territorial representatives, project proponents and evaluators, most jurisdictions and projects are measuring their performance and monitoring progress using a combination of HC accountability requirements and their own performance measurement and/or evaluation tools. It was reported that many jurisdictions have evaluation frameworks in place and are conducting provincial evaluations. However, the degree and type of monitoring does vary from jurisdiction to jurisdiction.

According to Health Canada representatives, the outputs of Health Canada's monitoring processes have been used to produce updates for First Ministers, for accountability purposes, and to ensure the Department is informed. However, how these monitoring processes are linked to the performance management of the Fund is not clear.

Summary

Variations in implementation occurred after the initial design of the Fund, particularly changes to the original Terms and Conditions, MOUs with BACLO and FNIHB, the refinement of objectives of certain Envelopes, and revisions to the budget for the Fund and within specific Envelopes. However, these variations are generally consistent with the original substance of the program as described in documents used to support the creation of the Fund. Instead, the noted variations reflect the evolving nature of the Fund and the dynamic environment in which primary health care renewal occurs.

The largest implementation obstacle cited was the delay between proposal submission and the receipt of funding (length of time required to formalize contribution agreements). Due to this delay, compressed time frames have occurred for many initiatives and this has compounded the issue of sustainability in some instances.

Findings from the document review and stakeholder interviews revealed that the PHCTF has several mechanisms in place to monitor the performance of the PHCTF and funded initiatives. However, the quality of information gathered through these processes is inconsistent and does not adhere to original reporting requirements . The progress reports, the primary source of information on performance monitoring, usually did not contain information that was directly related to the progress toward PHCTF objectives and outcomes. In addition, the use(s) of information gathered through these accountability processes was not clear and has not been linked to the performance management of the PHCTF.

REACH

In terms of reach, this formative evaluation sought to examine the extent to which the PHCTF fostered collaboration and communication with Fund stakeholders. The nature and extent of communication and collaboration is explored, including the mechanisms and the conditions that have facilitated interaction.

Communication and Collaboration Mechanisms

The available information from the document review and stakeholder interviews indicates that both formal and informal communication mechanisms are being used to communicate with program stakeholders. The F/P/T Advisory Group on Primary Health Care (AG) was identified as the main HC communication mechanism by all provincial/territorial respondents and by a few evaluators and project proponents. The F/P/T AG on PHC was established in 2000 as a collaborative forum to negotiate certain aspects of the Fund's design and provide the opportunity for ongoing collaboration in promoting primary health care renewal. The AG is composed of 15 members, including a Chairperson (Director of the PCHCD), the manager of the PHCTF, and a representative from each province and territory. Stakeholders indicated a high level of satisfaction with the AG, citing that it fosters partnership and collaboration. In 2004, the AG held three in-person meetings and three teleconference meetings. At the time of data collection for this evaluation, three meetings were planned for the first half of 2005.

In addition, the document review identified the National Strategy on Collaborative Care as a communication mechanism, which supports the integration of targeted disciplines in primary health care, as well as supporting professional development and training to support inter-disciplinary teams. Furthermore, the Primary Health Care Policy/Program Liaison Committee was established in 2004 and is expected to meet on a monthly basis. This Committee held its first meeting in June 2004 and its mandate is to:

- share information regarding respective activities;
- identify areas for collaboration; and
- advise on follow-up activities where collaborative activities have been identified.

Ongoing communication between projects and respective HC program officers was also identified as effective, which was supplemented by e-mail communications and the HC website. Respondents generally agreed that the communication mechanisms cited above have been appropriate, although a few (project proponents, provincial/territorial representatives, and evaluators) suggested that HC should facilitate more information sharing.

According to interview respondents, jurisdictions and initiatives have been using the internet, specifically a website, for communication purposes. Furthermore, several respondents identified e-mail as a key communication tool. Many evaluators, provincial/territorial representatives and proponents also identified working groups and regular meetings with

partners, including health organizations, regional health authorities, government representatives, and delivery partners, as a communication mechanism. Workshops, academic conferences and forums were also identified by several provincial/territorial respondents and evaluators as a communication mechanism.

Health Canada representatives described informal internal communication mechanisms and these varied from e-mails to discussions and conversations. Formal communication mechanisms were also described by HC representatives and these included:

- An internal HC working group for the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) initiative.
- Formal reporting in the Report on Plans and Priorities and the Departmental Performance Report.
- Primary Health Care Network, which is an information sharing body that is managed by the Primary Health Care Policy Unit.
- Periodic meetings between official language community representative organizations and HC staff.
- Internal communications with the Health Human Resources Strategy.

In May 2004, Manitoba hosted a national conference on primary health care, funded by the PHC Awareness Strategy (National Envelope), to facilitate collaboration and communication. Several interview respondents, across all categories, identified the National Conference held in Winnipeg in May of 2004 as a communication mechanism that was highly useful for attendees. According to the document review, the National Conference brought together more than 1,000 health care providers, policy and decision makers, health care administrators, and others interested in primary health care. Approximately 250 abstracts were submitted at this Conference.

Partnerships and Collaboration

Interview respondents identified a number of factors that have contributed to and inhibited partnerships and collaboration, although there were no identifiable themes or variations across respondents for this question. Many respondents identified the existence of the Fund as a contributing factor to collaboration. Some also identified the expectation or requirement that partnerships be undertaken for initiatives as a contributing factor. A few respondents cited opportunities for proponents and partners to meet face-to-face as another contributing factor. Other factors identified as contributing to collaboration and partnership were: clear objectives had been identified for the PHCTF; high awareness and profile for the Fund; and staff involvement and the efforts of Health Canada program officers.

Several respondents cited the time available to devote to partnerships and collaborations as an inhibiting factor. Similarly, delays in approval and implementation were also cited as inhibiting factors. Other inhibiting factors noted by respondents were: legislative barriers to collaborative approaches and models; federal/provincial/territorial resistance and issues;

resistance of primary health care providers to change; at the project level, liability concerns of physicians working in interdisciplinary environments; difficulties exchanging information about clients across settings and providers; and concerns about sustainability of projects.

All interview respondents, except researchers/NGOs, were asked if the PHCTF has contributed to partnerships/collaboration in primary health care renewal in Canada. All interview respondents believed that the Fund has contributed to partnerships/collaboration on primary health care renewal. Several examples were identified by interview respondents and these included:

- Many interview respondents noted that PHCTF has resulted in new partnerships between provinces and territories.
- Partnerships between NGOs, communities and Governments have been cited by several respondents, particularly because project proponents must seek approval through their provincial/territorial government.
- Several interview respondents, specifically from the proponent, evaluator and P/T categories, felt that the Fund has resulted in new partnerships between providers, health organizations and provider organizations.
- A few respondents indicated that partnerships have been developed between provinces/territories and district or regional health authorities as a result of the Fund.
- Some respondents believe that the Fund has encouraged partnerships with and between educational institutions, especially because of initiatives to address barriers to collaborative practice.
- Some respondents cited the OLMC envelope as a catalyst for a number of new partnerships.
- A few respondents indicated that partnerships between HC and First Nations communities have been strengthened as a result of the Fund.

The document review, particularly the progress reports, also provided a number of examples of collaboration and partnership and these included:

- The College of Family Physicians of Canada supported a proposal for a workshop on Chronic Disease Management (CDM) developed by the BC Ministry of Health Services, which was in collaboration with the Ontario Ministry of Health and Long-Term Care and Newfoundland and Labrador.
- Funding under the Provincial/Territorial Envelope has supported a series of multi disciplinary conferences, including one in 2003 (Teamwork in Action: There's a Role for Everyone) and one in 2004 (Working Together to Prevent Sexually Transmitted Infections).
- In the Yukon, presentations on the territory's activities have been made to Yukon Community Nurses Practitioners, First Nation Health Commissioners, the Yukon Public Health Association and the Yukon Health and Social Service Council.
- One of B.C.'s key activities has been the Quality Improvement Collaboratives.

- Alberta sponsored a joint provincial meeting for information exchange and funded a workshop to explore how to partner with municipal recreational organizations to provide recreational activities for the chronically ill.
- In Saskatchewan, intersectoral partner meetings have been held, which bring together the Departments of Learning, Social Services and Justice. Furthermore, a number of collaborative committees have been struck to oversee HealthLine.
- Ontario has participated in primary care conferences and related meetings to promote Ontario Family Health Networks.
- In Newfoundland, approximately 500 stakeholders were consulted and meetings were held with facilitators and included developmental activities.
- The National Envelope convened a Clinical Issues Presentation expert panel, which brought together a small group of regional and tertiary palliative care consultants. In addition, the CIHI proposal under the National Envelope to develop PHC indicators will involve consultation with numerous stakeholders.

Summary

As stated previously, one of the identified strengths of the Fund was the facilitation of collaboration and partnership among stakeholders, with many examples to support this position. This has been encouraged by the various communication mechanisms, formal and informal, that have been used to communicate with Fund stakeholders. In addition, a number of proponents believe that the mere existence of the Fund has contributed to collaboration, although the funding requirement of demonstrated collaboration has also promoted this situation. However, issues associated with the time frame of the Fund and delays in implementation were cited as inhibiting factors for collaboration and partnership. Furthermore, the issues of delays in implementation and the limited time frame of the Fund were linked to the issue of sustainability, which are all interrelated and reoccurring themes in the lines of evidence.

IMPACTS OF THE FUND

This section presents the findings related to the impacts of the PHCTF to date, based on evidence collected from the document review, stakeholder interviews, literature review, and the baseline study update. This section begins with the findings on the impacts of the PHCTF on primary health care renewal in Canada and the extent to which the PHCTF is on track to achieving its overall objectives; following this, the activities and outputs of the PHCTF are presented, by each funding envelope; finally, the findings section concludes with the assessment of progress to date. Unfortunately, progress and impact of the Fund focusses on the activities and outputs of the initiatives as opposed to the outcomes. The reasoning behind this is that there is no substantive information on the results or outcomes of the Fund to date. Outcome information will be reflected in the summative evaluation.

PRIMARY HEALTH CARE RENEWAL

The majority of interview respondents, across all categories, generally agreed that the PHCTF has had a positive impact on primary health care renewal in Canada; a very small number indicated that it is too early to identify impacts at this time. Many respondents identified examples of acceleration of pre-existing renewal efforts and new efforts that are a result of the Fund. Progress reports did outline initial results of the PHCTF, however, theses results are anecdotal at this time and consist primarily of start-up and implementation activities. According to the document review, the majority of activities were documented in initiatives funded under the Provincial/Territorial Envelope, which is expected since this was the first funding envelope to roll out. Activities in the initiatives funded under other envelopes were generally limited, which can be attributed to funding delays and timing issues.

Interview respondents, across categories, agreed that the PHCTF has fostered increased understanding and buy-in for PHC renewal. However, some respondents stated that while awareness and understanding has grown among stakeholders, it remains weak among the public. A few respondents felt that health care providers are more open to PHC renewal as a result of the Fund and a few respondents cited examples of increased understanding and buy-in among post-secondary institutions.

Interview respondents were asked to comment if the PHCTF is on track to achieving its overall objectives. All respondents, except two, agreed that the PHCTF is on track to achieving its objectives. However, many respondents are concerned that the achievement of these objectives might not be feasible in the time frame of the Fund. These respondents believe that five years is not enough time to effect major change, as per the objectives of the Fund. For instance, some believe the objectives related to access will take more than five years to achieve.

As mentioned previously, sustainability, in terms of impact and momentum, is a concern for several interview respondents. Some respondents did supply suggestions for changes or adjustments to the Fund in order to ensure success. These suggestions largely focussed on an extension of the time frame of the Fund and the identification of lessons learned. The literature review also highlighted sustainability as a central issue for health care innovation and new initiatives. It was indicated that initiatives, such as the Fund, are only part of a continuum of commitment that is needed to ensure success for renewal and tangible change in the future. The literature suggested that to realize success there is a need to understand the content, context and process of change as well as an effective implementation process is required. Sustainability itself is multi-dimensional and can encompass ideas, knowledge, funding, partnerships and, most importantly, outcomes.

ACTIVITIES AND OUTPUTS

This section describes the outputs of the PHCTF to date in terms of the funded initiatives and their allocations, whereas the previous section provided an overarching summary of impact. PHCTF funds have been allocated to a range of initiatives under the five funding envelopes, focussed on the fund's overall objectives as well as the objectives specific to the targeted funding envelopes. In addition, where available, information on progress to date has been provided (See Appendix A for a detailed listing of all PHCTF initiatives, including their funding allocation and partners).

Provincial/Territorial Envelope

The majority of the PHCTF ($576 million or 72 percent) is allocated to the provinces and territories, based primarily on a per capita basis with supplemental funding for jurisdictions with small population bases (Northwest Territories, Yukon, Nunavut, and Prince Edward Island). Each province and territory is undertaking reforms in their jurisdiction in an attempt to change how primary health care is organized, funded, and/or delivered to improve access by Canadians to primary health care. The most common themes among PHCTF funded initiatives under the P/T envelope are:

- the creation of teams of health care providers accountable for delivery of primary health care services to a defined population;
- a focus on chronic disease management; and
- change management/training initiatives to support the transition to new models of service delivery.

Other common themes include telephone health advisory lines, health promotion/illness and injury prevention, communications and public education, mental health, information technology, rural/remote service delivery, payment models, evaluation, telehealth, and shared care.

Table 5 PHCTF Initiatives in the Provinces and Territories	
Jurisdiction and PHCTF Allocation	**Activities**
Alberta $54,876,073	Alberta Health and Wellness allocated its PHCTF funding to a $16 million Primary Health Care Capacity Building Fund, which supports 10 programs designed to expand primary health care services in Alberta; all 10 initiatives have been implemented and are underway. Among the projects approved for funding include a program to help remote northern Albertans better manage their diabetes; a program to assist patients with chronic disease in the Chinook and Calgary Health Regions; and a network to improve children's and youth's health services in southern Alberta. The remaining PHCTF funds were allocated to Health Link Alberta, the implementation of a province-wide health information and triage telephone line in 2003 and two web-based components.
British Columbia $74,022,488	British Columbia's Ministry of Health Services has allocated most of its PHCTF funding (93 percent) directly to health authorities for developing initiatives designed to address regional challenges and expanding sustainable primary health care services. Funded initiatives include primary health care organizations and networks, community health centres, shared care, nurse managed care, and chronic disease management. Also, a portion of the PHCTF funding is being used to support province and system-wide initiatives; for example, the British Columbia Nurse Line has added pharmacist services on call to provide after-hours advice, which was supported by the PHCTF.
Manitoba $20,844,059	Manitoba Health employed a phased approach in allocating the funds received from the PHCTF. In Phase I, $8.8 million was spent on five initiatives that established the foundation for primary health care renewal in the province, including the expansion of the Health Links Call Centre, collaborative practise training initiatives, information technology initiative, primary health care public awareness, and emergency medical services enhancement. In Phase II, Manitoba Health approved over $11.9 million for 17 primary health care initiatives submitted by the regional health authorities to reform and enhance their primary health care services. Initiatives were selected based on their ability to support: advancing primary care access through networking of family physicians and advanced practice nursing, building community capacity, increasing regional health authority organizational strength, and creating integrated service delivery systems.
New Brunswick $13,689,805	New Brunswick Health and Wellness is using its PHCTF funding to support two main initiatives: the establishment of a network of Community Health Centres (CHCs) and the enhancement of ambulance services. The remaining PHCTF funds are being used to develop and implement a change management strategy, conduct an analysis of the management information system for public and mental health services sector, assist in the implementation of various telehealth initiatives, and evaluation. To date, New Brunswick has established five CHCs across the province with various hours of service, offering a range of primary health care services and programs, with a range of health professionals.
Newfoundland and Labrador $9,705,620	The PHCTF funding allocated to Newfoundland and Labrador's Department of Health and Community Services is being used to assist with the transitional costs associated with the planing, implementation, and evaluation of primary health care projects being implemented throughout the province. The Department is formalizing interdisciplinary teams across the province based on the needs of the population being served, including a range of health professionals.

Table 5 PHCTF Initiatives in the Provinces and Territories	
Jurisdiction and PHCTF Allocation	**Activities**
Northwest Territories $4,771,470	With the funds from the PHCTF, Northwest Territories Health and Social Services is undertaking eleven primary health care renewal initiatives which collectively support the transition to a primary community care approach to health and social services; these initiatives include public/staff education and coordination of primary care reform, the development of integrated primary health care teams and services, support for improved women's reproductive health services, and training for health care providers.
Nova Scotia $17,073,265	Nova Scotia's Department of Health is allocating its PHCTF funding to four main priority areas, including shifting the focus of primary health care to collaborative primary health care teams; developing a cultural shift among health care providers that supports a population health approach, collaboration, and an enhanced role for health promotion; changing the primary health care funding system; and transitioning the primary health care system toward implementation of electronic health records.
Nunavut $4,508,924	Nunavut's Department of Health and Social Services is undertaking a series of staged, transition initiatives that are expected to result in structural change to the territory's primary health care system. With the funding from the PHCTF, Nunavut is undertaking two main components: a change management process leading to integrated, coordinated, and patient- and community-focussed primary health care; and an information management strategy directed at the provision of information to support primary health care.
Ontario $213,170,044	Ontario's Ministry of Health and Long Term Care is using its PHCTF allocation to fund a range of primary health care renewal projects with the following objectives: facilitate the enrolment process for physicians participating in Family Health Networks and other primary care models; support projects designed to research and evaluate the integration of inter-disciplinary providers into primary care models; develop information systems to support efficient and timely payment to physicians in primary care models; support public and provider communication activities on primary health care renewal; develop a voluntary accreditation program for physicians and other inter-disciplinary providers working in primary care models; develop and implement a leadership training program for inter-disciplinary primary care providers in primary care models; facilitate linkages with mental health services and rehabilitation services; and support the Ministry's project management activities as well as some of the activities related to the Ontario Family Health Network.
Prince Edward Island $6,526,879	Prince Edward Island's Ministry of Health and Social Services is using it PHCTF allocation to undertake two main primary health care redesign initiatives, including promoting and evaluating each initiative. The most significant initiative entails the establishment of family health centres across the province, which consists of a collaborative practise of interdisciplinary teams of health care professionals, care management protocols, alternative payment plans, extended hours, patient registration, and enhanced information technology. The second initiative consists of the development and implementation of a strategy for healthy living using a population health approach

Table 5 PHCTF Initiatives in the Provinces and Territories	
Jurisdiction and PHCTF Allocation	**Activities**
Quebec $133,681,686	Quebec's Ministry of Health and Social Services (MSSS) is using its PHCTF allocation to fund the implementation of Family Medicine Groups (FMGs). A FMG is a group of family physicians who work in close cooperation with nurses to offer family medicine services to registered individuals. Family physicians who are members of FMGs will also work closely with other healthcare professionals in CLSCs, hospitals, community pharmacies, etc. to complement the services they offer. The MSSS intends to progressively implement approximately 300 FMGs throughout Québec so that the entire population will be registered by 2005.
Saskatchewan $18,592,405	Within the context of the 10 year Action Plan for Saskatchewan Health Care, Saskatchewan Health is using its PHCTF allocation to support some of the province's transitional activities within the first four years. Activities being funded include building capacity within the Department to define core services, develop and set standards, and establish performance indicators for primary health care services; building the capacity of Regional Health Authorities to manage regional implementation and change management; undertaking program development in community development and team training; and establishing a telephone advice line to provide assessment and referral services 24/7.
Yukon $4,537,282	Yukon's Department of Health and Social Services is using its PHCTF funds for two main activities. The first initiative refocuses organizational structures and processes to engage stakeholders in identifying barriers and solutions toward greater integration of services and emphasis on health promotion in the primary health care context. The second initiative entails the development of technological system supports to enhance primary health care information systems. In 2003, a Primary Health Care Planning Forum was held with 100 delegates from across the territory to consider ways to improve primary health care in the Yukon and identified the following priority areas: alcohol and drug treatment, healthy living, health information, chronic disease strategy, cooperation and collaboration, and a health blueprint. Building on these priority areas and recommendations, an implementation plan is being developed.

Multi-Jurisdictional Envelope

Five initiatives are being funded by the multi-jurisdictional envelope, totalling $30.2 million; two initiatives involve the Atlantic provinces and three involve Western provinces and territories. The main areas of focus among these initiatives are support for the creation and/or enhancement of telephone health advisory lines and support for the creation and/or enhancement of multi-disciplinary primary health care teams.

At the time of data collection, little information had been documented on progress toward the PHCTF objectives. Of the information that was available, progress to date focussed primarily on planning and implementation activities such as establishing governance structures and

project management for initiatives, establishing working groups/steering committees, stakeholder consultation, and sharing information among project stakeholders. A concern identified in several reports was the delay in the approval process and the length of time required to implement the project.

National Envelope

Under the National Envelope, 35 initiatives are being funded through three streams of funding for a total of $64 million to date: Targeted National Strategies, Tools for Transition, and National Initiatives.

Targeted National Strategies ($42.5 million) support and complement the P/T priorities and help maximize synergies by developing common approaches to primary health care renewal. The three key areas identified by the F/P/T Advisory Committee on the PHCTF for funding include collaborative care, awareness, and evaluation. The national strategy on collaborative care consists of five NGO-led initiatives addressing various aspects of collaborative care training, practice, and tools ($30.1 million); the national primary health care awareness strategy consists of two initiatives that are government-led and seek to raise Canadians' awareness of and support for primary health care renewal ($10 million); and the national primary health care evaluation strategy is government-led and consists of two initiatives to develop primary health care indicators and evaluation instruments ($2.3 million).[20]

Tools for Transition offers the opportunity to share information and experiences on change management in targeted areas of primary health care renewal. Under this stream, initiatives are funded through a F/P/T Directed Component or a Responsive component. Under the F/P/T directed component, initiatives must be led or sponsored by an F/P/T government and proposals must be submitted by a member of the F/P/T Advisory Group on the PHCTF. To date, 10 initiatives are being funded totalling $3.5 million. Under the responsive component, funding is available to F/P/T governments and not-for-profit non-governmental organizations up to $75,000 on a cost-shared basis and is intended for conferences or workshops. To date, funding has been provided to 8 initiatives totalling $397,160. In total, 18 initiatives have been funded under Tools for Transition totalling $4 million.

National Initiatives involve PHC renewal activities that are national in scope but occur in local/regional settings, where results will be generalizable to inform developments in other regions. Eight are being funded under this element, totalling $17.5 million, ranging from $471,900 to $4.3M. Funded initiatives focus on a range of issues, including enhanced provider partnerships in home care case management, performance monitoring in primary mental

[20] It should be noted that the national evaluation strategy funded under the PHCTF National Envelope is separate from the PHCTF Evaluation Strategy and consist of distinct activities.

health care, palliative care, chronic disease management, and increased access to PHC for target populations (e.g., interpreter services for those with language barriers, access for Francophone minority populations, and access for gay, lesbian, bisexual, and trans-gendered community).

Of those projects that did submit reports in 2003-2004, all projects indicated that they were in the project planning and implementation stage and therefore did not report any progress toward the PHCTF objectives. Most of the activities reported to date include the establishment of project management structures and developing collaboration among project stakeholders. Another theme in the progress reports was the identification of time lines as a concern for most initiatives.

Aboriginal Envelope

Funding under the Aboriginal Envelope (approximately $34.7 million) is provided under two funding streams, health system renewal and health system enhancement, and is intended to support initiatives specific to the renewal of primary health care services for Aboriginal peoples. Health system renewal initiatives are intended to renew entire primary health care delivery systems, and six initiatives have been funded to date, totalling $26.1 million. This stream of initiatives includes the $15 million Memorandum of Understanding transfer to FNIHB for the Health Integration Initiative and the Nursing Strategy Initiative. In addition, $8.6 million has been allocated to 4 health system enhancement initiatives, which aim to improve the delivery of health care in a way that specifically benefits Aboriginals.

Due to the timing of several initiatives funded under the Aboriginal envelope (many funded toward the end of the 2003-04 fiscal year), little progress was reported other than project management and implementation activities such as establishing governance structures, consultation with project stakeholders, and initial communications with relevant stakeholders. Under the FNIHB-funded initiatives (Nursing Strategy and Health Integration Initiative), outputs included the development and distribution of an educational tool, consultations with regions and partners, and the development of two HII projects.

Official Languages Minority Communities (OLMC)

Under the OLMC Envelope, Initiatives have been funded in two streams of funding: English speaking minority community initiatives ($10 million) and French speaking minority community initiatives ($6.3 million). The one Anglophone initiative identifies and selects regional initiatives across Quebec. The Francophone element has allocated funds under three initiatives to national networking activities, provincial/territorial-level networking activities, and service delivery initiatives.

At the time of data collection, initiatives funded under this envelope only chronicled project start-up and implementation activities.

RECOMMENDATIONS

The following recommendations are based on the findings and analysis of multiple lines of evidence that were developed to address the formative evaluation questions related to PHCTF design, implementation, reach, and impacts to date.

This evaluation study found that there were areas in which communication and information sharing amongst stakeholders could be enhanced. Also, several weaknesses with respect to the performance management of the PHCTF were identified. An assessment of program impacts was not possible due to the fact that the PHCTF performance measurement strategy was not implemented. To improve its ongoing communication and performance measurement and ensure that information is being collected in preparation for the summative evaluation, the following recommendations are presented.

1. PHCTF Management should examine its performance measurement strategy and monitoring activities, initiate planning for the summative evaluation, and ensure that performance information is being collected to inform the assessment of PHCTF outcomes and results. More specifically:

    a. PHCTF should develop a tracking system to document, monitor, and publicly report on progress towards the PHCTF outcomes.
    b. Monitoring activities should be formally integrated and fully linked with the logic model and the performance measurement strategy of the PHCTF.
    c. PHCTF should plan and communicate its summative evaluation strategy with P/Ts and PHCTF funded initiatives so that relevant performance information is collected in preparation for the summative evaluation.

2. To enhance communication with stakeholders, it is recommended that PHCTF management play an enhanced role in the development and dissemination of PHCTF information and results, to ensure sustainability of initiatives, to inform stakeholders of PHCTF progress in a timely manner, and to improve potential linkages among initiatives.

LESSONS LEARNED

The intent of the formative evaluation was twofold: first, to make recommendations to PHCTF management that could be implemented in the remaining time frame of the Fund. Second, the evaluation was intended to extrapolate lessons learned that could be applied to future Health Canada programs of a similar nature. The general lessons learned presented below, while based on the findings of the PHCTF evaluation, are not expected to be responded to or implemented by PHCTF management.

Based on the findings of the PHCTF formative evaluation, the following lessons learned are highlighted:

1. Time limited programs that provide funding to other orders of government should consider whether the use of contribution agreements is the appropriate mechanisms to transfer funds.
2. Performance measurement and evaluation requirements should be formally integrated into the program design. This recommendation entails that common definitions and indicators, data collection tools, reporting templates, and evaluation requirements be developed and communicated to funding recipients at the outset of program implementation.

3. If sustainability is relevant to the program, the concept should be defined and implications for funding recipients and program stakeholders should be considered and communicated at the program design stage. Defining concepts that are central to the success of the program at an early stage could ensure a consistent understanding of its implications and improve the chances of its successful application.

Appendix A

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
PROVINCIAL / TERRITORIAL FUNDING ENVELOPE	
Alberta	$54,876,073
British Columbia	$74,022,488
Manitoba	$20,844,059
New Brunswick	$13,689,805
Newfoundland and Labrador	$9,705,620
Northwest Territories	$4,771,470
Nova Scotia	$17,073,265
Nunavut	$4,508,924
Ontario Included in the per-capita component: Chronic Disease Management Workshop Lead: Ontario Ministry of Health and Long-Term Care Partners: The British Columbia Ministry of Health Planning and the Newfoundland and Labrador Department of Health.	$213,170,044
Prince Edward Island	$6,526,879
Quebec	$133,681,686

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Saskatchewan	$18,592,405
Yukon	$4,537,282
MULTI-JURISDICTIONAL ENVELOPE	
Building a Better Tomorrow: Engaging Current Providers in a Renewed Primary Health Care System for Atlantic Canada Lead: Nova Scotia (lead) Partners: New Brunswick, Newfoundland and Labrador, and Prince Edward Island.	$7,011,126
Health Lines Lead: Alberta Partners: British Columbia, Saskatchewan, Manitoba, Nunavut, Northwest Territories, and Yukon Territory.	$6,813,600
Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders Lead: University of British Columbia, Mental Health Evaluation and Community Consultation Unit Partners: Yukon Territory and British Columbia.	$1,500,000
Selfcare/Telecare Initiative for Atlantic Canada Lead: New Brunswick Partners: Nova Scotia, Newfoundland and Labrador, and Prince Edward Island.	$6,940,266
Western Canada Chronic Disease Management Infostructure Lead: Alberta (Under the Western Health Information Collaborative) Partners: British Columbia, Saskatchewan, and Manitoba.	$8,000,000
NATIONAL ENVELOPE	

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
National Envelope - National Strategies	
National Strategy on Collaborative Care	
Canadian Collaborative Mental Health Initiative Lead: College of Family Physicians of Canada Partners: Canadian Alliance on Mental Illness and Health, Canadian Association of Occupational Therapists, Canadian Association of Social Workers, Canadian Federation of Mental Health Nurses, Canadian Mental Health Association, Canadian Nurses Association, Canadian Pharmacists Association, Canadians Psychiatric Association, Canadian Psychological Association, Dieticians of Canada, and Registered Psychiatric Nurses of Canada.	$3,845,000
Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practice Lead: Canadian Psychological Association Partners: Canadian Association of Occupational Therapists, Canadian Association of Social Workers, Canadian Association of Speech-Language Pathologists and Audiologists, Canadian Coalition on Enhancing Preventative Practices of Health Professionals, Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association, Canadian Physiotherapy Association, College of Family Practice Association, and Dietitians of Canada.	$6,551,700
E-Therapeutics Drug Therapy Management: Tools and Technology to Enhance Collaboration and Communication to Improve Safety and Outcomes from Drug Therapy Lead: Canadian Pharmacists Association Partners: Alberta Health and Wellness, Best Medicines Coalition, Canada Health Infoway, Canadian Association of Chain Drug Stores, Canadian Coordinating Office for Health Technology Assessment, Canadian Institute for Health Information, Canadian Nurses Association, College of Family Physicians of Canada, Health Charities Council of Canada, IBM Canada, National Association of Pharmacy Regulatory Authorities, National Specialty Societies of Canada, Nova Scotia Department of Health, Quebec's MOXXI Project, and the Royal College of Physicians and Surgeons of Canada.	$8,840,300

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Nurse Practitioners in Primary Health Care Lead: Canadian Nursing Association Partners: Governments, nursing regulatory bodies, and other nursing organizations.	$8,914,526
Multi disciplinary Collaborative Primary Maternity Care Lead: Society of Obstetricians and Gynaecologists of Canada Partners: College of Family Physicians of Canada, Society of Rural Physicians of Canada, Association of Women's Health, Obstetric and Neonatal Nurses, and Canadian Association of Midwives.	$2,000,000
Primary Health Care Awareness Strategy	
National Primary Health Care Awareness Strategy Lead: Saskatchewan Health Partners: F/P/T Governments	$9,592,000
Moving Primary Health Care Forward Lead: Manitoba Health Partners: PHCTF, F/P/T PHCTF Advisory Group, Health Canada, Saskatchewan Health, Manitoba Association for Community Health, Manitoba Public Health Association, College of Family Physicians of Manitoba, Winnipeg Regional Health Authority, College of Registered Nurses of Manitoba, Rural/Northern Regional Health Authorities of Manitoba, University of Manitoba Faculties of Medicine, Nursing, and Medical Rehabilitation, Manitoba Medical Association, Manitoba Association of Registered Dieticians, and Manitoba Family Services and Housing.	$473,865
National Evaluation Strategy	

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Pan-Canadian Primary Health Care Indicators Initiative Lead: Canadian Institute for Health Information Partners: National experts, primary health care providers, stakeholders, F/P/T governments (including the F/P/T Advisory Group on the PHCTF), and others through an integrated series of working group and topic-specific meetings.	$1,814,753
Toolkit of Primary Health Care Evaluation Instruments Lead: Primary and Continuing Health Care Division, Health Canada and Howard Research and Management Consulting Inc. Partners: National experts, primary health care providers, stakeholders, F/P/T governments (including the F/P/T Advisory Group on the Primary Health Care Transition Fund) and others through an integrated series of working group and topic-specific meetings.	$489,871
National Envelope - Tools for Transition	
Federal/Provincial/Territorial Component	
Building Support for a Canadian Caregiving Strategy Among Primary Health Care Providers Lead: Canadian Caregiver Coalition Partners: CLSC René-Cassin Institute of Social Gerontology of Quebec, Caregiver Assessment Tool Research Team, McConnell Care Renewal: Reaching Out to Caregivers (Respite for Family Caregivers Initiative Phase II), and VON Canada.	$23,135

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Disseminating Best Practices in Interdisciplinary Teams Lead: Canadian Alliance of Community Health Centre Associations Partners: The Association of Ontario Health Centres, University of Western Ontario, Sunnybrook and Women's College of Health Services Centre, and University of Toronto.	$299,374
Enabling Primary Health Care in the North Through Traditional Knowledge: A Pan Territorial Initiative Lead: Nunavut's Department of Health and Social Services Partners: Yukon, Northwest Territories, representatives from the Aboriginal community in each jurisdiction, and the Elders within each territory.	$494,761
Enabling Primary Health Care Initiatives through Telehealth Workshop Lead: Manitoba Health Partners: Canada Health Infoway, Alberta Health and Wellness, British Columbia Provincial Health Services Authority, Nova Scotia Department of Health and NORTH Network (Ontario).	$249,500
Learning and Applying Facilitation within a Systems Model Lead: Faculty of Medicine at Memorial University of Newfoundland Partners: Departments/Ministries in five provinces (British Columbia, Manitoba, Ontario, Saskatchewan and Newfoundland) and Departments of Family Medicine in three provinces (University of Saskatchewan, University of Ottawa, Memorial University of Newfoundland).	$445, 600
Family Physician Compensation Models and Primary Health Care Renewal Lead: Nova Scotia Department of Health Partners: Nova Scotia District Health Authorities, the IWK Health Centre, and Doctors Nova Scotia.	$506,000

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Increasing Support for Family Physicians in Primary Care[21] Lead: College of Family Physicians of Canada Partners: The Society of Rural Physicians of Canada and representatives from each of the provincial chapters of CFPC.	$232,900
Measuring Cost-Effectiveness: A Proposal to Develop a Methodological Framework for Future Research Lead: Canadian Alliance of Community Health Centre Associations Partners: Association of Ontario Health Centres; McMaster University; University of Toronto; York University; Coalition of Community Health Centre Associations; Canadian Medical Association; College of Family Physicians of Canada; Canadian Nurses Association; Canadian Association of Occupational Health Therapists; Canadian Association of Speech-Language Pathologists and Audiologists; Canadian Pharmacists Association; Canadian Coalition on Enhancing Preventative Practices of Health Professionals; Canadian Physiotherapy Association; and Dieticians of Canada.	$351,174
National First Nations and Inuit Telehealth Summit: Planning for Community Telehealth Services: 2005–2015 Lead: The e-Health Solutions Unit, First Nations and Inuit Health Branch, Health Canada Partners: Assembly of First Nations Health Directorate, Aboriginal Nurses Association (ANAC), Aboriginal Telehealth Knowledge Circle (ATKC), Canada Health Infoway (CHI), First Nations and Inuit Health Branch, Health Canada, Inuit Tapiriit Kanatami (ITK), National Aboriginal Health Organization (NAHO) and Provincial Telehealth Directors.	$500,000

[21] This initiative is a jointly-funded Health Canada Initiative that is cost-shared by the PHCTF and the Health Human Resources and Strategies Division.

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Supporting Implementation of Electronic Medical Records in Multi-disciplinary Primary Health Care Settings Lead: Health Canada's Primary and Continuing Health Care Division Partners: An advisory committee with representation from F/P/T governments and stakeholders (e.g. provider organizations, health care professionals, and health regions).	$455,000
Responsive Component	
6th National Summit on Community Cancer Control: Community Cancer Control in Northern and Rural Communities Lead: Northwestern Ontario Regional Cancer Care Partners: The conference steering committee is comprised of senior representatives from stakeholder groups including the Canadian Cancer Society, British Columbia Cancer Agency, Alberta Cancer Board, Saskatchewan Cancer Agency, Cancer Care Manitoba, Cancer Care Ontario, Centre de coordination de lutte contre le cancer, Conseil Québecois de lutte contre le cancer, Atlantic Health Sciences Corporation, and Cancer Care. Nova Scotia, and Dr. H. Bliss Cancer Centre in Newfoundland and Labrador.	$75,000
Best Practices in Primary Health Care Centres - National Conference Lead: Community Health Co-operative Federation Ltd. Partners: Canadian Alliance of Community Health Centre Associations	$15,000
Building Blocks to a Sustainable Primary Health Care System Lead: College of Registered Nurses of Nova Scotia Partners: Nova Scotia Department of Health, Canadian College of Health Services Executives (Nova Scotia/ Prince Edward Island Bluenose Chapter), Doctors Nova Scotia, College of Family Physicians of Canada (Nova Scotia Chapter), Dalhousie University School of Health Services Administration, and Health Canada Atlantic Region.	$49,500

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Fetal Alcohol Spectrum Disorder in Newfoundland and Labrador: A Primary Health Care Approach in Labrador Lead: Newfoundland and Labrador Department of Health and Community Services Partners: Health Labrador Primary Health Care Office, the Northern Labrador Child Development Team, the Fetal Alcohol Syndrome Advisory Committee, and the Fetal Alcohol Spectrum Disorders Ad Hoc Committee.	$58,660
National Conference/Workshop on the Implementation of Primary Health Care Reform Lead: Ontario Family Health Network Partners: Queen's University School of Policy Studies, Centre for Health Services and Policy Research, and Centre for Studies in Primary Care.	$75,000
Supporting Uptake of Chronic Disease Management Best Practices Lead: British Columbia Ministry of Health Services Partners: The British Columbia Medical Association, the Society of General Practitioners of British Columbia, the British Columbia College of Family Physicians, the College of Physicians and Surgeons of British Columbia, and the University of British Columbia.	$75,000
Shaping the Future of Primary Health Care in Nova Scotia - Conference Lead: College of Registered Nurses of Nova Scotia Partners: Nova Scotia Department of Health, Canadian College of Health Services Executives (Nova Scotia and Prince Edward Island chapters), Medical Society of Nova Scotia, Nova Scotia College of Family Physicians, and Atlantic Region of Health Canada's Health Policy and Communications Branch.	$19,000

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Where's the Patient's Voice in Health Professional Education? Lead: The Division of Health Care Communication, College of Health Disciplines, University of British Columbia. Partners: The College of Health Disciplines and the University of British Columbia Interprofessional Continuing Education.	$30,000
National Envelope - National Initiatives	
Continuous Enhancement of Quality Measurement in Primary Mental Health Care Lead: Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia. Partners: St. Paul's Hospital, British Columbia Ministry of Health Services, Canadian Mental Health Association, McMaster University, University of Western Ontario, University of Toronto, National Public Institute of Quebec, University of Calgary, Saskatchewan Health Quality Council, University of Saskatchewan, and Canadian Institute for Health Information.	$2,000,000
Getting A Grip on Arthritis: A National Primary Care Community Initiative Lead: The Arthritis Society Partners: Canadian Nurses Association, Sunnybrook and Women's College Health Sciences Centre, Arthritis Health Professions Association, Canadian Rheumatology Association, Patient Partners in Arthritis, Arthritis Community Research and Evaluation Unit, Canadian Alliance of Community Health Centre Associations, the Ontario Family Health Network and other pertinent national stakeholder groups and associations.	$3,876,685

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Health Care Interpreter Services - Strengthening Access to Primary Care Lead: Access Alliance Multicultural Community Health Centre Partners: Healthcare Interpretation Network (Toronto), Critical Link Canada, Ontario Ministry of Citizenship and Immigration, British Columbia Provincial Health Services Authority, "Régie régionale de la santé et des services sociaux de Montréal-Centre", universities and colleges, various professional health care associations.	$471,900
Issues of Quality and Continuing Professional Development: Maintenance of Competence Lead: The Association of Canadian Medical Colleges Partners: All Canadian medical schools, including the Northern Ontario Medical School.	$985,000
National Home Care and Primary Health Care Partnership Initiative Lead: Canadian Home Care Association Partners: Ontario Community Care Access Centres (Halton and Peel), Calgary Regional Health Authority, federal government, primary health care providers, research and academia, and other stakeholder associations.	$2,682,100
Pallium Integrated Care Capacity Building Initiative Lead: The Alberta Cancer Board Partners: Health Canada, other national and regional palliative and end-of-life organizations and associations, and participating jurisdictions (eight Canadian universities, regional health authorities and seven provinces and territories).	$4,317,000

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Physicians and Care of Quality for Canadian Francophone Minority Communities Lead: The Association of Canadian Medical Colleges Partners: University of Sherbrooke, University of Manitoba, University of Ottawa, "Programme de formation médicale francophone du Nouveau-Brunswick", all Canadian medical schools, interested provincial/territorial governments, community health centres, Federation of Francophone and Acadian Communities, Canadian College of Family Physicians, "Société Santé en français inc." and "Consortium national de formation en santé".	$888,972
Rainbow Health - Improving Access to Care Lead: Canadian Rainbow Health Coalition Partners: organizations and professionals associations, educational institutions, regional and district health authorities, and organizations from the gay, lesbian, bisexual, and trans-gendered community.	$2,307,000
ABORIGINAL ENVELOPE	
Aboriginal Envelope - Health System Renewal	
Bigstone-Aspen Shared Care Initiative Lead: The Bigstone Health Commission Partners: Bigstone Cree Nation, Aspen Regional Health Authority, Alberta Region of Health Canada's First Nations and Inuit Health Branch, Alberta Health and Wellness, University of Alberta, and Alberta Heritage Foundation for Medical Research.	$1,995,000
Community and Organizational Transition to Enhance the Health Status of All Northerners Lead: Northern Health Strategy Working Group Partners: Northern Inter-Tribal Health Authority, Athabasca Health Authority, Keewatin Yatthè Regional Health Authority, Kelsey Trail Regional Health Authority, Mamawetan Churchill River Regional Health Authority, Saskatchewan Health, Northern Relations, and First Nations and Inuit Health Branch, Saskatchewan Region.	$3,272,536

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Nursing Strategy: Health Canada's First National and Inuit Health Branch Lead: The Office of Nursing Services, First Nations and Inuit Health Branch, Health Canada. Partners: Canadian Nurses Association, Canadian Association of Schools of Nursing, Aboriginal Nurses Association, and various clinical and academic consultants across Canada. Note that funding to FNIHB for the Nursing Strategy and Health Integration Initiative totals $15,000,000.	$4,200,000
Health Integration Initiative Lead: The Strategic Policy, Planning Analysis Directorate of the First Nations and Inuit Health Branch, Health Canada. Partners: FNIHB regional offices, provincial/territorial governments, First Nations and Inuit organizations and communities. Note that funding to FNIHB for the Nursing Strategy and Health Integration Initiative totals $15,000,000.	$10,800,000
Northern and Aboriginal Population Health and Wellness Initiative Lead: The Northern and Aboriginal Population Health and Wellness Institute Partners: Manitoba Keewatinowi Okimakanak, Burntwood Regional Health Authority, other regional health authorities, Manitoba Métis Federation, Keewatin Tribal Council, Cree Nation Tribal Council, federal and provincial government departments, and municipal governments.	$2,925,150
Tui'kn Initiative Lead: Membertou Development Corporation Partners: District Health Authorities, Nova Scotia Department of Health, Atlantic Region of Health Canada's First Nations and Inuit Health Branch, and Dalhousie University.	$2,946,380

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Aboriginal Envelope - Health System Enhancement	
A Tool to Help People From Far Away - The IIU Telehealth Network Lead: Nunavut's Department of Health and Social Services Partners: digital communication firms and specialists, community representatives, health care practitioners, and other social service community stakeholders.	$2,700,041
Aboriginal Midwifery Education Program Lead: Manitoba Health Partners: Aboriginal organizations such as the Kagike Danikobidan, Manitoba Keewtinowi Okimakanak, Southern Chiefs Organization, and Manitoba Metis Federation, the Standing Committee of the College of Midwives of Manitoba, educational institutions, federal and provincial governments, and regional health authorities.	$1,690,927
Enhancing Access and Integrating Health Services - KO Telehealth/North Network Partnership Expansion Plan Lead: The Keewaytinook Okimakanak (Northern Chiefs) Council Partners: Sioux Lookout First Nations, Kuh-ke-nah Network of SMART First Nations, North Network, Health Canada's First Nations and Inuit Health Branch, Northern Ontario Heritage Fund, and Industry Canada's Federal Economic Development Initiative for Northern Ontario.	$3,441,495
Implementing a Digital Radiology and Tele-Radiology System Lead: Nunavik Regional Health and Social Services Board Partners: The McGill University Health Centre, the Nunavik Health Centres, and Quebec's ministére de la Santé et des Services sociaux.	$801,900

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
OFFICIAL LANGUAGES MINORITY COMMUNITIES ENVELOPE	
English Speaking Minority Communities	
Improving Access to Primary Health Care Services for English-Speaking Persons in Quebec Lead: Community Health and Social Services Network Partners: Regional health and social services authorities and health and community-based organizations.	$10,000,000
French Speaking Minority Communities	
Reseautage Sante en Francais Lead: Société Santé en français inc., Résautage Santé en français Partners: health institution managers, health professionals, community representatives, representatives of educational institutions, and government officials.	$1,900,000
Setting the Stage Lead: Société Santé en français (SSF) Partners: The provincial and territorial networks affiliated with the SSF and provincial and territorial health departments, in particular those in charge of planning the organization of health services.	$4,005,000
Co-ordination of Official Language Minority Community Envelope Projects Lead: Société Santé en français (SSF) Partners: The 17 provincial and territorial networks affiliated with the SSF.	$460,000
Société Santé en français Network Initiatives	
La composante francophone du BC Health Guide, (The BC Health Guide in French) Lead: Société Santé en français, British Columbia Network	$411,575

PHCTF Initiatives Funded as of June, 2005	
Initiative	**Total PHCTF Allocation**
Improving Access to Health Care Services for Francophones in Vancouver Coastal Health Lead: Société Santé en français, British Columbia Network	$200,000
Improving Access to Health Care for Francophones in British Columbia Lead: Société Santé en français, British Columbia Network	$365,126
La composante francophone du Centre d'appel provincial Info Santé / Health Links, (The French Component of the "Health Links" Provincial Call Centre) Lead: Société Santé en français, Manitoba Network	$135,615
Mise en place de centres de santé primaire, (The Implementation of Primary Health Care Centres) Lead: Société Santé en français, Manitoba Network	$135,000
Projet de répertoire des professionnels de la santé, (Directory of Health Professionals Project) Lead: Société Santé en français, Newfoundland and Labrador Network	$200,550
Enfants, aînés : Le coeur d'une communauté en santé, (Children and Seniors: Key to a Healthy Community) Lead: Société Santé en français, Saskatchewan Network	$573,000

Appendix B

PRIMARY HEALTH CARE RENEWAL IN CANADA

As per the PHCTF Evaluation Framework, one of the lines of evidence being conducted to inform the assessment of the PHCTF's progress is the comparison of performance information at several points in time. In 2004, a baseline study was completed that described the primary health care system in Canada, in each province and territory, and of the target populations funded by PHCTF at the outset of the Funding 2001/2002. This study relied on information gathered through several lines of evidence and publicly reported on indicators by the P/Ts as well as the F/P/T reports on comparable health indicators.

At the time of the present study, there was little performance information in the annual progress reports that could be used to make an assessment of progress toward the PHCTF objectives, for several reasons. As noted in a previous section, while a reporting template is provided, P/Ts and funded initiatives provide variable information and do not always adhere to the reporting requirements. In addition, because initiatives are funded at different times, at the time of data collection, many projects were still in the planning and implementation stages and therefore did not provide any performance information. As a result, evaluators relied on publicly reported indicators related to primary health care to characterize the nature and degree of change with respect to primary health care renewal in Canada; the primary source of information for the 2004 data were the F/P/T reports on comparable health indicators 2004, which used information from national data sources provided by Statistics Canada, Health Canada, and the Canadian Institute for Health Information.

There are several considerations of indicator quality and comparability that should be noted when reviewing the following information. First, while every attempt was made to assemble performance information that could be compared to the information presented in the baseline study, the indicators are not comparable across time periods and across provinces and territories and should not be perceived as such. The 2004 comparable health indicators reports are not the same as the 2002 reports, as a common core set of indicators were adopted in 2004, excluding some of the previous indicators and adding new indicators in 2004. In addition, there are differences in the reporting methods for some of the indicators, as some are reported using age standardization while others are not. Second, the PHCTF is a complex program, funding a range of programs and initiatives across the country. However, due to limited performance information, the data presented in this section of the report is based on publicly accessible information available at the time of data collection, and may only reflect a portion of the activities and outcomes associated with the PHCTF. Alternatively, because this

information is not specific to PHCTF activities, any perceived change related to primary health care can not be attributed to the PHCTF. Finally, given that P/Ts are at different stages of renewal and have placed varying emphasis on the PHCTF objectives, comparisons of indicators across P/Ts should not be made.

The following section describes the primary health care renewal impacts to date in Canada and each province and territory, since the inception of the PHCTF. For the national picture, information is presented for the baseline period (2001-2002) followed by information at the time of data collection for the formative evaluation (2004). For each jurisdiction, information is provided on the baseline situation in 2001-2002, followed by a description of primary health care renewal priorities in each jurisdiction as well as PHCTF initiatives, and finally the description on the state of primary health care in the P/T at the time of the evaluation study (2003-2004). The ordering of the information is intentional so as to avoid data comparisons across time and making comparisons across the P/Ts.

CANADA

PHCTF Baseline information 2001 - 2002

PHCTF Objective: Increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population.

Information available at the outset of the Fund pertaining to access of Canadians to primary health care indicates that in 2001, eighty-eight per cent of Canadians reported having a regular family physician. Furthermore, of the 16 percent who did not have a regular physician, 29 percent cited physician availability as the reason. In terms of the quality of family physician care reported by those with a regular family physician, 53 rated the care as "excellent" and 39 percent as "good." Overall, 11 percent of Canadians reported having unmet health care needs.

According to the 2001 JANUS Survey, less than one quarter of family physicians reported their practice status as completely open (accepting new patents); 70 percent indicated that their practices were conditionally closed except under certain circumstances; and 5 percent were unequivocal in stating that they do not accept new patients. In terms of practise settings, almost three quarters of family physicians (73 percent) considered a private office or clinic to be their main practice setting, whereas 12 percent reported practising primarily in community clinics or community health centres.

PHCTF Objective: Increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases.

In 2000-2001, 26 percent of Canadians aged 12 and over reported having an influenza immunization within the last 12 months; during the same time period, 63 percent of Canadians aged 65 and older received an influenza immunization.

The JANUS project collects information from family physicians on a range of issues. Results of the JANUS survey of family physicians provides some information on the proportion of family physicians who indicated they frequently or very frequently provided a range of preventive medical services in 2001, including obtained history of tobacco use (98 percent); counselling about breast feeding (59 percent); mammography for women aged 50-69 (94 percent); counselling on safe sex practices (75 percent); pap smears (93 percent); counselling about regular physical activity (87 percent); and blood pressure screening (97 percent).

PHCTF Objective: Expand 24 hour, 7 day-a-week (24/7) access to essential services.

In 2001, the majority of Canadians (94 percent) accessed first contact services in the previous 12 months and 18 percent indicated they had difficulties accessing the services. In the same time period, 91 percent reported accessing routine care with 11 percent citing difficulty; 46 percent accessed health information or advice with 13 percent citing difficulty; and 34 percent accessed immediate care for a minor health problem with 19 percent reporting difficulty. Overall, 11 percent of Canadians reported having unmet health care needs in 2001, with 5 percent having unmet health care needs with respect to health information and advice and 9 percent reporting unmet needs for immediate care for a minor health problem. In terms of the time of day, 90 percent of Canadians required routine or on-going care during regular office hours and 29 percent required the same during evenings and weekends.

PHCTF Objective: Establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider.

In 2001, 84 percent of Canadians described the overall quality of health care services they receive as "excellent" or "very good."

PHCTF Objective: Facilitate coordination and integration with other health services, i.e., in institutions and in communities.

No national baseline information relative to this objective.

PHCTF Formative Evaluation Information 2003 - 2004

PHCTF Objective: Increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population.

Access to first contact services was examined in 2003. At that time, 57 percent of Canadians required access to routine care in the previous 12 months, 42 percent required access to health information and advice, and 35 percent required immediate care for a minor health problem. Among those Canadians who required care at any time of day, 16 percent reported difficulty accessing routine or ongoing care, 16 percent reported difficulty accessing health information or advice, and 24 percent reported difficultly accessing immediate care for a minor health problem.

Overall, 85 percent of Canadians reported high levels of satisfaction (very or somewhat satisfied) with overall health care services received. More specifically, 83 percent reported satisfaction with community based care received and 84 percent reported the same for health line services received.

In 2003, 87 percent of Canadians reported having a regular family physician. According to the Canadian Community Health Survey, in 2003, 86 percent of Canadians reported having a regular family doctor; of those who did not, 9 percent indicated they had not looked for one and 4 percent indicated they couldn't find a doctor. In, 2003, the majority of Canadians (91 percent) indicated they were "very or somewhat" satisfied with the way physician care was provided.

According to the 2004 JANUS Survey, one quarter of family physicians in Canada reported their practise status as completely open; 42 percent indicated that their practices were conditionally closed except under certain circumstances; and 18 percent indicated they were completely closed. When asked about practise settings, 47 percent of family physicians in Canada reported their main practise setting as a private office or clinic and 5 percent reported the same as a community clinic/community health centre.

In a 2004 telephone survey of adults' experiences with primary health care in five countries, 86 percent of Canadian respondents indicated they had a regular family physician and 53 percent reported having the same family physician for the last five years.

PHCTF Objective: Increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases.

Results of a 2004 survey indicated that 87 percent of Canadians has a doctor visit in the past year. In addition, the survey found that 74 percent and 73 percent of women received pap testing and mammograms at recommended interval and age, respectively; 55 percent of Canadian indicated their doctors provided advice or counselling in weight, nutrition, or exercise; and when asked about doctor diagnoses of chronic diseases, 20 percent reported hypertension, 6 percent reported heart disease and diabetes, 20 percent reported arthritis, 12 percent reported lung problems, 13 percent reported depression, and 48 percent reported at least one of six chronic diseases.

PHCTF Objective: Expand 24 hour, 7 day-a-week (24/7) access to essential services.

In 2004, a survey of Canadian adults revealed that 29 percent of Canadians indicated it was very or somewhat easy to obtain care on nights, weekends, or holidays without going to an emergency room; 59 percent indicated it was very or somewhat difficult; and 8 percent indicated they never needed care outside of regular working hours.

PHCTF Objective: Establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider.

Information was not available for this objective at the time of data collection.

PHCTF Objective: Facilitate coordination and integration with other health services, i.e., in institutions and in communities.

Information was not available for this objective at the time of data collection.

ALBERTA

2002

In 2001, the majority of Albertans (92 percent) accessed at least one type of first contact care in the previous 12 months and of those who accessed these services, 21 percent reported difficulties. At the same time, 91 percent reported accessing routine care, 43 percent accessed health information or advice, and 33 percent accessed immediate care for a minor health problem. Overall, eleven percent of Albertans reported having unmet health care needs in all services.[22]

The majority (84 percent) of Albertans had access to a regular family physician in 2001; of those respondents, 91 percent rated the quality of family physician care as either excellent or good. Of the 16 percent of Albertans reporting having no regular family physician, 24 percent cite physician availability as the reason.[23]

The majority (82 percent) of the province's population reported being at least somewhat satisfied with the health care system.

In 2001, there were 2,274 FPs in Alberta with 78 percent practising primarily in a private office or clinic. In terms of all practise settings, 81 percent of FPs report practising in a private/office or clinic at any time, 6 percent report working in a community clinic or community health centre, 12 percent in a free standing walk-in clinic, and 4 percent in an academic family medicine teaching unit. In terms of accepting new patients, 35 percent of FPs report their practise status as completely open. When asked to rate perceived access to health care services in their community on a five-point scale, 53 percent of FPs rated referrals to psychiatrists as poor and 35 percent rated access to diagnostics services as fair or poor.[24]

---

[22] Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001*. Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

[23] Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001*. Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

[24] JANUS, Ibid.

Primary Health Care Renewal

Alberta has been implementing primary health care reforms through changes to the organization, funding, and delivery of services. From 1998 to 2006, Alberta allocated $54 million to 66 projects that explore innovative ways to improve primary health care.[25] In addition, some of the key strategies being used include the implementation of Local Primary Care Initiatives, which are formal arrangements between groups of physicians and their regional health authorities; in 2004, the implementation of Alberta Electronic Health Record, a provide-wide clinical health information system that links health care providers and patient information on-line; and the use of a Health Sustainability Initiative to support capital infrastructure costs for primary health care renewal.[26]

PHCTF

In addition to the initiatives above, Alberta's portion of the PHCTF ($54,876,073) has gone to a $16 million Primary Health Care Capacity Building Fund, which supports 10 programs designed to expand primary health care services in Alberta; all 10 initiatives have been implemented and are underway. Among the projects approved for funding include a program to help remote northern Albertans better manage their diabetes; a program to assist patients with chronic disease in the Chinook and Calgary Health Regions; and a network to improve children's and youth's health services in southern Alberta. The remaining PHCTF funds were allocated to Health Link Alberta, the implementation of a province-wide health information and triage telephone line in 2003 and two web-based components. The health line is expected to receive more than 800,000 calls a year.[27] Finally, PHCTF funding has been used to fund provincial coordination activities

2004[28]

In 2003, Albertans required first contact services at varying rates. Forty seven percent required routine care, 41 percent required health information or advice, and 36 percent required immediate care for a minor health problem.

---

[25] Government of Alberta. (2004). *Alberta: Moving Primary Health Care Forward*. Retrieved on September 3, 2004. http://www.health.gov.ab.ca/about/building_fund/moving_forward.html

[26] Ibid.

[27] Government of Alberta. (2004). *Alberta Health Reform Implementation Team, Final Report.* Retrieved on March 24, 2005. http://www.healthreform.ca/

[28] All data from the 2004 Comparable Health Indicators reports are age-standardized.

In terms of accessing services at any time of the day, 14 percent of Albertans reported difficulties accessing routine or ongoing care, 12 percent reported difficulties accessing health information or advice, and 22 percent reported difficulties accessing immediate care for a minor health problem.[29]

In 2003, 83 percent of Albertans report being satisfied with the health services they received in the past 12 months. They have very high levels of satisfaction (83 percent) with telephone health line services and high levels of satisfaction (78 percent) with community-based care.[30]

At the same time, 86 percent of Albertans had access to a regular family physician and 15 percent reported having no regular family physician.

BRITISH COLUMBIA

2002

In 2001, the majority (92 percent) of people in British Columbia accessed a least one first contact service in the previous 12 months, and of these individuals, 18 percent reported difficulties in accessing the service. Of the majority of individuals (91 percent) that accessed routine care, 10 percent reported difficulties accessing this service; of the half (51 percent) of individuals in the province who accessed health information or advice, 13 percent reported difficulties, and of the 31 percent who accessed immediate care for a minor health problem, 19 percent reported difficulties. Overall, 12 percent of people in British Columbia reported unmet health care needs in 2001.

In 2001, ninety percent of the population in British Columbia had access to a regular family physician and 10 percent reported having no regular family physician. Of those who did not have a family physician, 36 percent cited physician availability as the reason.[31]

---

[29] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[30] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retrieved on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[31] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retrieved on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

According to the JANUS survey, in 2001, there were 3,832 family physicians/general practitioners (FPs) working in British Columbia. The majority (83 percent) of FPs indicated that they worked primarily in a private office or clinic, while only 4 percent indicated they worked primarily in a community clinic or community health centre.[32]

Primary Health Care Renewal

The British Columbia Ministry of Health works in partnership with the health authorities in the province toward primary health care renewal. The Ministry is responsible for setting policy and the health authorities are responsible for the planning and implementation of primary health care renewal initiatives. A provincial steering committee comprised of Ministry, health authority, professional organizations, and academia provides advice and guidance on primary health care renewal. In addition, a number of working committees are responsible for technical and operational advice on implementation, program development, and evaluation. This approach to renewal is expected to lead to improved access to health professionals, increased access to family practises, improved health outcomes, and increased access to education on risk factors, disease management, and self-care to enhance health and wellness.[33]

PHCTF

British Columbia has allocated most (93 percent) of its PHCTF funding ($74,022,488) directly to health authorities for developing initiatives designed to address regional challenges and expanding sustainable primary health care services. Funded initiatives include primary health care organizations and networks, community health centres, shared care, nurse managed care, and chronic disease management. Also, a portion of the PHCTF funding is being used to support province and system-wide initiatives. For example, the BC Nurse Line has added pharmacist services on call to provide after-hours advice, which was supported by the PHCTF. Between the years 2001/2002 and 2003/2004, call volume on the Nurse Line increased by over 141 percent, and received over 250,000 calls.[34]

---

[32] The College of Family Physicians of Canada. (2002). *The JANUS Project: Family Physicians Meeting the Needs of Tomorrow's Society*. Retreieived on April 21, 2005. http://www.cfpc.ca/English/cfpc/research/janus%20project/default.asp?s=1

[33] British Columbia Health Services. (2004). *Making Progress: Primary Health Care Renewal In British Columbia*. Retrieved on March 28, 2005. http://www.healthservices.gov.bc.ca/phc/pdf/phc_renewal_BC_may2004.pdf

[34] British Columbia. Ministry of Health Services. (2003). *2003/04 Annual Service Plan Report*. Retrieved on January, 19, 2005. http://www.bcbudget.gov.bc.ca/annualreports/hs/hs.pdf.

2004

Accessing first contact services in British Columbia poses challenges for some. In 2003, 12 percent of citizens reported difficulties accessing routine or ongoing care, 16 percent reported difficulties accessing health information or advice, and 20 percent reported difficulties for immediate care for a minor health problem.[35]

Despite having difficulties accessing services, overall, 81 percent of people in the province reported being very or somewhat satisfied with the health care services received they received in the past year; in addition, 83 percent report satisfaction with community based care and 85 percent with telephone health line services.[36]

The majority (87 percent) of British Columbians reported having a regular family physician in 2003.

MANITOBA

2002

In 2001, the majority (94 percent) of Manitobans accessed first contact services and of these people, 26 percent reporting difficulties accessing this care. In addition, 91 percent accessed routine care, 48 percent accessed health information or advice, and 37 percent accessed immediate care for a minor health problem.[37] Overall, 14 percent of the population reported unmet health care needs in the province.

At the same time, 86 percent of the provincial population reported having a regular family physician, and of those who reported not having one, 32 percent cited physician availability as the reason.[38]

According to the JANUS survey in 2001, there were 885 FPs practising in the province. The majority of FPs work primarily in a private office or clinic (64 percent) while 14 percent work primarily in community clinics. When asked about their practice status, 34 percent indicated

---

35 Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retrieved on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

36 Ibid.

37 Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

38 Ibid.

they were completely open to accepting new patients while 66 percent indicated they were either conditionally or completely closed. FPs in Manitoba are most likely to rate access to various health services in their communities as fair to good, but are most likely to give a poor rating to access to psychiatric referrals (33 per cent) and access to physicians of a preferred gender (also 33 per cent).[39]

Primary Health Care Renewal

Health care in Manitoba is the collective responsibility of the provincial government and regional health authorities. Both the provincial ministry and the Regional Authorities are responsible for broad policy direction, assessment of health status, and ensuring effective health planning and delivery. The delivery of Manitoba's health services is the responsibility of the province's eleven regional health authorities, who are responsible for policy direction, assessing and prioritizing needs and health goals, and developing and managing an integrated approach to their own health care system.[40]

In 2002, Manitoba Health developed a Primary Health Care Policy framework to guide ongoing reform in the province. The vision for reform in the province is that Manitobans will have access to community-based, integrated, and appropriate primary health care services based on the following principles: community participation, population health, interdisciplinary care, accessibility, appropriateness, continuity of care, efficiency, and affordability and sustainability.[41]

PHCTF

Manitoba Health employed a phased approach in allocating the funds received from the PHCTF ($20,844,059). In Phase I, $8.8 million was spent on five initiatives that established the foundation for primary health care renewal in the province, including the expansion of the Health Links Call Centre, collaborative practise training initiatives, information technology initiative, primary health care public awareness, and emergency medical services enhancement. In Phase II, Manitoba Health approved over $11.9 million for 17 primary health care initiatives submitted by the regional health authorities to reform and enhance their primary health care services. Initiatives were selected based on their ability to support:

---

[39] JANUS, Ibid.

[40] Government of Manitoba. (n.d.) *Regional Health Authorities.* Retrieved on April 18, 2005. http://www.gov.mb.ca/health/rha/index.html

[41] Manitoba Health. (2003). *Primary health Care Reform in Manitoba*. Retrieved on May 3, 2004. http://www.gov.mb.ca/health/primaryhealth.html

advancing primary care access through networking of family physicians and advanced practice nursing, building community capacity, increasing regional health authority organizational strength, and creating integrated service delivery systems.[42]

2004

In 2003, an estimated 54 percent of Manitobans required routine care, 47 percent required health information or advice, and 34 percent required immediate care for a minor health problem. In terms of access to first contact services at any time of the day, 19 percent of Manitobans reported difficulties accessing routine or ongoing care, 18 percent reported difficulties accessing health information or advice, and 25 percent reported difficulties accessing immediate care for a minor health problem.[43]

At the same time, 83 percent of Manitobans report being satisfied with the health services they received in the past 12 months. They reported high levels of satisfaction (84 percent) with telephone health line services and high levels of satisfaction (81 percent) with community-based care.[44]

At the same time, 86 percent of Albertans had access to a regular family physician and 14 percent reported having no regular family physician.[45]

NEW BRUNSWICK

2002

In 2001, 94 percent of the province accessed at least one first contact service in the previous year, and of these people, 20 percent reported difficulty accessing this service. At the same time, of the 92 percent that accessed routine care, 13 percent reported difficulty; of the half of

---

42 Manitoba Health. (2003). *News Release: 17 Projects Announced for Phase Two of Primary Health Care Transition Fund* . Retrieved on April 18, 2005. http://www.gov.mb.ca/chc/press/top/2003/04/2003-04-30-02.html

43 Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

44 Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retrieved on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

45 Ibid.

the population that accessed health information or advice, 15 percent reported difficulty; and of the 29 percent that accessed immediate care for a minor health problem, 20 percent reported difficulty. Overall, 10 percent of the population reported having unmet health care needs. [46]

In 2001, 95 percent of people in New Brunswick reported having a regular family physician, and of those who did not have one, 29 percent cited physician availability as the reason.[47]

According to the 2001 JANUS Survey, there were 478 FPs in New Brunswick with just over three quarters (77 percnt) indicating they practised primarily in a private office/clinic. While only 6 percent of FPs reported working primarily in a community clinic, 11 percent practice in them at least some of the time. In terms of practise status of FPs accepting new patients, 13 percent indicated they were completely open while 87 percent indicated they were conditionally or completely closed. FPs in the province tend to rate access to the majority of services in their communities as fair to good, but are more likely to rate access to psychiatrist referrals and long-term care beds as poor (48 percent and 35 percent, respectively).[48]

Primary Health Care Renewal

Primary health care is an integral component of health care renewal in New Brunswick and implementation of this reform is largely the responsibility of the regional health authorities.[49] New Brunswick has eight regional health authorities that serve several functions, including developing and implementing a three year Regional Health and Business Plan, identifying regional health needs, and reporting on outcomes of performance measures.

A health care renewal policy developed in 2000 features a number of items relevant to primary health care, including interdisciplinary teams, integrated health systems, Community Health Centres, and an electronic health record.

---

46 Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

47 Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

48 JANUS, Ibid.

49 Wilson, et. al. (2004). *Implementing Primary Health Care Reform: Barriers and Facilitators.* McGill-Queens University Press: School of Policy Studies. p. 179.

PHCTF

New Brunswick Health and Wellness is using its PHCTF funding ($13,689,805) to support two main initiatives: the establishment of a network of Community Health Centres (CHCs) and the enhancement of ambulance services. The remaining PHCTF funds are being used to develop and implement a change management strategy, conduct an analysis of the management information system for public and mental health services sector, assist in the implementation of various telehealth initiatives, and evaluation. To date, New Brunswick has established five CHCs across the province with various hours of service, offering a range of primary health care services and programs, with a range of health professionals.

2004

In 2003, 64 percent of New Brunswickers required access to routine care, 41 percent to health information or advice, and 38 percent to immediate care for a minor health problem. Among those who required care at any time of the day, 16 percent reported difficulty accessing routine or ongoing care; 17 percent reported the same for health information or advice, and 24 percent reported the same for immediate care for a minor health problem. Overall, the majority of people in New Brunswick reported high levels of satisfaction with the health care services they received; 87 percent of people in the province reported high levels of satisfaction with overall health care services; 92 percent were satisfied with community based care and 88 percent were satisfied with telephone health line services provided.[50]

Ninety two percent of people in the province reported having a regular family physician. [51]

NEWFOUNDLAND AND LABRADOR

2002

The majority (95 percent) of Newfoundland and Labrador's population reported having access to first contact services in 2001, and of these people, 23 percent reported difficulty accessing the service. In terms of other first contact services, 94 percent accessed routine care (with

---

[50] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[51] Ibid.

16 percent reporting difficulty); 33 percent accessed health information or advice (with 17 percent reporting difficulty); and 37 percent access immediate care for a minor health problem (and 24 percent reported difficulty). Overall, 12 percent of the population reported having unmet health care needs for all services.[52]

Eighty-six percent of the population in Newfoundland and Labrador reporting having a regular physician; of the 12 percent who did not, 66 percent cited physician availability as the reason.[53]

In 2001, there were 410 FPs in Newfoundland and Labrador, with sixty-three percent of FPs working primarily in a private office or clinic and 15 percent working primarily in a community clinic or community health centre; nearly one-quarter (22 percent) work at least sometimes in a community clinic or community health centre. One-third of FPs report their practise status as accepting new patients and most FPs tended to rate access to various health care services as fair to good, but rated access to long-term care beds, psychiatrist referrals, and hospitals as poor (43 percent, 29 percent, and 25 percent respectively).[54]

Primary Health Care Renewal

The Department of Health and Community Services and regional health boards work collaboratively to delivery health services in Newfoundland and Labrador. The Department provides a leadership role in health, community services programs, and policy development and support the regional boards. Health programs and services are provided by 13 health boards: six Regional Institutional Boards, four Regional Health and Community Services Boards, two Regional Integrated Boards, and a Regional Nursing Home Board.[55]

Primary health care is central to health system reform in Newfoundland. In 2003, the Department of Health and Community services released a framework for the implementation of primary health care renewal in the province. The framework was developed based on consultation and focusses on enhanced accessibility and sustainability of primary health care services; an emphasis on self reliant and healthy citizens and communities; promotion of comprehensive, integrated, and evidence-based approach to service provision; and enhanced

---

52 Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

53 Ibid.

54 JANUS, Ibid.

55 Newfoundland and Labrador Department of Health & Community Services. (n.d) *Departmental Profile.* Retreiveid on April 18, 2005. http://www.health.gov.nl.ca/health/department/default.htm

accountability and satisfaction of health professionals.[56] An Advisory Council, with provincial and stakeholder representation, advises the Minister on the implementation and evaluation of the framework.

PHCTF

The PHCTF funding ($9,705,620) allocated to Newfoundland and Labrador is being used to assist with the transitional costs associated with the planing, implementation, and evaluation of primary health care projects being implemented throughout the province. The Department is formalizing interdisciplinary teams across the province based on the needs of the population being served, including a range of health professionals.

2004

In 2003, 84 percent of the population in Newfoundland and Labrador reported being very or somewhat satisfied with overall health care services. In terms of accessing first contact services, 57 percent of the population required first contact services, 36 percent required health information or advice, and 37 percent required immediate care for a minor health problem. Among those who required care at any time of the day, 20 reported difficulties accessing routine or ongoing care, 15 percent reported difficulties accessing health information or advice, and 24 percent reported the same for immediate care for a minor health problem.[57]

Eighty six percent of the population reported having a regular family physician.[58]

NORTHWEST TERRITORIES

Primary Health Care Renewal

In the Northwest Territories, the Department of Health and Social Services and eight regional health authorities are responsible for the planning, management, and delivery of a range of community and facility-based services. The territory's approach to health is known as primary

---

[56] Newfoundland and Labrador Department of Health & Community Services. (2003). *Moving Forward Together: A Framework for Primary Health Care in Newfoundland and Labrador.* Retrevied on May 4, 2004. http://www.health.gov.nl.ca/health/publications/pdfiles/Moving%20Forward%20Together%20apple.pdf

[57] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[58] Ibid.

community care, which is synonymous with primary health care. The territorial government developed a 2002- 2005 Action Plan for Health, which describes new ways of service delivery for primary health care. There are plans to formalize an integrated Health and Social Services Delivery Model by early 2003. Integration demonstration projects based on this model are expected shortly thereafter. Nurse practitioners are being trained, and legislation was passed in 2002 allowing them to undertake various diagnostic and therapeutic activities.

PHCTF

With the funds from the PHCTF ($4,771,470), the Northwest Territories is undertaking eleven primary health care renewal initiatives which collectively support the transition to a primary community care approach to health and social services; these initiatives include public/staff education and coordination of primary care reform, the development of integrated primary health care teams and services, support for improved women's reproductive health services, and training for health care providers.

2004

In 2003, 82 percent of the population in Northwest Territories were very or somewhat satisfied with overall health care services received. More specifically, 86 percent reported high levels of satisfaction with community based care and 81 percent[59] reported the same with telephone line of tele-health services.[60]

NOVA SCOTIA

2002

In 2001, 96 percent of the population in Nova Scotia reported accessing at least one first contact service and of these people, 23 percent reported difficulties accessing this care. More specifically, 95 percent accessed routine care with13 percent reporting difficulty; 42 percent accessed health information or advice with 19 percent reporting difficulty; and 37 percent accessed immediate care for a minor health problem with 24 percent reporting difficulty. Overall, 10 percent of the provincial population reported having unmet health care needs.[61]

---

[59] This information should be interpreted with caution due to a high level of variability.

[60] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[61] Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

Ninety four percent of residents in Nova Scotia reported having a regular family physician and of those who reported not having a regulars physician, 60 percent indicated physician availability was the reason.[62]

As of 2001, 84 percent of FPs surveyed by JANUS practised primarily in a private office or clinic, with just eight percent working in a community clinic or community health centre at any time. The majority of FPs reported their practise as being conditionally or completely closed while only 17 percent reported it as being completely open.[63]

Primary Health Care Renewal

In 2001, the Department of Health established an Advisory Committee on Primary Health Care Renewal and based on consultation with a range of stakeholders, developed a vision for primary health care renewal in the province. This strategy envisions a primary health care system in the province that is community-based, family-focussed, and person-centred; comprehensive; responsive and flexible; accessible; integrated, collaborative, and innovative; accountable; and sustainable.[64]

PHCTF

Nova Scotia's PHCTF funding ($17,073,265) is being allocated to four main priority areas, including shifting the focus of primary health care to collaborative primary health care teams; developing a cultural shift among health care providers that supports a population health approach, collaboration, and an enhanced role for health promotion; changing the primary health care funding system; and transitioning the primary health care system toward implementation of electronic health records.

2004

In 2003, 62 percent of the population in Nova Scotia requires access to routine care; 47 percent required access to health information or advice, and 39 percent required access to immediate care for a minor health problem. Among those who required care at any time of day, 15 percent reported difficulty accessing routine or ongoing care; 15 percent reported difficulty accessing health information or advice; and 26 percent reported difficulty accessing

---

62 Ibid.

63 JANUS, Ibid.

64 Nova Scotia Department of Health. (n.d). *Primary Health Care Renewal: Vision*. Retrieved on April 18, 2005. http://www.gov.ns.ca/health/primaryhealthcare/vision.htm

immediate care for a minor health problem. Overall, patients reported high levels of satisfaction with health care services received; 84 percent of the population reported high levels of satisfaction with overall health care services, 86 percent were satisfied with community based care, and 92 percent were satisfied with telephone health line services.[65]

Ninety four percent of the population reported having a regular family physician.

NUNAVUT

Primary Health Care Renewal

After the dissolution of three boards in 2000, the management and delivery of Nunavut's health services were integrated into the overall operations of the territorial Department of Health and Social Services. The Department's mandate is to "promote, protect and provide for the health and well being of Nunavut in support of leading self-reliant and productive lives" through the delivery of a range of program and services in primary and acute health care, child protection, family services, mental health, health promotion and protection, and injury prevention.[66]

While Nunavut does not have a policy on primary health care, it does adhere to its Bathurst Mandate, which states that the "health of Nunavut depends on the health of each of its physical, social, economic, and cultural communities and the ability of those communities to serve Nunavummiut in the spirit of Inuuqatigiitiarniq; the healthy inter-connection of mind, body, spirit and environment."[67] Plans for health reform have been articulated, including recruitment, training, and retention activities; the development of a Telehealth Network; a Capacity Plan; and Wellness Plans for each community.

---

[65] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[66] Government of Nunavut. (2000). *Health and Social Services: Improving Nunavuts Health.* Retrieved on April 21, 2005. http://www.gov.nu.ca/hsssite/hssmain.shtml

[67] Government of Nunavut (2000). *The Bathurst Mandate Pinasuaqtavut : that which we've set out to do.* Retrieved on April 18, 2005. http://www.gov.nu.ca/Nunavut/English/departments/bathurst/health.shtml

PHCTF

Nunavut's Department of Health and Social Services is undertaking a series of staged, transition initiatives that are expected to result in structural change to the territory's primary health care system. With the funding from the PHCTF ($4,508,924), Nunavut is undertaking two main components: a change management process leading to integrated, coordinated, and patient- and comunity-focussed primary health care; and an information management strategy directed at the provision of information to support primary health care.

2004[68]

In 2003, 74 percent of the population in Nunavut reported high levels of satisfaction with health care services received and 91 percent reported the same for community based care.[69]

ONTARIO

2002

In 2001, 96 percent of the population in Ontario reported accessing at least one first contact service in the previous 12 months, and of these people, 18 percent reported difficulties accessing the service. Furthermore, 94 percent reported accessing routine care (with 11 percent citing difficulty); 49 percent accessed health information or advice (with 10 percent citing difficulty); and 34 percent accessed immediate care for a minor health problem (with 18 percent citing difficulty). In terms of health care needs, 11 percent of Ontarians reported having unmet health care needs related to all services.[70]

Most people in Ontario (94 percent) reported having a regular family physician and for those who reported not having one, 50 percent cited physician availability as the reason.[71]

---

[68] Information is not available for Nunavut on some of the primary health care indicators (difficulty obtaining health service, information or advice, and immediate care) as the territory was not included in the applicable surveys. In addition, information is not available on telephone health lines or tele-health services as these services are not available in Nunavut.

[69] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[70] Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

[71] Ibid.

In 2001, there were 8,730 FPs in Ontario with the majority (82 percent) working primarily in private offices and clinics; three percent report working primarily in community clinics or community health centres while six percent report practising in community health centres or community clinics some of the time. Most Ontario FPs are either conditionally or completely closed to accepting new patients, while less than one-fifth report being completely open.[72]

Primary Health Care Renewal

The Ontario Ministry of Health and Long Terms care is responsible for the administration and delivery of health care programs and services throughout the province. Health care reform in the province has been ongoing and has resulted in the establishment of several primary care models in the province, including Family Health Networks, Family Health Groups, Primary Care Networks, and Community Health Centres. In addition, initiatives such as the Primary Care Nurse Practitioner Program and the Telehealth Ontario are aimed at improving access to care.

PHCTF

Ontario's allocation of the PHCTF ($213,170,044) has been used to fund a range of primary health care renewal projects with the following objectives: facilitate the enrolment process for physician participating in Family Health Networks and other primary care models; support projects designed to research and evaluate the integration of inter-disciplinary providers into primary care models; develop information systems to support efficient and timely payment to physicians in primary care models; support public and provider communication activities on primary health care renewal; develop a voluntary accreditation program for physicians and other inter-disciplinary providers working in primary care models; develop and implement a leadership training program for inter-disciplinary primary care providers in primary care models; facilitate linkages with mental health services and rehabilitation services; and support the Ministry's project management activities as well as some of the activities related to the Ontario Family Health Network.

2004

In 2003, 57 percent of the population in Ontario required routine care, 44 percent required health information or advice, and 36 percent required immediate care for a minor health problem. In terms of difficulty accessing first contact services, among those who required care

[72] JANUS, Ibid.

at any time of day, 16 percent of the population reported difficulty accessing routine or ongoing care, 18 percent reported difficulty accessing health information or advice, and a quarter of the population reported difficulty accessing immediate care for a minor health problem.[73]

According to the survey, 85 percent of the population in Ontario reported being very or somewhat satisfied with overall health care services received. Furthermore, 82 percent of the provincial population reported high levels of satisfaction with community based care and 84 percent reported the same with telephone health line services.[74]

Ninety percent of the population in Ontario report having a regular family doctor.

PRINCE EDWARD ISLAND

2002

In 2001, 94 percent of Prince Edward Island's population reported accessing at least one first contact service and of these people, 26 percent reported difficulties accessing this care. In addition, 92 percent accessed routine care with16 percent reporting difficulty; 46 percent accessed health information or advice with 18 percent reporting difficulty; and 34 percent accessed immediate care for a minor health problem with 26 percent reporting difficulty. Overall, 13 percent of the provincial population reported having unmet health care needs.[75]

Ninety four percent of residents in Nova Scotia reported having a regular family physician and of those who reported not having a regulars physician, 76 percent indicated physician availability was the reason.[76]

---

[73] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[74] Ibid.

[75] Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

[76] Ibid.

There were 187 FPs in Prince Edward Island in 2001 with the majority (87 percent) working primarily in a private office or clinic and only 2 percent working primarily in a community/community health clinic. In terms of practise status, 22 percent of FPs reported being completely open to accepting new patients while 78 percent reported being conditionally or completely closed.[77]

Primary Health Care Renewal

Prince Edward Island's Ministry of Health and Social Services is comprised of the Department of Health and Social Services and five health authorities; these authorities include four health regions and the Provincial Health Services Authority who are responsible for the management and delivery of core programs and services. Primary health care is a central element of the province's strategic health plan; improving access to primary health care services is seen to be a means of achieving a number of the province's health goals.

Prince Edward Island has undertaken a number of strategies aimed to reform primary health care in the province using a 'Primary Health Care Redesign' model, based on the principles of primary health care as defined by the World Health Organization in 1978. The model includes creating family health centres that will integrate physicians, nurses, and other health care providers working in collaborative arrangements. A provincial implementation committee is in place to oversee development as well as address sustainability issues.

PHCTF

PEI received $6,526,879 from the PHCTF and is undertaking two main primary health care redesign initiatives, including promoting and evaluating each initiative. The most significant imitative entails the establishment of family health centres across the province, which consists of a collaborative practise of interdisciplinary teams of health care professionals, care management protocols, alternative payment plans, extended hours, patient registration, and enhanced information technology. The second initiative consists of the development and implementation of a strategy for healthy living using a population health approach.

2004

In 2003, 58 percent of Prince Edward Island's population required access to routine care, half of the population required health information or advice, and 38 percent required immediate care fore a minor health problem. At the same time, the province's population reported varying rates of difficulty for access to first contact services at any time of day; 18 percent

[77] JANUS, Ibid.

reported difficulty accessing routine or ongoing care, 17 percent reported difficulty accessing health information or advice, and 28 percent reported difficulty accessing immediate care for a minor health problem.[78]

Patient satisfaction with services is one indicator of the quality of services. In 2003, 89 percent of Prince Edward Island's population reported being very or somewhat satisfied with overall health care services received; 85 percent reported the same for community based care; and 76(E) percent for telephone health line services.[79]

The majority of the province's population (91percent) reporting having a regular family physician.[80]

QUEBEC

2002

In 2001, 91 percent of the population of Quebec reported accessing at least one first contact service in the past 12 months, with 17 percent citing difficulty accessing this service. In addition, of the 86 percent who accessed routine care, 10 percent indicated they had difficulty accessing the care; of the 39 percent that accessed health information or advice, 15(E) percent reported difficulty; and of the 35 percent who accessed immediate care for a minor health problem, 17 percent reported difficulty. Overall, 10 percent of the province's population reported having unmet health care needs.[81]

In 2001, just over three-quarters of the population in Quebec (76 percent) reported having a regular family physician; of the 24 percent who did not, 16 percent cited physician availability as the reason.[82]

---

78 Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

79 Ibid.

80 Ibid.

81 Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

82 Ibid.

According to the JANUS survey, in 2001, there were 6,728 FPs in Quebec, with over half working primarily in a private office or clinic; 15 percent report working primarily in a community health clinic or CLSC and 24 percent report working in the same at least some of the time. Over one-quarter of FPs report their practise status as completely open while 73 percent indicated they were either conditionally or completely closed.[83]

Primary Health Care Renewal

Québec's health care system is organized into the central, regional, and local levels. The Québec Ministère de la santé et services sociaux establishes strategic directions and allocates budgetary resources; at the regional level, 18 health and social services agencies are responsible for organizing and coordinating services, as well as budgetary allocations; at the local level, health and social services centres and local services networks are collectively responsible for the population of their local territories, which they fulfill within a clinical and organizational project.[84]

The primary care network is the foundation of Quebec health system. In response to the Clair Commision, the Ministère initiated family medicine groups (FMGs) to strengthen primary care through the enhancement of collaboration between local community health centres and private medical practises.[85] FMGs are composed of family physicians working as a group in close collaboration with nurses who provide essential medical care to registered patients. Each FMG signs an agreement with a local community service centre and the range of services offered by FMGs include the provision of care suited to the health status of registered patients, disease prevention and health promotion, and medical assessment, diagnosis, and treatment of acute and chronic conditions.

PHCTF

Quebec's allocation of the PHCTF ($133,681,686) is being used to fund the implementation of FMGs. A FMG is a group of family physicians who work in close cooperation with nurses to offer family medicine services to registered individuals. Family physicians who are members of FMGs will also work closely with other healthcare professionals in CLSCs, hospitals, community pharmacies, etc. to complement the services they offer. The MSSS intends to progressively implement approximately 300 FMGs throughout Québec so that the entire population will be registered by 2005.

---

[83] JANUS, Ibid.

[84] Québec Ministère de la santé et services sociaux. (2005). *Quebec's Health and Social Services System.* Retreiveid on April 21, 2005. http://www.msss.gouv.qc.ca/en/reseau/system.html

[85] Haggerty, Jeannie et al. (2004). *Continuity and Accessibility of Primary Care in Quebec: Barriers and Facilitators.* Retreieved on Jnaury 13, 2005. (p.1) http://www.medfam.umontreal.ca/chaire_sadok_besrour/ressource/PDF/continuity_report.pdf

2004

In 2003, 63 percent of people in Quebec required access to routine care, 41 percent required access to health information or advice, and 33 percent required access to immediate care for a minor health problem. At the same time, among those who required care at any time of day, 20 percent reported difficulty accessing routine or ongoing care, 15 percent reported difficulty accessing health information or advice, and 26 percent reported difficulty accessing immediate care for a minor health problem.[86]

In terms of satisfaction with health services, 87 percent of Quebec's population reported high levels of satisfaction with overall health care services, 89 percent reported the same with community based care, and 84 percent reported the same with health line services.[87]

Seventy three percent of the provincial population reported having a regular family physician.[88]

SASKATCHEWAN

2002

Ninety five percent of Saskatchewan's population accessed at least one first contact service in 2001, and among these people, 18 percent reported difficulty accessing the service. At the same time, 92 percent accessed routine care with 10 percent reporting difficulty; 48 percent accessed health information or advice and 17 percent reported difficulty; and 42 percent accessed immediate care for a minor health problem and 13 percent reported difficulty. Overall, 11 percent of the province's population reported unmet health care needs in 2001.[89]

In 2001, ninety percent of people in the province reported having a regular family physician, and among those without one, 39 percent cited physician availability as the issue. [90]

---

[86] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[87] Ibid.

[88] Ibid.

[89] Statistics Canada. (2002). *Access to Health Care Services in Canada, 2001.* Catalogue 82-575-XIE. Retrieved on April 6, 2005. http://www.statcan.ca/english/freepub/82-575-XIE202001.pdf.

[90] Ibid.

According to the JANUS survey, there were 766 FPs in Saskatchewan in 2001 with 73 percent working primarily in a private clinic or office; 7 and 6 percent indicated they worked primarily in a community clinic and walk-in clinic, respectively. In terms of practise status, 43 percent reported being completely open to new patients while 57 percent indicated they were conditionally or completely closed.[91]

Primary Health Care Renewal

The Saskatchewan Department of Health and the system of Regional Health Authorities work collaboratively to deliver health care programs and services throughout the province. Saskatchewan has 12 Regional Health Authorities, which are responsible for a variety of services, including community health services, supportive care, mental health services, rehabilitation services, and emergency response services. The province has an Action Plan for Health Care that places priority on primary health care, including a focus on establishing teams of health care providers and networks, improve health information systems, establishing a health information line, improving 24/7 access, and recruiting and training health care providers.

Building on previous primary health care initiatives and the work of the previous health districts, in 2002, Saskatchewan Health implemented an Action Plan for Primary Health Care, based on an integrated system of health services available on a 24/7 basis through Regional Health Authority managed networks and teams of health care providers. The plan aims at reorganizing the primary health care system and is based on characteristics such as accessibility, effective health promotion and disease prevention, proactive and collaborative approach to management of chronic diseases, appropriate use of technology, patient/client centred care, human resources continuum, and integration and coordination of services.[92] The goal is to have networks and team established in all regions with accessibility to 100% of the population within ten years.

PHCTF

Within the context of the 10 year Action Plan for Saskatchewan Health Care, the province's allocation of the PHCTF ($18,592,405) is being used to support some of the province's transitional activities within the first four years. Activities being funded include building capacity within the Department to define core services, develop and set standards, and

---

91 JANUS, Ibid.

92 Saskatchewan Health. (2002). *The Saskatchewan Action Plan for Primary Health Care.* Retreieived on December 13, 2004. http://www.health.gov.sk.ca/ph_phs_publications/phs_action_plan_for_primary_health_care.pdf

establish performance indicators for primary health care services; building the capacity of Regional Health Authorities to mange regional implementation and change management; undertaking program development in community development and team training; and establishing a telephone advice line to provide assessment and referral services 24/7.

2004

In 2003, just over half of Saskatchewan's population (52 percent) required access to routine care, while 47 percent required health information or advice and 33 percent required immediate care for a minor health problem. At the same time, among those who required care at any time of day, 13 percent reported difficulty accessing routine or ongoing care, 12 percent reported difficulty accessing health information or advice, and 17 percent reported difficulty accessing immediate care for a minor health problem.[93]

In terms of patient satisfaction with overall health care services, 88 percent of the population reported high levels of satisfaction with health care services received; eighty two percent and eighty one percent of the population reported high satisfaction with community based care and health lines services provided, respectively.[94]

Eighty six percent of people in Saskatchewan reported having a regular family physician.[95]

YUKON

Primary Health Care Renewal

The Yukon Department of Health and Social Services administers health service delivery in the territory. While Yukon does not have a formal policy, the territorial government is taking a two-fold approach to implementing primary health care renewal: increasing emphasis on health promotion disease and injury prevention, and management of chronic diseases, particularly related to alcohol and drug abuse; and facilitating coordination and integration with other health services.

---

[93] Statistics Canada. (2004) *Comparable Health Indicators, Canada, provinces and territories, 2004.* Retreived on March 31, 2005. http://www.statcan.ca/english/freepub/82-401-XIE/2002000/primarycare.htm

[94] Ibid.

[95] Ibid.

PHCTF

The PHCTF provided Yukon with $4,587,282 for primary health care renewal in the territory and these funds are being used for two main activities. The first initiative refocuses organizational structures and processes to engage stakeholders in identifying barriers and solutions toward greater integration of services and emphasis on health promotion in the primary health care context. The second initiative entails the development of technological system supports to enhance primary health care information systems.

In 2003, a Primary Health Care Planning Forum was held with 100 delegates from across the territory to consider ways to improve primary health care in the Yukon and identified the following priority areas: alcohol and drug treatment, healthy living, health information, chronic disease strategy, cooperation and collaboration, and a health blueprint. Building on these priority areas and recommendations, an implementation plan is being developed.

2004

In 2003, 85 percent of residents in Yukon reported being very or somewhat satisfied with overall health care services received and 86 percent reported the same for community based care.