THE IMPACT OF GOVERNANCE AND REMUNERATION REFORM ON PRIMARY MENTAL HEALTH CARE: A COMPARATIVE ANALYSIS OF THREE CANADIAN PROVINCES

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By:
Miranda Elisha Brown
Regina, Saskatchewan
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Miranda Elisha Brown, candidate for the degree of Master of Public Policy in Health Systems Research, has presented a thesis titled, *The Impact of Governance and Remuneration Reform on Primary Mental Health Care: A Comparative Analysis of Three Canadian Provinces*, in an oral examination held on December 9, 2013. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

External Examiner: *Dr. Nuelle Novik, Faculty of Social Work*

Supervisor: Dr. Gregory Marchildon, Johnson-Shoyama Graduate School

Committee Member: Dr. Bruno Dupeyron, Johnson-Shoyama Graduate School

Committee Member: *Dr. Daniel Beland, Adjunct*

Chair of Defense: Dr. Tom McIntosh, Department of Political Science

*via Teleconference*
ABSTRACT

Introduction: The quality of general practitioner-delivered primary mental health care (PMHC) is a concern for Canadian policy-makers. To improve quality, policy reforms must target the length of consultations, interdisciplinary collaboration, and system coordination. PMHC governance and physician remuneration are structural barriers that impede quality improvement efforts.

Purpose: The purpose of the research is to determine which PMHC governance and mode of physician remuneration policy reforms can most effectively facilitate greater system coordination, interdisciplinary coordination, and longer, more involved consultations in Canadian PMHC.

Methods: A comparative case study of three Canadian provinces, specifically British Columbia, Manitoba, and Saskatchewan, was completed. These cases represent the range of Canadian PMHC policy reforms. To evaluate progress and performance, reforms were ranked on a PMHC best practices ordinal scale. New Zealand and Australia were selected for comparison with the Canadian cases. Ultimately, the integration of international cases in the comparative case study supplied policy lessons on revolutionary and evolutionary PMHC.

Results: In Canada, governance and remuneration PMHC reforms are incremental. In fact, British Columbia and Manitoba physician remuneration policy reforms demonstrate some progress towards improving physician-delivered PMHC remuneration structures. While governance was not a component of the PMHC reforms implemented by British Columbia, Manitoba, and Saskatchewan, PMHC reforms in Australia and New Zealand
demonstrated evolutionary and revolutionary options to reform governance and physician remuneration to improve PMHC quality.

**Conclusion:** PMHC quality improvement requires governments to address the structural barriers imposed by governance and physician remuneration. The legacies of these barriers influence the capacity of health systems to support high quality, innovative, and more collaborative primary mental health care.

**Key Words:** primary mental health care, physician remuneration, governance.
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<td>DHB</td>
<td>District Health Board</td>
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<td>FFS</td>
<td>Fee-for-Service</td>
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<td>Full-Service Family Practice Incentive Program</td>
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<td>GP</td>
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<td>National Primary Mental Health Network</td>
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<td>Primary Health Organisation</td>
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<td>PIN</td>
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<td>PMHC</td>
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<td>PSB</td>
<td>Psychiatric Services Branch</td>
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<td>Practice Support Program</td>
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<td>QBIF</td>
<td>Quality-Based Incentive Funding</td>
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<td>SCMHA</td>
<td>Saskatchewan Branch of the Canadian Mental Health Association</td>
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<td>SSC</td>
<td>Specialist Services Committee</td>
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<td>WHRA</td>
<td>Winnipeg Regional Health Authority</td>
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1 INTRODUCTION

Identifying the Policy Problem

In 2011, the Mental Health Commission of Canada estimated that 6.7 million Canadians currently live with mental illness, but only a third of these individuals receive care (Smetanin et al. 2011; Peachy, Hicks, and Adams 2013). While the reasons for under treatment are complex, the Canadian health care system structure is a major contributing factor. For example, the Canadian system is composed of institutions that organize, deliver, and finance mental health care services provide; however, these institutions simultaneously limit access to effective clinical care.

In Canada, publicly financed mental health services are supplied by three broad sectors. The acute care sector delivers inpatient and emergency services to clients with serious mental illness. The community-based sector delivers both short-term and long-term outpatient services to clients with moderate to severe mental illness. Finally, the primary mental health care (PMHC) sector provides first-contact care including early intervention and/or preventative services, direct access to psycho-pharmaceuticals, and less intensive psychological therapies (Clatney and Shah 2008; Fleury and Grenier 2012). Typically, PMHC is an essential resource for persons with mild to moderate mental illness.

In these three mental health sectors, physicians are the primary mental health service providers. Historically, physicians have had exclusive prescriptive authority over psycho-pharmaceuticals, and they have had control over specialist referrals. Furthermore, in the acute and community sectors, psychiatrists provide behavioural therapies and psycho-pharmaceuticals (Romanow and Marchildon 2003; Fierlbeck 2011). General practitioners
(i.e. family physicians) provide pharmaceutical therapy and a limited range of counseling services in that physician fee-schedules do not remunerate for cognitive behavioural therapies (CBTs). As well, education and time influence general practitioner mental health service delivery, as they are not typically trained as mental health service specialists. In addition, the nature of fee-for-service remuneration requires physicians to limit the time spent per patient (Fleury et al. 2012a; Fleury et al. 2012b).

Other providers, such as psychologists, are trained extensively in CBTs. However, they do not have prescriptive authority for psycho-pharmaceuticals and the services they provide in private practice are not publicly insured. In contrast, general practitioners receive remuneration as private practitioners through state-funded fee schedules (Fierlbeck 2011). This arrangement means that general practitioners are the first point of access for persons with mental illness. As a consequence, much of the initial recognition and early mental illness intervention is dependent on general practitioners (Clatney and Shah 2008; Fleury and Grenier 2012).

The capacity and capability of general practitioners to “detect, diagnose, and treat patients with mental disorders adequately” is an increasing concern (Roberge et al. 2011; Fleury and Grenier 2012, 357; Kosteniuk, Morgan, and D’Arcy 2012). For example, general practitioners do not detect approximately 30% to 70% of mental disorders. Additionally, the time between the on-set of symptoms and initial treatment contact is quite long, approximately six to eight years for mood disorders and nine to 23 years for anxiety disorders (Fleury and Grenier 2012). The length of time between the on-set of symptoms and treatment is partially influenced by the ability of general practitioners to recognize and accurately diagnose mental illness.
Recently, efforts to improve the quality of the PMHC sector have involved the implementation of collaborative mental health care models. These models are designed to increase the capacity of primary care to manage a diverse range of mental health problems, while increasing patient access to a diverse range of services (Kates et al. 2011). However, structural barriers are a common problem for successful, long-term implementation. These barriers include the fee-for-service framework used to remunerate general practitioners and the form of governance used to allocate power, resources, decision-making, and accountability for PMHC services. This problem is particularly pervasive because PMHC is almost entirely organized around physicians. Moreover, the physician-centered organization is reinforced by the power dynamics that exist between the medical profession and the government. Consequently, there are three important structural implications for the quality of Canadian PMHC.

First, mental health assessments and treatments often require longer consultations, but the relatively short time periods physicians spend with patients inhibit consultation quality (Paulenko 2005). The fee-for-service mode of remuneration (fee-for-service) partially causes this because it rewards volume-based service delivery.

Second, fee-for-service is a barrier to inter-disciplinary care, since the financial incentive for collaboration may be absent from or inadequately remunerated in fee agreements. As a result, non-physician providers are systematically and institutionally excluded from fee agreements, meaning that physicians cannot bill provincial health plans for non-physician mental health services provided in their practices, and non-physician providers cannot privately bill provincial health plans for referrals received from family physicians. This lack of support for inter-disciplinary collaboration
contributes to deficiencies in inter-provider communication and follow-up care, which limits PMHC effectiveness (Paulenko 2005).

The third problem is the lack of system coordination in the PMHC governance structure. Here, the payment for private general practitioner services in Canada is a strict state-physician duopoly, with provincial governments as the sole payer. This authority is not shared with or delegated to the regional health authorities (RHAs). As a result, PMHC services provided by general practitioners from RHA mental health services are structurally and financially isolated. Furthermore, the RHAs do not hold the same political agency as provincial governments and physicians because they have been historically excluded in the fee-negotiation process. The result is separate financing and accountability structures for physicians and RHAs, which contributes to poor PMHC service coordination within provincial health systems. Ultimately, the lack of system coordination contributes to decreased PMHC continuity across the primary care and community-based health services continuum (Durbin et al. 2006).

**Problem Definition & Research Question**

PMHC governance and mode of physician remuneration are problematic to PMHC because they do not provide the structural support required to improve consultation quality, nor do they encourage interdisciplinary collaboration or enhance system coordination for primary mental health services. While research in this area has identified the need to establish supportive PMHC governance and remuneration structures, there is little research to identify precisely which structures are the most supportive (Mulvale and Bourgeault 2007). To address this problem, the following
research question is proposed: Which policy reforms to governance and physician remuneration can facilitate better system coordination, improve interdisciplinary collaboration, and encourage longer consultations for Canadian PMHC?

**Thesis Organization**

Chapter two will provide the policy context regarding the historical implications of physician remuneration and governance for the current state of Canadian PMHC. The legacy of public insurance for hospital and physician services is an important focus of this chapter. These legacies engrained the practice of a physician-centered primary care system and fee-for-service as the dominant mode of physician remuneration. Another policy legacy includes the exemption of PMHC from regionalization, which established a permanent physician-state governance structure for PMHC services. In turn, these policy legacies have important implications for the quality of PMHC and capacity for provincial governments to implement effective reforms.

The policy legacies identified in chapter two provide the necessary background to develop a theoretical framework that describes the dominant policy PMHC framework in Canada. In chapter three, this theoretical framework is developed using historical institutionalism to explain how these legacies shape PMHC in Canada. Historical institutionalism helped to identify the dominant institutions and ideas that create specific policy paths. These paths are largely controlled by the power dynamics that exist between policy actors and institutions. The result is a dominant policy framework that describes the primary features of PMHC policy in Canada. Following the development of this
framework, the chapter describes the use of the comparative case study method to study PMHC reform in Canada.

Chapter four presents the results of the comparative case study of three Canadian provinces: British Columbia, Manitoba, and Saskatchewan. PMHC policy reforms in each of these jurisdictions were compared to the dominant PMHC policy framework developed in chapter three. This analysis determined the extent of PMHC reforms achieved in each province. A benchmarking method was added to examine the potential impact these reforms have on the quality of PMHC. In conclusion, the analysis determined that all three provinces achieved very incremental changes to the dominant policy framework. As a result, the reforms do not effectively address the existing physician remuneration and governance policy legacies that influence the quality of PMHC.

Since the Canadian policy cases did not result in major changes to the dominant PMHC policy framework, policy lessons were drawn from Australia and New Zealand. Australia presented PMHC reforms that were incremental in nature but were able to modify the dominant policy framework in order to accommodate more inter-disciplinary care, mental health-specific financial incentives for physician services, and better physician education to improve the quality of PMHC services. The New Zealand case offers a more revolutionary approach to PMHC reform, where reform to the governance of PMHC services is the primary approach. The changes to governance present an opportunity to improve system coordination of PMHC services by coordinating the financing, organization, decision-making, and delivery of PMHC services at a regional level.
Building on the policy lessons from chapter four and five, chapter six provides PMHC policy reform options for Canada. Three options are presented: status quo, incremental, and revolutionary reform. Each option and its corresponding implications are analyzed in detail. The status quo option presents the least risk in terms of changes to the health system; however, this option will have the least impact on quality. Incremental reform remains modest with respect to the minor changes to the dominant PMHC policy framework. The advantage to this option is that reforms can be gradually built into the health system. Finally, revolutionary governance reform is the most radical. This option simultaneously presents great political and financial risk, but offers the opportunity to significantly change the existing physician remuneration and governance structures that prevent substantial improvement to PMHC.

To conclude the research presented in the previous chapters, the final chapter provides a summary of the study’s primary research contributions. The limitations of the comparative case study method, benchmarking method, and use of historical institutionalism are also discussed. Drawing upon these limitations, a future research agenda is proposed to strengthen the research results and to build on the PMHC literature.
2 POLICY CONTEXT

Introduction

The development and evolution of Canadian universal health insurance, commonly known as Medicare, significantly shaped the financing, organization, and delivery of primary mental health care (PMHC) services to be pre-dominantly physician-centered and dependent on fee-for-service physician remuneration. The most influential policies and events in Medicare history include: The Hospital and Diagnostic Services Act 1957, the Saskatchewan doctors’ strike, and resulting 1962 Saskatoon Agreement, the deinstitutionalization of psychiatric facilities, the 1966 Medical Care Act, the 1984 Canada Health Act, and regionalization. The following chapter will discuss the historical influence these policies impose on the PMHC sector. This discussion provides the historical context to interpret Canadian PMHC policy reform trends.

Public Insurance for Hospital Services

In Canada, PMHC was historically provided in provincial asylums and rural cottage hospitals that were largely segregated from urban populations. Following the Second World War, mental health care delivery changed significantly. In fact, institutionalized psychiatry and work-based therapies receded to new pharmaceutical therapies (Dyck 2011). There was also an increased emphasis on neuroscience to complement the continued focus on psychoanalytic and Freudian-based therapies (Dyck 2011). During this period, provincial governments sought to deinstitutionalize provincial asylums and expand the service delivery role of community hospitals and community-based psychiatry (Sealy and Whitehead 2004; Dyck 2011).
While deinstitutionalization occurred predominantly in the late 1960s and early 1970s, political discussions and policy action began in the early 1950s (Sealy and Whitehead 2004; Marchildon 2011). These policies clashed with the introduction of universal hospital insurance and medical care insurance. During this period, Saskatchewan was among the first Canadian provinces to implement both community-based psychiatry and universal hospital insurance. The Saskatchewan experience illustrates the implications of this interaction on the PMHC sector.

The Saskatchewan division of the Canadian Mental Health Association (SCMHA) was a strong political ally of then Saskatchewan Premier Tommy Douglas and was initially receptive of Douglas’ plan for universal hospital insurance. The SCMHA also occupied an influential social advocacy position within the Psychiatric Services Branch (PSB) in the Saskatchewan Department of Public Health (Marchildon 2011). By the mid-1950s, the PSB, in concert with the SCMHA, developed the Saskatchewan Plan, which advocated for the expansion of small community mental hospitals to replace the large psychiatric hospitals in Weyburn and North Battleford. Ultimately, the Saskatchewan Cabinet rejected the plan since the construction and operating costs of the new facilities were well beyond the government’s resource capacity. Instead, the Douglas government opted to modify the Saskatchewan Plan to include 50-bed units attached to acute care hospitals. These beds qualified for federal funding under the 50/50 cost-sharing program stipulated by the recently passed Hospitals and Diagnostic Services Act, 1957.

The decision created a deep rift between the Douglas government and the SCHMA because the SCMHA believed the government’s inaction on the Saskatchewan Plan would marginalize mental health care (Marchildon 2011). In fact, when the Douglas
government moved to include physician care in universal health care in 1962, the SCMHA joined the medical profession’s efforts to oppose Medicare. The SCMHA argued that the development of small psychiatric hospitals should take priority over Medicare because the SCMHA feared the loss of progress and political support to improve the treatment of the mentally ill in provincial psychiatric institutions (Marchildon 2011). Ultimately, the Saskatoon Agreement ended a 23-day doctors’ strike against Medicare. It privileged fee-for-service remuneration, and resulted in a shift from PSB-salaried psychiatrists to fee-for-service psychiatrists acting as independent contractors. As a result, the “dream of a publicly-delivered system of hospitals and outpatient clinics, staffed by publicly employed PSB psychiatrists, nurses, and social workers was never achieved” (Marchildon 2011, 328). Instead, Medicare and the Saskatoon Agreement created a distinct dichotomy in mental health service organization and delivery. Publicly funded, private practice general practitioners and psychiatrists provided PMHC, while psychiatrists delivered acute psychiatric care in general hospitals and specialized psychiatric hospitals.

**Public Insurance for Physician Services**

The inclusion of physicians into universal health care required a compromise between the state and the medical profession, and ultimately produced an important policy legacy for the Canadian PMHC sector. Before its formal inclusion in Medicare, fee-for-service was the dominant physician remuneration mode in private practice (Lawson 2012). At that time, physicians were professionally autonomous, self-governing, and exercised maximum entrepreneurial discretion in setting their own prices. Upon the
establishment of universal hospital insurance in 1958, the Saskatchewan government sought to include physician services under the government-funded single-payer model (Badgley and Wolfe 1967; Naylor 1986; Taylor 1987). Saskatchewan physicians objected to state interference on their professional freedom, and they feared the potential loss of their rising incomes. This prompted physicians to organize a political campaign against Douglas’ plan. The Saskatchewan College of Physicians and Surgeons (the College) was their main organizing mechanism and it attracted influential political allies, including the Canadian Medical Association, the Ontario Medical Association, the American Medical Association, private health insurers, and the Canadian business community (Tuohy 1999; Marchildon and Schrijvers 2011). On July 1, 1962, the tension between the parties transitioned into a 23-day doctor’s strike. To end the strike, the Saskatchewan government negotiated a compromise with organized medicine\(^1\). The resulting 1962 Saskatoon Agreement incorporated physicians into the public insurance model, but with the assurance that they retained their professional autonomy as private practitioners, and the right to opt out of Medicare if they so chose (Marchildon and Schrijvers 2011).

Further, it was agreed that the fee-for-service mode of remuneration would remain the dominant physician payment model for physician services, including primary mental health care services.

In 1966, the Canadian Medical Care Act entrenched the legacy of fee-for-service as a dominant mode of remuneration and the private contracting model as the dominant form of governance for physician services. The Act outlined the Canadian federal government’s offer to cost share physician and hospital services with the provinces and

\(^1\) Organized medicine refers to politically active groups of physicians that seek to influence policy and process within health care systems.
For PMHC services, this meant that general practitioners retained their privileged status at the centre of provincial and territorial health plans, compared to non-physician mental health professionals who were excluded from the fee-for-service billing system (Romanow and Marchildon 2003). Replacing the Medical Care Act and the Hospital Insurance and Diagnostic Services Act, the Canada Health Act 1984 continued to privilege hospital and physician services. This shift occurred due to the replacement of the federal 50/50 cost sharing program with block funding transfers in the Established Programs Financing Act 1977 (Fierlbeck 2011). Regardless of these changes, the business of remunerating physicians under the fee-for-service model continued, as did the relationship between the provincial governments as the primary payer for physician services and the provincial medical associations as physician bargaining agents (Tuohy 1999). While provinces were not barred from providing a broader range of services, federal transfers to the provinces for insured services under the Canada Health Act provided a strong incentive for provinces to structure their systems around these federally subsidized services.

Regionalization

Throughout the 1980s and 1990s, the regionalization of health care governance and service delivery sought to eliminate the duplication of services and the better integration of managerial and resource allocation decisions at the hospital, district and (eventual) regional health authority (RHA) level (Boychuk 2012). While, RHAs provide a broad continuum of services, including acute care, community care, long-term care, and home care, PMHC services have largely been exempted from RHA management. This
division of PMHC from other mental health services is due to separate financing structures. More specifically, RHAs receive global budgets from the provincial ministries of health to employ a diverse set of providers to deliver PMHC services. However, they do not have authority over physician payment because physicians are independent contractors hired by provincial governments (Lewis and Kouri 2004; Fierlbeck 2011; Boychuk 2012). In addition, negotiating with provincial medical associations may be too cumbersome for the smaller RHAs, who do not have the same collective bargaining power as larger RHAs and the provincial government. Thus, this divided governance and financial arrangement impedes regional PMHC coordination and integration.

The Primary Mental Health Care Sector in the 21st Century

In the decades following the Canada Health Act, policies defining the organization, delivery, and financing of PMHC services remain firmly entrenched in a deeply institutionalized private practice, physician-centered fee-for-service structure (Mulvale, Ableson, and Goering 2007; Hutchinson 2008; Hutchinson et al. 2011). However, as health care delivery shifts from an emphasis on acute-care to primary or home-based care, new opportunities have emerged to challenge this existing institutionalized structure. One such opportunity is greater implementation of interdisciplinary collaboration between general practitioners and non-physician mental health professionals (Bourgeault and Mulvale 2006; Kates et al. 2011). Furthermore, there is a deep-seated belief among policy makers, providers, and researchers that physicians alone simply cannot address all patient PMHC needs. These actors view the expansion of the PMHC sector to include inter-disciplinary collaboration as a solution.
However, this has not been achieved on a system-wide level because integration and quality improvement strategies do not effectively address structural system barriers, such as physician remuneration and governance.

**Fee-for-Service in Primary Mental Health Care**

Two key features define the technical components of physician remuneration. The first is the specific payment mechanism, which financially compensates physicians for services rendered to patients. Fee-for-service is a volume-based payment mechanism that involves risk-sharing elements between the provider (the physician) and the payer (the government in publicly funded systems) (Robinson 2001; Deber, Hollander, and Jacobs 2008; Devlin and Sarma 2008; Léger 2011). This risk sharing is due to the principal-agent relationship between the insurer or payer (the principal) and the physician (the agent) acting on behalf of the patient. Here, information asymmetry exists between the principal and agent, since physicians have specialized knowledge regarding the services required by the patient. As a consequence, fee-for-service allows physicians to shift the financial risk of high-use patients on to the insurer (Develin, Sarma, and Hogg 2006; Deber, Hollander, and Jacobs 2008; Devlin and Sarma 2008). This allocation of risk is considered efficient since the state possesses a larger pool of resources to bear the financial risk. This means that there is incentive for physicians to maximize their income by over-providing services.

Beyond mode of remuneration as the technical “how” of physician payment, the second technical feature of remuneration is Medicare services. Since fee-for-service physicians are paid per unit of service, physicians are paid according to a schedule of set fee items. The absence of remuneration for key services to improve PMHC, such as
inter-professional collaboration, restricts physician participation in quality improvement efforts (Dewa, Hoch, and Goering 2001; Bourgeault and Mulvale 2006). These technical features are significant because they are the primary structural elements of physician remuneration, which ultimately affect PMHC service organization and delivery.

**Quality Issues with Fee-for-Service Remuneration**

In recent years, general practitioners have faced increasing demands to deliver more complex services, such as chronic disease management. As a result, practitioners, researchers, and policy-makers worry that general practitioner consultation length may be too short to provide high-quality psychological care (Pollock and Grime 2003). Fee-for-service, as a payment mechanism, imposes a specific structure on primary care visits: physicians are remunerated by each item of service. As such, fee-for-service creates an incentive to treat even larger numbers of patients in shorter periods of time (Godsen, Pedersen, and Torgerson 1999; Robinson 2001; Devlin, Sarma, and Hogg, 2006). This incentive is problematic for the recognition, diagnosis, and treatment of psychological illnesses since they require longer consultations compared to other medical services because diagnosing psychological illnesses requires proper communication, an effective relationship with the patient, and supportive advice and treatment (Pollock and Grime 2003). This means that despite being able to bill for multiple fee codes for consultations, there is little incentive for general practitioners to provide PMHC beyond a pharmaceutical therapy prescription.

Although the relationship between the mode of physician remuneration, consultation length and quality of primary care services is complex, evidence suggests
that remuneration influences practice decisions such as consultation length. For example, the recent *Dutch National Survey of General Practitioners* found that consultation length correlated negatively with patient list size (Van den Berg et al. 2009). This study surveyed 104 general practices and 195 general practitioners using electronic medical records, video-taped consultations, and postal surveys to collect the information. Of the two groups of physicians surveyed (i.e. salaried and fee-for-service), fee-for-service physicians, on average, had higher caseloads. Further, a study analyzing 302 video-taped pediatric consultations observed that fee-for-service pediatricians talked less and spent less time with patients compared to pediatricians on salaried schemes (Van Dulmen 2000). In fact, consultations lasted on average four minutes longer for salaried pediatricians and the surplus time was used to provide more information and advice to patients and their families (Van Dulmen 2000). Moreover, the pediatricians also spent more time on psychosocial questions, psychosocial information, and psychosocial advice than their fee-for-service counterparts.

The implications on general practitioner PMHC service quality are significant, since hurried consultations are not conducive to disclosure and recognition of mental illness (Pollock and Grime 2003). For example, Hutton and Gunn (2007) found that physicians who process more patients were less likely to deal with psychosocial problems and more likely to prescribe medications. In contrast, longer consultations were associated with physicians who spent more time talking to patients and addressing more psychosocial questions than physicians who consulted with more patients.

PMHC quality is also influenced by the capacity of fee-for-service to accommodate interdisciplinary collaboration between general practitioners and other
mental health professionals. In Canada, mental health services delivered in hospitals and in community clinics are financed through global budgets awarded to regional health authorities by provincial and territorial governments (Fierlbeck 2011). Alternatively, primary care sector mental health care is predominantly financed through physician fee-for-service schedules negotiated between provincial governments and provincial medical associations. This institutional arrangement implies that physicians are the dominant, and, in some cases, exclusive publicly insured provider of primary mental health services. Unlike physicians, non-physician mental health professionals, such as psychologists, social workers, and nurses, cannot bill provincial health plans for services rendered by private practice patients. Furthermore, publicly insured access to these providers is restricted to regional health authority clinics and hospitals, and access to these services is acquired through physician referral or hospitalization (Bourgeault and Mulvale 2006). Additionally, physicians cannot be reimbursed for the administrative costs related to working with these professionals in their private primary care practices, and related physician time for consultations is often not reimbursed through provincially administered fee-schedules (Dewa, Hoch, and Goering 2001). While, on occasion, provinces have temporarily established non-physician mental health professionals to provide some PMHC services, such as counseling or psychotherapy, the funding for these arrangements is usually structured through temporary contracts or pilot projects (Gagné 2005). Inevitably, this arrangement produces insecure non-physician provider arrangements in publicly funded, private general practitioner practices.

A multivariate analysis of the 2001 National Family Physician Workforce Survey and the 2004 and 2007 National Physician Surveys demonstrated that fee-for-service
physicians were statistically (p < 0.001) less likely to collaborate with other professionals relative to physicians paid through alternative remuneration schemes, such as salary, blended payment, and capitation (Sarma et al. 2012). In this context, the implications for quality in primary mental health care include restricted access to, and development of, collaborative approaches to PMHC, such as on-site, interdisciplinary services or shared care. In fact, access to non-physician mental health professionals, who may contribute more specialized experience and training compared to general practitioners, is considered an important component of improved integration and continuity of services within a health system (Kates et al. 2011). Therefore, access to a broad spectrum of health professionals in private practice is further exacerbated by the lack of public insurance for these services. This creates a barrier for physicians attempting to refer patients with little or no private insurance to private psychological services (Dewa, Hoch, and Goering 2001; Romanow and Marchildon 2003).

**Primary Mental Health Care Governance**

Beyond the mode of physician payment, PMHC service governance is another crucial structural barrier because governance involves the distribution of power in the form of decision-making authority and accountability, which is driven by the power dynamics of the Canadian single-payer system (Tuohy 2003). First, the Canadian PMHC sector is governed by an agency relationship between the state and the medical profession. Here, physicians retain their power through contractual autonomy in exchange for the role of the state as the exclusive payer. This arrangement translates into a close political relationship and accommodation with provincial governments as the
principal, and the independent physician as the agent (Tuohy 2009). In this instance, the physician is represented by two entities: the provincial medical associations that negotiate the mode and level of payment in provincial fee schedules, and the provincial colleges of physicians and surgeons who sets clinical practice guidelines and standards.

Decision-making authority for the allocation of physician services is principally controlled by an institutional duopoly between the state and the medical profession. In this context, the state is in a position to exercise its monopsony powers to negotiate the allocation of medical resources (Tuohy 1999). This type of professional authority and intimate political relationship with the state are not equally awarded to non-physician mental health professionals, such as psychologists. Unlike physicians, psychologists and other non-physician mental health professionals are employed by RHAs. This means that RHAs have more control over the psychological services they employ or procure through salaried employees.

The founding bargain between the state and the medical profession included professional self-regulation (Tuohy 2009). This is a critical accountability PMHC governance component because provincial colleges of physicians and surgeons are required to regulate the performance of their own members and determine educational standards. In this context, PMHC quality is under the purview of these colleges, because the role of the colleges is to review, investigate, and respond to registered member performance. Consequently, PMHC quality improvement requires close collaboration with provincial colleges to ensure that self-regulation is operating in the best interest of patients. However, the College’s oversight is limited in some respects because their
actions to improve quality tend to be more retroactive (i.e. responding to complaints) compared to pro-active (i.e. enforcing quality standards).

**Quality Issues with the Form of Governance**

In the PMHC sector, organized medicine and the provincial government heavily influence decision-making and policy development. As a product of these institutions, the fee-for-service legacy influences health system strategy coordination and service continuity within regionalized structures. Although most provincial governments have devolved responsibility for the funding, planning, managing, and coordinating of a wide range of RHA services, physician service payments remain centralized in provincial health ministries (Lewis and Kouri 2004; McFarlane and Durbin 2005; Wiktorowicz et al. 2010).

Regionalized governance has facilitated greater integration between health agencies, sectors, and services; however, little coordination has been achieved in integrating private practice physicians into these planning and service delivery efforts (Wiktorowicz et al. 2010; Fierlbeck 2011). This is because the bulk of primary care services and, by default, PMHC services, provided by publicly funded, private practice general practitioners remains largely segregated from RHA budgets. Actually, the private fee-for-service arrangement leaves RHAs with little control or policy leverage over physician groups when coordinating larger integrative practices or service delivery models. For this reason, the payment for primary mental health care through segregated budgets hinders interdisciplinary care team delivery of primary mental health care services (Bourgeault and Mulvale 2006).
The lack of RHA agency in PHMC services suggests greater service fragmentation, which may have negative outcomes for PMHC patient continuity. This lack of continuity results in higher readmission rates to hospital general psychiatric units because the system is unable to effectively respond to patient needs (Durbin et al. 2006). Further, the legacy of private fee-for-service physician practices means that accountability and a PHMC collective voice does not exist on a system level, since jurisdictionally, RHAs are isolated from PMHC decision-making processes. As a consequence, this divided governance arrangement has resulted in fragmented PMHC policy development, where the coordination of PMHC services is centralized with provincial governments and publicly funded private general practitioners rather than RHAs (Bourgeault and Mulvale 2006).

Conclusion

As discussed throughout this chapter, a number of policy legacies have established governance and fee-for-service remuneration as important barriers to PMHC quality improvement. The next step to identifying which reforms facilitate better PMHC is to identify the most dominant policies through a theoretical framework. This framework will be necessary for interpreting and comparing Canadian policy reform. The following chapter builds on the policy background by proposing the use of historical institutionalism to develop the dominant policy framework.
3 RESEARCH DESIGN AND THEORETICAL FRAMEWORK

Introduction

Primary mental health care (PMHC) policy is largely dependent on entrenched historical experience and decisions. As a result, the study of reform requires a distinct consciousness of this historical background. To achieve this, the following chapter will explain and critically discuss the use of historical institutionalism as a theoretical framework. The product of this discussion is a dominant policy framework that will be used in the comparative case studies of Canadian and international PMHC reform. The proposed research methods, case selection, and data collection are also discussed within this chapter. Through the theoretical framework and the proposed research methods, the following research question will be answered: Which policy reforms to governance and physician remuneration can facilitate better system coordination, improve interdisciplinary collaboration, and encourage longer consultations for Canadian PMHC?

Theoretical Framework

Historical Institutionalism

In this thesis, historical institutionalism provides the theoretical framework to explain how policy legacies have shaped Canadian PMHC. Historical institutionalism theorizes policy making as a discrete process determined by “historically contingent political institutions and policy legacies” (Béland 2010, 617). Within this framework, both state and society are composed of complex institutions: formal or informal processes, rules, procedures, norms, and conventions (Hall and Taylor 1996). For example, institutions include legislation, regulations, formal agreements between key actor groups, formal
organization of government (parliamentary models), budget cycles, legislative, executive, and judiciary powers, constitutional powers, and remuneration methods. These historically constructed institutions, along with dominant ideas and ideology, structure the behaviours, interests, and relationships of state and societal political actors (Béland 2009). In this context, historical institutionalism is the most appropriate theoretical framework because it can explain “how configurations of governmental institutions affect what the state does and how unique patterns of historical development can constrain subsequent choices about public problem-solving” (Howlett, Ramesh, and Perl 2009, 44).

The distinct focus on the role of institutions to constrain future policy choices contrasts with individual, class, and group-based policy theories, that do not consider institutions to play a significant role in policy development (Thelen 1999; Kay 2005; Peters, Pierre, and King 2005; Howlett, Ramesh, and Perl 2009).

Other public policy theories such as pluralism and public choice are not appropriate for the purposes of this research. For example, pluralism theorizes policy development as the product of collective interests and competition among groups (Howlett, Ramesh, and Perl 2009). Here, policy actors are the primary entities that drive the policy process, while governments and institutions have a passive role. The key problem with pluralism is that the theory does not account for power dynamics, which is a critical part of policy development because some actors and groups have greater access to political power and have the capacity to engage in political communication and negotiation (Howlett, Ramesh, and Perl 2009).

Public choice is another public policy theory. It theorizes that policy actors make rational decisions outside the influence of government and institutions (Howlett, Ramesh,
and Perl 2009). However, this theory underestimates the role of institutions in shaping preferences and ultimately in influencing policy decisions. The PMHC sector is not exempt from the influence of governments, politics, and institutions, and, as a result, historical institutionalism is the most appropriate set of public policy theories for studying PMHC policy and reform. The following discussion will explain the institutions, ideas, and actors most relevant to the PMHC sector.

Institutions

A number of key institutions influence the PMHC sector. These include the *Canada Health Act*, the provincial and territorial ministries of health, medical insurance legislation, organized medicine, physician-fee agreements, and regional health authorities. On a national level, the 1984 *Canada Health Act* consists of five core principles and values of universal health insurance: public administration, comprehensiveness, universality, portability, and accessibility (Marchildon 2013a). Under the Act, these values form the essential funding criteria for federal transfers to provinces and territories. While the funding criteria is voluntary, provincial compliance is maintained through the threat of federal government claw-backs of cash transfers to provinces as well as public pressure to uphold the values and principles of the *Canada Health Act* (Fierlbeck 2011). Under the Canada Health Transfer, the Act requires provinces to provide first-dollar universal coverage for physician and hospital services in return for federal cash transfers. This arrangement favours general practitioners as the gatekeepers to other mental health services and psychiatrist specialist services. Provinces
are not obligated to include non-medical mental health practitioners, such as psychologists, counsellors, and social workers, as part of Medicare.

At the provincial and territorial level, the ministries of health function as institutions that structure the types of services insured under their respective plans and administrative mechanisms. Since general practitioners are remunerated through provincially administered fee-agreements, the ministries of health are the principals that determine financing, organization, and delivery of primary mental health services, while general practitioners are the key agents. These ministries also devolve some decision-making authority for the planning, financing, and delivery of hospital, community, and some PMHC services to RHAs (Fierlbeck 2011).

Organized medicine is another key institution that determines PMHC policy development. Provincial medical associations are the main vehicles used by physicians to lobby government at the provincial and territorial levels. More importantly, these associations are responsible for negotiating fee schedules and alternative payment models for their members. Since Medicare was first introduced, this bilateral “negotiating” arrangement created an almost exclusive power dynamic between provincial ministries of health and organized medicine (Tuohy 1999).

**Ideas**

In addition to the key institutions influencing policy development in PMHC, dominant ideas and ideologies shape the political, social, and economic priorities and assumptions of decision-makers (Béland 2009). In turn, these ideas and ideologies legitimize, preserve, or challenge existing PMHC institutions and policies (Béland,
2009). The concept of the general practitioner as the first and most legitimate point of contact for PMHC is an example of a historically established dominant idea in the Canadian health care system. The medical profession, governments, and the public uphold this idea, both politically and socially, and thereby preserve the physician-government duopoly over the organization of health systems and health service delivery.

The medical profession’s individualistic philosophy of medical liberalism has also helped shape Canadian health policy development (Marchildon and Schrijvers 2011). This ideology promotes professional self-regulation and physician control over fees, and encourages free choice by both patients and physicians. Medical liberalism advocates for the preservation of individual practitioner clinical judgment and privacy of the physician-patient relationship absent from state control or regulation. The power of this ideology is evidenced by the significant compromise made by the Saskatchewan government in the Saskatoon Agreement, where the fee-for-service contractual model of physician remuneration was entrenched. This agreement set the precedent for the rest of the country, since medical associations across Canada, including the national organizational body of the Canadian Medical Association, supported the position of organized medicine in Saskatchewan (Marchildon and Schrijvers 2011).

**Actors**

Policy actors are integral to historical institutionalism because of their capacity to influence the policy development process. Actors usually possess some form of political agency and have respective public authority over key policy issues. Their privileged position awards them a close relationship with governmental decision-makers. For example, Senator Michael Kirby, whose leadership on the 2006 federally appointed
Standing Senate Committee on Social Affairs, Science, and Technology, is a policy actor for the mental health sector. His work and advocacy has focused policy attention on the state of mental health care in Canada. The landmark report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* led to the development of a National Mental Health Commission, and the release of a national mental health strategy to improve mental health care, including PMHC. However, the PMHC sector currently lacks a powerful policy actor, such as a Minister of Health or Deputy Minister of Health, to instill dedicated political action in the PMHC sector. For this reason, the role of policy actors in shaping PMHC policy is limited and thereby represents a minor component of the proposed theoretical framework.

**The Dominant PMHC Policy Framework**

As discussed above, historical institutionalism has provided a lens to identify the key institutions and ideas that influence PMHC policy. Building on this discussion, historical institutionalism is used to isolate the key features of a dominant policy framework. The framework will be used to collect and interpret policy information. More importantly, the dominant policy framework is used to compare PMHC reforms.

Two theoretical components of historical institutionalism are essential to the construction of the dominant Canadian PMHC policy framework. First, historical institutionalism underscores the power dynamics among and between social groups and policy actors in policy development processes (Hall and Taylor 1996). For historical institutionalists, policy decisions produce both winners and losers since power is unevenly distributed among actors, allowing those with greater political and economic
agency to have greater control in decision-making processes. In the PMHC sector, these power dynamics are evidenced by the distribution of political and professional agency, from provincial ministries of health to private practice general practitioners. In effect, these privileged actors determine the organization and administration of PMHC delivery and the direction of reforms.

Second, historical institutionalism describes policy development as path-dependent, where policy change is composed of extended periods of stability and periodic interruptions by formative political and economic events (Hall and Taylor 1996). In this context, past policy decisions create new, stable institutions that lock in political, social, and economic commitments, which constrain future choices or options (Peters, Pierre, and King 2005). This lock-in effect may be explained as a self-reinforcing process of increasing returns that is the product of large sunk costs, network effects, learning effects, and adaptive expectation (Kay 2005). As policy change takes place at formative events or ‘critical junctures,’ the formal and informal contracts between actors involve major investments or divestments of resources. As a result, these contracts become permanent features in the policy landscape because they would potentially incur great political and economic costs to modify. For example, path dependency explains some of the resistance to changing the remuneration and governance structures in PMHC. Ultimately, any alterations to these structures, including the implementation of collaborative forms of PMHC, are destined to encounter path dependency as a significant institutional barrier.

Using the key theoretical components of historical institutionalism, such as institutions, actors, ideas, path dependency, and power dynamics, a high-level policy framework was developed for Canadian PMHC. With emphasis on PMHC governance
and physician remuneration, this model includes three features of PMHC policy that are typically influenced by path-dependent legacies that have an impact on the quality of services provided. To achieve successful implementation, reforms targeting quality improvement of PMHC services must address these institutionalized policy features.

The first feature of the dominant PMHC policy framework is that of the physician-centered primary care system, which defines general practitioners as gatekeepers to publicly insured mental health services, pharmaceutical therapy, and referral to RHA or affiliate mental health services. Three critical pieces of evidence support this PMHC policy framework feature. First, provincial Medicare legislation and federal law institutionalizes public insurance for physician services (Flood and Archibald 2001). Consequently, primary mental health services delivered by general practitioners are privileged over services provided by non-physician practitioners, who are not awarded the same publicly insured professional discretion (Goering, Wasylenki, and Durbin 2000; Romanow and Marchildon 2003).

Second, physician-centered PMHC is further upheld by a gatekeeper system that restricts specialist referral and prescriptive authority to general practitioners. For example, a physician monopoly on prescriptive authority is authorized by legislation and regulation-based institutions, such as the Saskatchewan Pharmacy Act 1996, the Pharmaceutical Act 1991 (Manitoba), and the Pharmacy Operation and Drug Scheduling Act 2003 (British Columbia). Physicians are among a limited group of professionals granted the authority to prescribe Schedule I, IA (BC only), II and III drugs. Among these professionals, physicians retain the most expansive authority for prescribing medications. In the context of PMHC, prescriptive authority is important, since physicians are the
primary prescribers of psychotropic medications in Canada and are likely to be the key contact for medication updates, renewals, and follow-ups. Alternatively, clinical psychologists are not permitted to prescribe medication, despite the fact that psychologists often possess more specialized training in psychological care (i.e. behavioural therapies) than general practitioners (Romanow and Marchildon 2003).

Further, the Canadian gatekeeper system is maintained by the condition that access to medical specialists (i.e. psychiatrists and sometimes regionally employed psychologists and mental health counsellors) requires a general practitioner’s referral. While direct access to specialized psychological care from psychiatrists is not explicitly prohibited by provincial regulations, the fee-for-service system encourages gate keeping by providing higher remuneration for services that result from a general practitioner’s referral. As a result, there is a financial penalty for psychiatrists that accept patients without referral (Steele et al. 2009). Most RHA clinics also require a referral from a physician or psychiatrist, or entry through emergency care or hospitalization. Moreover, the physician-gatekeeper arrangement is sustained by the private sector, in which employment insurance plans usually require the beneficiary to obtain a physician’s referral to qualify for private psychological service coverage.

A second feature of the dominant policy framework includes the physician-state duopoly in which both the payer (the government) and the provider (the physicians) are limited in their options to engage in relationships with other payer or provider parties. The establishment of physician services in Canadian Medicare has meant that physicians have accepted the single payer role of the government (Tuohy 1999). The basis of this agreement was contractual, as physicians exchanged “entrepreneurial constraints” (i.e.
one payer) for powerful clinical autonomy that rendered physicians private, self-employed contractors (Tuohy 1999; Fierlbeck 2011). The resulting governance structure specifies that provincial governments administer medical service plans (i.e. fee-for-service and alternative remuneration) through a departmental unit. The physician then bills the government on a negotiated fee schedule, or is remunerated through an alternative payment mechanism (Fierlbeck 2011). In this exchange, physicians retain clinical autonomy, which includes “location of practice, scheduling, labour, and other inputs and the volume and mix of services delivered” (Tuohy 1999, 205).

Since physicians largely provide PMHC, RHAs are left with marginal authority over the depth and breadth of PMHC services. When a majority of Canadian provinces adopted regionalization during the 1990s, the authority to administer or allocate budgets for physician remuneration was not devolved to RHAs (Marchildon 2013a). As a result, the role of RHAs/health districts in physician contract negotiations has been traditionally isolated from the direct contractual relationship between the medical associations and the government. While some RHAs may engage a few physicians in shared care models or primary health care teams, the majority of physicians remain outside the planning and delivery decisions of the RHAs.

The final feature of the dominant PMHC policy framework includes fee-for-service as the dominant mode of publicly financed and administered physician remuneration. The dominance of fee-for-service is institutionalized through the 1962 Saskatoon Agreement, which brought physicians into government public health insurance plans under the condition that physicians retained their professional autonomy as independent contractors (Tuohy 1999). The agreement simultaneously sealed the fate of
physician remuneration into a dominant path of remuneration for most physicians, and for
general practitioners in particular. In recent years, provinces have experimented with new
modes of remuneration such as salary, capitation, and pay-for-performance; nevertheless,
many of these new payment methods are layered on top of fee-for-service, which remains
the dominant mode of remuneration.

Research Method

The comparative case method systematically compares a small number of cases
across systems (Lijphart 1975; Collier 1993; Yin 2009; Gupta 2012). The primary goal,
according to Gupta (2012), is to “establish general empirical connections between the
characteristics of the system and the phenomenon under investigation” (Gupta 2012, 12).
These empirical connections assist public policy researchers define how policy processes
occur and why different jurisdictions produce different outcomes. This approach is
valuable since many governments with publicly insured health systems face similar
policy problems despite differences in values and cultural contexts (Geva-May 2002;
Rose 2005). Consequently, the approaches pursued by other jurisdictions, both successful
and unsuccessful, provide opportunities for researchers to derive policy lessons and
produce shared learning (Block 1997).

This study uses the comparative method to examine policy cases across provincial
and international health systems where the phenomenon under investigation is PMHC
policy. The comparative method is the most appropriate method because the data
representing PMHC policy cannot be experimentally controlled. Further, there is limited
availability of PMHC-specific data that does not permit statistical analyses. According to
Lijphart, an intensive study of a small number of cases may be more effective in testing hypotheses than a superficial statistical or experimental study of a large number of cases (Lijphart 1975). By selecting this method, this study will achieve two critical goals: determine how health systems differ with respect to PMHC policy and the implications for quality of care as well as develop key policy lessons that inform which PMHC policies facilitate better quality of care.

The comparative method is applied by developing a minimum data set and a comparative policy model (Block 1997; Rose 2005). This model guides the interpretation of how specific policy actions or decisions relate to provincial and international patterns and historical trends (Block 1997). The dominant PMHC policy framework outlined in the previous section operates as this comparative policy model. From here, a minimum data set was established through the collection of secondary data according to the policy framework’s key themes: governance, organization, and funding.

The analysis compares provincial policy models to each other in order to distinguish the level of reform achieved (by each case). These reforms are then categorized as non-targeted gradualist reform, incremental reform, or revolutionary reform. A benchmarking method is further applied to the provincial policy models to calculate the relative success of provincial PMHC reforms. More discussion on the benchmarking method is provided in chapter four.

Finally, a comparative analysis is completed on Australia and New Zealand, whereby the same comparative policy model used for the provincial cases guides the data collection and interpretation. These policy models are then compared to the Canadian model in order to draw policy lessons for Canada from international experiences.
Case Selection

Two criteria were used to select provincial cases for comparison. Table 3.1 summarizes the criteria involved in case selection. The first criterion includes comparable regional governance structures. Regionalization of health care governance in Canada has not been implemented uniformly across the country (Martin, Pomey, and Forest 2010; Marchildon 2013a). However, policy activity throughout the 1990s and early 2000s produced three models of regionalization reflecting different levels of decentralization.

The regional governance structures in British Columbia, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, and Newfoundland and Labrador comprise the first model. These provinces have two levels of governance: one at the provincial level; and a second at the sub-provincial regional health authority level. Alberta and Prince Edward Island have one centralized governance structure, although it should be noted that in addition to the ministries of health, each also has a delivery body at the provincial level. Ontario and Quebec have three levels of regional governance. In Ontario the three levels include: provincial government, local health integrated networks, and hospitals. In Quebec, these levels comprise the provincial government, regional health and social service agencies, and local health care services networks. To ensure consistent comparison, only provinces with two levels of regional governance were selected.

Case selection also depended on the presence of remuneration or governance PMHC reforms. Each case represents a different type of PMHC reform. British Columbia implemented remuneration-based reforms, with no changes to the dominant governance structure. Alternatively, PMHC reforms in Manitoba involved changes to both governance and remuneration. Saskatchewan has implemented no PMHC reforms to date.
The acute and community mental health sectors in Saskatchewan have experienced minimal policy activity since the deinstitutionalization of psychiatric beds in 1960s and 1970s and the transition to community-based care in the late 1980s and early 1990s (Sealy and Whitehead 2004). Given the limited policy activity, Saskatchewan was selected as the status quo case. New Brunswick and Nova Scotia were excluded because PMHC reforms did not include remuneration or governance components. Finally, Newfoundland and Labrador were excluded because recent mental health care reforms were focused on acute care.

To expand on the reforms observed in British Columbia, Manitoba, and Saskatchewan, policy lessons were drawn from two international cases: Australia and New Zealand. First, the cases were selected because the regions have a similar Westminster-style parliamentary democracy. Second, Australia and New Zealand have universal, publicly funded health care for citizens. The single-payer structure of the insurance system is similar to that of Canada, and the only major difference is that the national governments in Australia and New Zealand are the single payers. Third, these regions have a common history of physician-dominated PMHC delivery. This comparative feature is important in that lessons may be drawn from the steps Australia and New Zealand have taken to move away from that model. Finally, Australia and New Zealand were selected because their experiences with PMHC reform offer policy lessons that speak to more progressive incremental reform and revolutionary reform.
Table 3.1: Case Selection

<table>
<thead>
<tr>
<th>Province</th>
<th>Levels of Governance</th>
<th>Include in Case Study</th>
<th>Reason for Case Inclusion or Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>Ministry of Health &amp; RHAs</td>
<td>Include</td>
<td>Presence of recent remuneration-based PMHC reforms and comparable governance structures with other provinces</td>
</tr>
<tr>
<td>Alberta</td>
<td>Ministry of Health &amp; Provincial Service Delivery Agency</td>
<td>Exclude</td>
<td>Lack of comparable governance structure with other provinces.</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Ministry of Health &amp; RHAs</td>
<td>Include</td>
<td>No PMHC reforms to date; however, this case provides a status quo option with similar governance structures as British Columbia and Manitoba</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Ministry of Health &amp; RHAs</td>
<td>Include</td>
<td>Presence of recent remuneration and limited governance reforms to PMHC and comparable governance structures</td>
</tr>
<tr>
<td>Ontario</td>
<td>Province, Local Health Integrated Networks &amp; Hospitals</td>
<td>Exclude</td>
<td>Lack of comparable governance structure with other provinces.</td>
</tr>
<tr>
<td>Quebec</td>
<td>Province, Regional Service Delivery Agencies, and Local Networks</td>
<td>Exclude</td>
<td>Lack of comparable governance structure with other provinces.</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Ministry of Health &amp; RHAs</td>
<td>Exclude</td>
<td>The 2011 Provincial Mental Health Action Plan outlines a number of PMHC options; however, no reforms implemented to date regarding governance and/or remuneration.</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Ministry of Health &amp; RHAs</td>
<td>Exclude</td>
<td>Recently developed a mental health strategy that speaks to PMHC; however, no reforms implemented to date regarding governance and/or remuneration.</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>Ministry of Health &amp; Provincial Service Delivery Agency</td>
<td>Exclude</td>
<td>Lack of comparable governance structures with other provinces with the possible exception of Alberta.</td>
</tr>
<tr>
<td>Newfoundland &amp; Labrador</td>
<td>Ministry of Health &amp; RHAs</td>
<td>Exclude</td>
<td>Mental health reforms have been acute care focused on acute care rather than on PMHC.</td>
</tr>
</tbody>
</table>
**Data Collection**

Grey literature was the primary source of information and evidence for the comparative case study. Publicly available government documents were also collected. These documents included: policy papers, strategic plans, formal program and policy evaluations, published and un-published case studies, stakeholder position papers, legislation, annual reports, provider service agreements, and technical reports. A comprehensive list of the collected is provided in Appendices A through C.

The documents were identified through keyword searches in Google™, Google Scholar™, as well as, the search functions available on provincial and national government websites. To ensure high-quality information sources, the documents were carefully assessed for authenticity, credibility, representativeness, and meaningfulness. This process entailed crosschecking references with other documents and academic literature, as well clarification of content through personal correspondence. Once collected and verified, the documents were organized by year of publication and categorized into the following themes: remuneration, governance, inter-disciplinary collaboration, system coordination, and consultations. This established links between a specific reform, initiative, or government directive and the use of physician remuneration and/or governance to improve PMHC quality.

Other forms of secondary data, such as data collected by the Canadian Institute for Health Information (CIHI) and Statistics Canada, were not appropriate for the current research because the data do not capture the PMHC sector. Currently, pan-Canadian PMHC indicators are not available from these organizations. The mental health indicators available (e.g. hospitalization ratios) measure quality of care in the acute care sector.
rather than the primary care sector. As well, policy success cannot be easily gauged from these data sources since the data are broad and high-level. Any observed changes may be linked to a number of different variables and policies. Finally, physician-billing data, which provides information on physician remuneration, did not accurately represent the remuneration practices and PMHC trends. The physician remuneration data available from CIHI was too high-level for the research purposes and could not be further broken down into specific areas (e.g. general practitioners delivering PMHC). In addition, the raw data collected by provincial governments were not publicly accessible and the time required to obtain approvals was prohibitive to the research time-lines.

Primary data was not available for the research topic because the primary research methods, such as surveys, interviews, and experimentation, involve a number of stages that require more time than was allocated for the project. For example, surveys and interviews require ethical approvals, identification, and confirmation of sample and/or interviewees, as well as approval from government to interview or survey public servants. Policy experiments, on the other hand, are more longitudinal in nature, such that they require long periods of time to observe the effects of a particular policy or regime.

**Conclusion**

In this chapter, historical institutionalism was used to identify three features of the dominant PMHC policy framework: physician-centered primary care system, physician-state duopoly, and fee-for-service as the dominant mode of remuneration. Using this framework, policy information was collected to conduct comparative case studies on three Canadian provinces: British Columbia, Manitoba, and Saskatchewan. Information
was also collected on Australia and New Zealand in order to compare policy lessons with
the dominant Canadian PMHC policy approach. The next chapter will use the dominant
policy framework to compare the state of PMHC reform in the three Canadian
jurisdictions. The extent of reform will be evaluated to determine which Canadian reform
effort is best suited to facilitate greater system coordination, interdisciplinary-disciplinary
collaboration, and longer, more involved consultations in PMHC.
4 THE STATUS OF PRIMARY MENTAL HEALTH CARE IN CANADA

Introduction

In Canada, provincial governments have the constitutional responsibility to fund and administer health services (Marchildon 2013a). This arrangement produces some variation in primary mental health care (PMHC) policy decisions among provinces and, as a result, creates an opportunity for comparative policy learning. The following chapter presents a comparative analysis of major Canadian PMHC reforms. These reforms will be compared against the dominant PMHC policy framework proposed in Chapter Three. To complement the comparative analysis, the PMHC reforms are then benchmarked with a simple heuristic device. This approach will demonstrate the extent of reform achieved in each jurisdiction. The combined method of comparative analysis and benchmarking will help determine which forms of PMHC governance and which mode of physician remuneration are best suited to improve interdisciplinary collaboration, system coordination, and encourage longer, more involved consultations.

The status of Canadian PMHC reform is demonstrated by three provincial cases: British Columbia, Manitoba, and Saskatchewan. Each case presented in Table 4.1 represents a different stage of Canadian PMHC reform. First, British Columbia demonstrates the greatest degree of reform with a targeted incentive program designed to improve the delivery of mental health services by fee-for-service general practitioners. The case of Manitoba illustrates a moderate-level of Canadian PMHC reform with the Physician Integrated Network (PIN) program and the Winnipeg Regional Health Authority (WRHA) Shared Mental Health Care Program. Finally, Saskatchewan represents the provinces that have not yet initiated any targeted PMHC reforms. While
Saskatchewan has launched a number of primary care reforms, such as increasing the number of primary care teams throughout the province, the dominant model of PMHC remains unchallenged because majority of residents receive PMHC from fee-for-service general practitioners.
## Table 4.1: Canadian PMHC Reform

<table>
<thead>
<tr>
<th>Policy/Program</th>
<th>British Columbia</th>
<th>Manitoba (Winnipeg RHA)</th>
<th>Manitoba (PIN)</th>
<th>Saskatchewan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/Program</td>
<td>Full Service Family Practice Incentive Program (FSFPIP)</td>
<td>WHRA Shared Mental Health Care Program</td>
<td>Physician Integrated Networks – Quality-Based Incentive Funding (QBIF)</td>
<td>No targeted PMHC reform</td>
</tr>
<tr>
<td>Years Active</td>
<td>2003 – present</td>
<td>2003 – Present</td>
<td>2008 – present</td>
<td>N/A</td>
</tr>
<tr>
<td>Administration</td>
<td>General Practitioner Services Committee (GPSC)</td>
<td>Joint WRHA &amp; Manitoba Ministry of Health</td>
<td>Manitoba Ministry of Health</td>
<td>Saskatchewan Ministry of Health</td>
</tr>
<tr>
<td>Targeted PMHC Providers</td>
<td>GPs remunerated by the BC MSC</td>
<td>GPs, psychiatrists, counselors, and psychologists</td>
<td>GPs practicing in Physician Integrated Networks (PINs)</td>
<td>All GPs remunerated through Saskatchewan FFS</td>
</tr>
<tr>
<td>Funding Source</td>
<td>Annual program funding allocated to GPSC by the Ministry of Health. Incentive payments are delivered to GPs through the MSC FFS schedule</td>
<td>2003-2006: Federal Government Primary Health Care Transition Fund. (GPs salaried) 2006 – present: The WRHA global budget permanently funds non-physician practitioners. 2009 - present: GPs remunerated through traditional fee schedules.</td>
<td>GPs receive incentive payments from the Manitoba Ministry of Health Blended funding: FFS from provincial fee schedule + incentive payments</td>
<td>GPs remunerated for basic psychological services through provincial fee schedule.</td>
</tr>
<tr>
<td>Key Policy Features</td>
<td>Annual bonus payments and new Medicare fee items for designated. Examples: (1) Patient Management Conference Fee (2) Complex Patient Clinical Conference Fee (3) Mental Health Planning Fee (4) Mental Health Consult Fee (5) Additional Counseling Fee</td>
<td>Co-location GPs, psychiatrists, psychologists, and counselors in GP primary care practices. Shift from salary to FFS intended to engage remaining FFS GPs in the health region. Stipends added to cover overhead administrative costs associated with supporting a co-located program</td>
<td>Performance incentive component of the PINs, where GPs receive additional funding for providing depression screening, treatment &amp; follow up. This funding may be used to hire additional mental health resources (i.e. counselors)</td>
<td>Basic consultation fees available for GPs delivering psychological services to patients. No additional</td>
</tr>
</tbody>
</table>

Some primary care teams throughout the province, but these do not serve the majority of the population.
Primary Mental Health Care Organization

All provincial PMHC reforms described in Table 4.1 produced minimal change to PMHC organization. In British Columbia’s Full Service Family Practice Incentive Program (FSFPIP), mental health fee items are designed around a physician-centered model of health care delivery. These new incentives are exclusive to general practitioners who are remunerated through the provincial fee schedule. Consequently, these reforms do not directly support an inter-professional and collaborative mode of PMHC organization (GPSC 2007; GPSC 2008; BC 2010; GPSC 2010; GPSC 2011; Mazowita and Cavers 2011).

Similarly, Manitoba retained the dominant PMHC organization framework, since Manitoba’s PIN program specifically targets physician networks to provide depression screening, diagnosis, and treatment through performance incentives (Quality-Based Incentives or QBIs) (MB 2012). Alternatively, the WRHA Shared Care Program represents a minor exception to the path-dependent trend of the dominant PMHC organization because the program is designed to improve collaboration between general practitioners, psychiatric specialists, and non-physician mental health providers. However, this approach specifically targets existing general practitioners who operate publicly funded, fee-for-service private practices, by organizing the Shared Mental Health Care program around these practices (WHRA 2012).

Finally, the Saskatchewan case demonstrates no improvement to the existing dominant organization of PMHC, since targeted PMHC governance and remuneration reforms have not yet been implemented. While minor improvements exist with the interdisciplinary primary care teams, these teams are typically general practitioner-led.

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2 Dominant PMHC organization refers to the physician-centered monopoly over PMHC services.
and are implemented predominantly in rural areas. It should be noted that since 2008 the Saskatchewan Government has implemented Lean across the entire health system to reduce inefficient care processes and improve the quality of care and patient experience. Lean is a consumer-centered philosophy that originated in the manufacturing sector and has been applied to other sectors since the mid-1990s (Marchildon 2013b). In the health care sector, Lean is defined as a “patient-centered approach to manage and deliver care” (Saskatchewan Health Quality Council 2013). To apply this philosophy system-wide, the Ministry, RHAs, and Health Quality Council have undertaken extensive training and Lean certification efforts for all employees. The training is intended to encourage employees to continuously improve the quality of care, patient and staff flow, as well as reduce waste such as time and resources (Marchildon 2013a). Further, approximately 300 Lean-driven improvement projects have been completed or are currently underway in the 13 RHAs, within the Ministry, and at the Saskatchewan Cancer Agency (Saskatchewan Government 2013).

Saskatchewan is undertaking an initiative to develop a provincial mental health strategy although it is only at the stage of collecting public input to inform the strategy. Given Saskatchewan’s commitment to Lean as a long-term and system-wide initiative, it is expected that Lean will be used in the development and deployment of the upcoming mental health strategy. While it is not clear how Lean will shape Saskatchewan’s PMHC reforms, Lean may be used to improve the everyday management and delivery of PMHC. For example, the use of Lean tools such as value stream mapping and rapid process improvement sessions will help the government identify existing barriers within current structures and processes. However, since Lean tends to focus on immediate
improvements to the management and delivery of care, the dominant PMHC policy framework is not likely to be reformed through the application of Lean whatever its potential to produce more patient-centered PMHC.

Overall, British Columbia, Manitoba, and Saskatchewan collectively demonstrate a tendency to retain the dominant PMHC organization through remuneration reforms. As a consequence, all current and future PMHC and physician remuneration reforms require assimilation into the dominant institutionalized structure to secure feasible implementation.

**PMHC Governance**

PMHC reforms in British Columbia, Manitoba, and Saskatchewan produced no change to the dominant governance structure of the physician-state duopoly for physician remuneration. In British Columbia, the Medical Services Commission (MSC) in collaboration with the British Columbia Medical Association (BCMA) have the authority to allocate resources to the General Practitioner Services Committee (GPSC) in order to finance enhanced mental health fee items (BC 2005; BC 2006; BC 2009; Mazowita and Cavers 2011). The health authorities are not included in the reformed fee-schedule decisions for the GPSC. This distribution of decision-making authority for PMHC reforms signals the continuation of an exclusive physician-state relationship in remuneration decision-making in PMHC. Future change to this dominant structure is possible because the GPSC is allocated some funding to encourage general practitioners to contract with RHAs or other health care providers; however, these changes do not signal a major decision-making power shift (GPSC 2007; BC 2009).
The design of PINs in Manitoba reflects the preference for a privileged physician-state relationship in the development of this program. This is because medical associations and the provincial government control the performance incentives used to enhance mental health care, while regional health authorities do not have a significant decision-making and accountability role for the incentive structure. The Winnipeg Regional Health Authority (WHRA) Shared Mental Health Care Program retained a similar divided-governance arrangement between Manitoba Health, which remunerates the general practitioners participating in the program, and the WHRA, which uses global budgets to finance the services of other mental health professionals in the shared practice (WRHA 2012). In fact, this governance division was identified as a key organizational barrier for the shared care program, since the existing fee-for-service policy framework excluded the WRHA from the physician remuneration process, which, to date, has not been resolved (WRHA 2012). Finally, Saskatchewan’s dominant state of physician-delivered PMHC experienced no changes to PMHC governance structures and provided no evidence of problem identification on part of the government. This indicates some institutional resistance to reform the existing physician-state PMHC governance structure.

**Physician Remuneration in PMHC**

The three provincial cases demonstrate fee-for-service to be the dominant mode of physician remuneration because the reforms to PMHC quality involved minimal changes to the existing remuneration mode. For example, British Columbia created the FSFPIP, delivered by a government appointed committee, to implement an enhanced fee-schedule
to encourage general practitioners to provide more comprehensive PMHC services (GPSC 2007). More specifically, the Community Mental Health Initiative component of the FSFPIP enables general practitioners to bill the Medical Services Plan for a specialized mental health-planning fee. In addition to this fee, general practitioners may also bill for mental health telephone and email management between the general practitioner and other health providers, and a mental health management fee that can be provided to general practitioners with additional (time and payment) resources to follow-up and monitor their patients. Other mental health-related fees were also implemented, including the GPSC’s facility patient conference fee and a community patient conference fee. Although these fee items are not specifically designated for mental health services, they enable physicians to receive additional payment for more complex patients, including those with chronic mental illness (GPSC 2008; GPSC 2010). The FSFPIP has also recently undertaken initiatives to encourage shared care in primary care. This means that fee item reforms may include incentive payments to encourage inter-disciplinary mental health care collaborations.

Manitoba opted to improve PMHC with a performance incentive initiative administered through the PINs, which were designed within the existing system of fee-for-service family physicians (MB 2012). Mental health care was targeted through the Quality Based Incentive Funding initiative, which provides monetary performance incentives to PINs to achieve specified goals for mental health care with respect to depression screening and treatment. The Manitoba incentive program contrasts with the British Columbian approach because FSFPIP fee items were not tied to physician performance and the mental health fee items are available province-wide to general
practitioners. Instead, the PINs are exclusive to physicians participating in primary care networks.

The WRHA’s Shared Mental Health Care Program initially financed the salaries of participating general practitioners through the federal government’s Primary Care Transition Fund. However, in 2009, the WRHA sought to engage more private practice general practitioners in the multi-disciplinary collaborative program. To achieve this, the WRHA replaced salaried physician remuneration in favour of fee-for-service remuneration administered by Manitoba Health. No extra financial incentive was provided other than top-up funding (stipends) for overhead administrative expenses to offset some of the financial costs involved in the implementation of shared care (WRHA 2012). The fact that the WRHA reverted back to the dominant fee-for-service framework is crucial since it signals that provincial governments are not willing to permanently allocate resources to RHAs for physician salaries. The WRHA referred to their decision to use fee-for-service as a way to “balance the needs of multiple systems” (WRHA 2012, 46). The use of this language indicates that the RHAs are perhaps unwilling to absorb the costs of employing salaried physicians within the WHRA’s integrated model of PMHC without a permanent commitment from the Ministry of Health to increase RHA operational budgets. In contrast, Saskatchewan produced no targeted changes to physician practice and mode remuneration to improve PMHC. While the province has an alternative payment program to administer salaried and sessional contracts, explicit targeting of PMHC in these initiatives was not observed.
**Benchmarking Method**

Benchmarking is an analytical tool for the comparative method and is used to compare the strengths and weaknesses of a particular system, set of practices, or policies (Rose 2005; Conference Board of Canada 2012). In addition, benchmarking is a comparative tool for learning from other jurisdictions (Conference Board of Canada 2012). The Conference Board of Canada has outlined the basic elements of the benchmarking process: defining a benchmarking goal, agreement on a comparative standard for policies or programs, selection of a ranking method, and confirmation of data availability and reliability (Conference Board of Canada 2012).

According to Rose (2005), the use of benchmarking in comparative research simultaneously offers “a means of evaluating a national program and learning about programs elsewhere” (35). Past benchmarking of mental health care across health systems have a predominantly quantitative focus (Lauriks et al. 2012; Moran and Jacobs 2013). This approach is insufficient to capture PMHC because these studies tend to compare performance on acute care measures such as in-patient hospitalization, re-admission rates, and self-injury hospitalizations. A few studies have attempted to develop and obtain consensus on PMHC quality indicators (Shield et al. 2003; Addington et al. 2010; Waraich et al. 2010). However, the chief barrier to implementing these indicators is limited data availability and a lack of data uniformity (Wait and Nolte 2005). Currently, a standard pan-Canadian or international PMHC data set does not exist. As such, this thesis proposes a qualitative approach to benchmarking PMHC policy success or achievements. While this form of benchmarking is not as rigorous as more quantitative approaches, this
approach attempts to measure policy performance in the absence of standard, comparable PMHC data.

To answer the research question proposed in chapter one, the provincial PMHC reforms are benchmarked on a PMHC best practices index to comparatively determine which policy reforms have most successfully addressed the barriers of governance and remuneration. This index is composed of seven criteria that are ranked on a three-point ordinal scale. For each criterion, a score of three indicates that the PMHC best practice was implemented as a defined component of provincial reforms to the mode of remuneration. A score of two indicates that the inclusion of the PMHC best practice is under consideration or development for inclusion of the reform effort or the feature that exists within the provincial PMHC sector, but is not directly linked to the reform effort. An example of this includes the attachment of education requirements to incentive payments for mental health planning. A score of one signifies that the best practice is not targeted towards PMHC, but may target other primary care programs. This means that there is potential for an expanded focus of similar initiatives in the PMHC sector. Finally, a score of zero signifies the absence of PMHC reform. The cumulative score, out of twenty-one, calculated by the sum of each ranked criterion, demonstrates the capacity of a provincial case (i.e. British Columbia, Manitoba, Saskatchewan) to align reform with best practices to improve system coordination, interdisciplinary collaboration, and longer PMHC consultations.

As a central component of the policy index, the seven criteria representing PMHC best practices were developed through a review of the PMHC literature. In this context, best practices are defined as PMHC-specific features added to the governance structure or
remuneration mode to enhance PMHC quality. The criteria here do not represent a comprehensive set of best practices in PMHC; instead, they capture key practices that may be addressed through targeted reform to governance and remuneration. A detailed discussion of each criterion is provided below.

**PMHC Criterion 1: Collaboration**

The first best practice criterion is collaboration, specifically physician collaboration with other mental health providers, such as psychiatrists, psychologists, social workers, nurses, and mental health counsellors to provide mental health care. Collaborative care is a complex, but effective intervention to provide pro-active and preventative mental health care (Kates et al. 2011). Collaborative care is often associated with increased provider confidence and job satisfaction, as well as increased treatment compliance, follow-up care, and accessibility to a more complete range of primary care services, such as chronic disease management (Craven and Bland 2006; Kates et al. 2011). Since collaborative care is provided within the primary care environment, patients perceive this form of mental health care to be less stigmatizing. In another study, a cluster randomized controlled trial of 27 general practices in the Netherlands found that collaborative mental health care, compared to regular (i.e. non-collaborative) primary care, produced shorter referral delays, fewer appointments, higher patient satisfaction, and reduced treatment times (Van Orden et al. 2009).

Finally, collaborative care is most effective in improving patient outcomes when it is designed around pre-existing clinical arrangements and is accommodated by adequate preparation, time, and support structures (Craven and Bland 2006). Consequently,
supportive remuneration structures are crucial to the successful application of collaborative care in private practice primary care environments (Mulvale and Bourgeault 2007). Thus, the first best practice criterion measures whether a specified component of the remuneration mode was implemented to encourage or enable general practitioners to collaborate with other mental health professionals.

**PMHC Criterion 2: Financial Incentives for Providing More Intensive PMHC**

A second best practice criterion specifies adjustments to physician remuneration that encourage tailored care planning, management, and follow-up care for PMHC patients. Financial incentives such as the addition of new fee items to encourage development of patient care plans by general practitioners are examples of this approach. While the effects of patient care plans in PMHC have not been extensively studied, other areas of primary care have benefited from their development. For example, a cluster randomized controlled multi-centre trial consisting of 903 patients with coronary heart disease, registered with one of 48 general practices in Northern Ireland and the Republic of Ireland, demonstrated a statistically significant decrease in hospital admission over the 18-month study period (Murphy et al. 2009). The practices that implemented tailored patient care plans experienced greater declines in hospital admission compared to general practices that did use patient care plans (Murphy et al. 2009). These patient care plans included motivational interviewing, goal identification, and target setting for lifestyle change, and were followed up by a review every four months.

The implementation of patient care plans for PMHC differs from coronary heart disease, but nonetheless provides an opportunity to address the needs of the patient from
their perspective and it may also be used in stepped care strategies for depression or collaborative care models (Newbould et al. 2012). Consequently, some efforts to improve implementation may include reforms to the mode of general practitioner remuneration in order to encourage and support the development and communication of patient care plans in primary care. The performance criterion here is defined as changes to the mode of remuneration that incentivize the development of mental health care plans for patients who receive mental health care from general practitioners.

**PMHC Criterion 3: Permanent Funding Structures**

The third criterion measures the availability of stable funding for reformed modes of remuneration that support alternative organization and PMHC delivery. For example, Mulvale and Bourgeault (2007) identify the instability of funding for both physicians and non-physician providers to be a key barrier to successful collaborative mental health care. The stability of new modes of remuneration is dependent on their implementation for system-wide use (i.e. accessible to all physicians in the province), and they must be incorporated into permanent funding structures for physicians. In contrast, piloted modes of remuneration are dependent on research grants, which are vulnerable because funding levels vary from year to year, and these projects are usually limited to small segments of provincial populations. As a result, this best practice criterion evaluates whether a specific reform to remuneration is secure in the dominant physician payment policy framework.

**PMHC Criterion 4: Longer PMHC Consultations**
One of the key quality barriers with the fee-for-service mode of remuneration includes the incentives for volume-based service delivery, since longer consultations are remunerated at relatively the same rates as patients requiring shorter consultations (Dewa, Hoch, and Goering 2001; Robinson 2001). In fact, aligning remuneration modes with options to accommodate or encourage longer consultations may encourage the provision of cognitive-behavioural therapy or other interventions, better patient education, and screening for various mental and physical conditions (Goldberg 1999; Van Dulmen 2000). Although longer consultations do not necessarily guarantee higher quality of services, creating supportive practice environments for the physician to deliver services that require more time to properly render the service. The fourth criterion measures the inclusion of longer-consultations as a key feature in PMHC policy reforms.

**PMHC Criterion 5: Continuity of PMHC with Community and Institutional Care**

The fifth best practice criterion evaluates whether PMHC reforms target the continuity of mental health care between the primary care sector and the community and acute care sectors. Greater continuity between services and patient pathways within and between sectors are important as they ensure the appropriate intervention and referral, which is important in stabilizing patients discharged from hospital (Durbin et al. 2006). Targeted reforms to remuneration that focus on supporting greater continuity of primary mental health services indicate better system coordination across care sectors and potentially greater collaboration between mental health providers. For example, reforms may include fee schedule items for general practitioner participation in referral pathway mechanisms or telemedicine initiatives, or remuneration for other mental health
providers, such as psychiatrists, psychologists, nurses, and social workers to provide PMHC with general practitioner referral.

**PMHC Criterion 6: Physician PMHC Education**

Primary mental health care improvement through supportive remuneration structures also includes on-going educational support for physicians to ensure that physicians accurately diagnose mental illness, provide appropriate referrals, understand the roles of other mental health providers, and feel confident in managing mental illness. For this reason, the sixth criterion measures the alignment of PMHC reform with physician education. A systematic review of 36 studies (29 randomized controlled trials and non-randomized controlled clinical trials, five controlled before-and-after studies, and two interrupted time-series studies) evaluated primary care physician education interventions (Gilbody et al. 2003). This study demonstrated that physician education programs were most effective in collaborative care, nurse case management, or intensive quality improvement programs (Gilbody et al. 2003). The education best practice criterion reflects adjustments in the mode of remuneration for education initiatives for physicians. Cases that implement these changes in addition to or as a multi-faceted component of other PMHC strategies will receive a higher score on the policy index.

**PMHC Criterion 7: Systems Coordination by Regional Health Authorities**

The final criterion ranks provincial PMHC reforms on their efforts to address the physician-dominated PMHC governance structure. A comparative analysis of 10 Canadian mental health networks demonstrated that coordinated care required supportive
governance structures, primarily through alignment of budget authority and service planning (Wiktorowicz et al. 2010). This study found that the coordination of mental health services between community and acute care sectors was most effective when budget control resided at the regional or network level. Although this study did not include PMHC services, similar principles apply in that regional health authorities are often disconnected from the decision-making and accountability for PMHC services. This misalignment of financial and resource management leads to poor coordination of mental health services between the primary, community, and acute care sectors. In fact, the implications for the PMHC quality are such that effective collaboration between mental health professionals is dependent on the coordination between regional health authorities and the primary care sector. This is because regional health authorities employ a broad range of mental health professionals, while the bulk of general practitioners are beyond RHA budgetary and service planning authority. Consequently, reforms must address the underlying power dynamics that control decision-making authority and PMHC service accountability.

**Results and Discussion**

The results from ranking the inclusion of PMHC best practices in policy reforms to PMHC governance and mode of physician remuneration are illustrated in Table 4.2. The performance of each case on the policy index demonstrates provincial capacity to address the institutionalized barriers of PMHC governance and the mode of remuneration. High total scores signal more targeted reforms, while low scores indicate the absence of targeted reform to improve PMHC. The discussion immediately following
Table 4.2 elaborates on the overall trends observed in the reforms to the mode of physician remuneration. The implications of the results to the improvement of PMHC will be discussed using the conceptual lens of historical institutionalism. Overall, this assessment identifies which provincial reform effort facilitates greater improvement to the three overarching quality features of PMHC: system coordination, interdisciplinary collaboration, and longer consultations.
### Table 4.2: PMHC Best Practices Index

<table>
<thead>
<tr>
<th>#</th>
<th>Best Practice Criteria</th>
<th>BC GPSC Full-Service Family Practice Incentive Program</th>
<th>MB WHRA Shared Care Program</th>
<th>MB PIN Initiative</th>
<th>SK Status Quo – No Reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Encourages physician contact or collaboration with other mental health providers.</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Encourages targeted planning, management, and follow-up care for primary mental health services.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Stable funding source (for reformed mode of remuneration).</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Encourages longer consultations.</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Supports communication and/or planning with the community and hospital sector to enhance the continuity of PMHC with other mental health care services.</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Paired with on-going education and mentorship for general practitioners.</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Targeted &amp; changed traditional PMHC governance structures</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td><strong>Total Score Out of 21 =</strong></td>
<td><strong>14</strong></td>
<td><strong>14</strong></td>
<td><strong>9</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>
Broadly, Table 4.2 demonstrates that British Columbia’s GPSC Full-Service Family Practice Incentive Program and Manitoba’s WRHA Shared Mental Health Care produced the closest alignment of reform to the mode of physician remuneration with PMHC best practices. Compared to Saskatchewan’s status quo policy and Manitoba’s PIN program, the results from the policy index indicate that remuneration reforms in British Columbia and Manitoba have produced more structurally supportive modes of remuneration to improve PMHC quality delivered by general practitioners. Alternatively, the results suggest that the status quo case, i.e. Saskatchewan, and the Manitoba PIN program do not re-align remuneration policy to PMHC best practice criteria. As a result, the dominant mode of remuneration in these cases continues to serve as a barrier to PMHC quality improvement.

However, the reforms to PMHC presented in all provincial cases demonstrate extremely incremental reform. There are three pieces of evidence, from Table 4.2, to support this assertion. First, all provincial reforms retained the physician-as-gatekeeper PMHC model, which indicates resistance to organize PMHC around non-physician practitioners, such as psychologists, nurses, or social workers. Second, all cases demonstrated no change to governance structures; instead, these structures were path dependent with respect to the physician-government duopoly over physician remuneration in PMHC. Third, PMHC reforms to the mode of physician remuneration, as expressed in Table 4.2, represent only minor modifications to the existing fee-for-service remuneration mode. For example, the British Columbia FSFPIP created new fee items to enhance physician-delivered primary mental health services and the Manitoba PIN initiative developed financial performance incentives for depression screening.
Further, the WHRA Shared Mental Health Care Program initially remunerated participating physicians through a salaried model, only to revert back to fee-for-service to expand the program’s inclusion of private primary care practices. In all, the incremental nature of these reforms demonstrates the layering of new “elements onto an otherwise stable institutional framework” (Béland 2010, 618). Essentially, the modifications made to physician remuneration exemplify the path dependency of dominant political institutions, such as fee-for-service, the physician-government duopoly, and the gatekeeper organization model. This is because the reforms do not change the underlying relationships between institutions and actors, nor do they fundamentally shift power from one group of policy actors to another. Therefore, improvement efforts to PMHC are restricted to minimal modification to the mode of physician remuneration; and while meaningful change may be achieved within these institutional boundaries, there is a discernable limit to the extent of reform possible. This means that some beneficial policy changes, such as greater system coordination for PMHC services through reform to the physician-state duopoly, are not feasible simply through minor adjustments to the dominant fee-for-service PMHC structure. Rather, more aggressive, revolutionary reform is required.

Conclusion

The comparative case analyses of the three Canadian cases produced important differences between PMHC and physician remuneration reform. For example, British Columbia demonstrated the most progress by using enhanced fee-schedule items to incentivize the provision of comprehensive mental health services by general
practitioners. Alternatively, Saskatchewan exemplified adherence to the status quo features of the dominant model. Further, the comparative analyses established that all three provincial cases did not address the governance of physician remuneration within their respective PMHC reforms, since the payer-provider relationship continued to favour the duopoly of the physician-state policy making. In addition, the centralized role of the general practitioner as mental health sector gatekeeper was retained by all provincial cases. In conclusion, Canadian PMHC reform remains incremental with only small changes to the fringes of the dominant PMHC policy framework. Given these incremental tendencies, policy lessons from international jurisdictions are required to highlight potential policy options that may improve reform efforts.
5 POLICY LESSONS FROM ABROAD: AUSTRALIA & NEW ZEALAND

Introduction

In Canada, primary mental health care (PMHC) reform policy cases share a dominant policy framework that more or less dictates the nature and extent of reform. This shared framework limits the range of policy answers to the proposed research question: Which policy reforms to governance and physician remuneration can facilitate better system coordination, improve interdisciplinary collaboration, and encourage longer consultations for Canadian PMHC? To answer this question beyond the limits of the Canadian experience, policy lessons are drawn from Australia and New Zealand. The lessons derived from this chapter will inform the PMHC policy reform options presented in chapter five.

Lessons from Australia

In Australia, PMHC policy and financial decisions are centralized nationally through the Australian Commonwealth (the Commonwealth) (Healy, Sharman, and Lokuge 2006). The Commonwealth finances and administers the Medicare Benefits Schedule (MBS) through Medicare Australia. The MBS is a fee schedule that sets out specific fees for general practitioner services. These practitioners may directly bill Medicare Australia, a practice termed “bulk-billing,” or the patient may be billed by the general practitioner and then seek reimbursement from Medicare Australia.

Australian general practitioners are the primary providers of PMHC services and act as specialist service gatekeepers. They are also politically organized with the Australian Medical Association, which is the primary political-lobby organization that
consults with the Commonwealth on remuneration, clinical practice, and medical workforce planning issues (Healy, Sharman, and Lokuge 2006; Philippon and Braithwaite 2008). Further, medical profession interests are represented in government consultations by the Royal Australasian College of Physicians, who are responsible for training, educating, and representing physicians and pediatricians in Australia and New Zealand. Lastly, Australian physicians self-regulate through their own Medical Board of Australia, which registers general practitioners and medical students, develops standards, protocols, and guidelines, investigates complaints, administers disciplinary actions, sets accreditation standards, and assesses international medical graduates (Philippon and Braithwaite 2008).

While PMHC reform remains incremental, the Australian approach offers four important comparative lessons for Canada. First, the Commonwealth identified quality challenges specific to the PMHC sector as physician-centered and relied, at least initially, on educational initiatives for resolution. Along these lines, the 1997 *National Mental Health Strategy* described the relationship between private practice general practitioners and community mental health service specialists (Callaly and Fletcher 2005). In 1999, following the development of this strategy, the Commonwealth implemented the National Primary Mental Health Network (NPMHN) of general practitioners and psychiatrists. The NPMHN facilitated general practitioner access to mental health education and strove to enhance professional linkages between general practitioners and specialist mental health services in the public, private, and non-profit sectors. Moreover, NPMHN initiatives were physician-administered through the Commonwealth and were funded by the Australian Divisions of General Practice (the Divisions): geographically localized networks or
groups of 100 to 300 general practitioners. These divisions were tasked with providing professional support, linking general practitioners with other health professionals, facilitating and administering educational activities for their members, coordinating shared care projects, and financing and administering health promotion initiatives (Healy, Sharman, and Lokuge 2006).

Next, the Commonwealth built on general practitioner mental health education by targeting the MBS as a means to incent PMHC delivery. Implemented in 2001, the Better Outcomes in Mental Health Care (Better Outcomes) program introduced fee items that reimbursed general practitioners for consultation time and patient care planning with other health professionals (Callaly and Fletcher 2005). To encourage general practitioners to manage their patient’s mental health through the development of a three-step episode care plan, and provide two follow-up visits and a six month review, new MBS fee items were implemented (Hickie and Groom 2002). MBS fee items for general practitioners were created to incentivize cognitive behavioural therapy, patient psycho-education, relaxation therapies, and interpersonal therapies (Hickie and Groom 2002). Billing incentives were also added to the MBS for psychiatric consultation or case conferencing. Moreover, they were intended to provide additional resources for general practitioners who encountered psychiatric emergencies (Hickie and Groom 2002). In addition, billing and receipt of payment for the new MBS items was conditional on the completion of government-funded training in psycho-education, cognitive-behavioural therapy, and interpersonal therapies (Harrison, Britt, and Charles 2012).

From here, efforts to improve interdisciplinary collaboration complemented MBS reforms. Better Outcomes achieved this by creating the Access to Allied Psychological
Services (ATAPS) program, which facilitated access to non-physician health specialists to provide non-pharmacological therapies through a referral pathway. This component of the program, delivered by local Divisions of General Practice, was operated through general practitioner referral to pilot programs. Rather than employ specific practitioners, the Divisions have the authority to purchase sets of non-pharmaceutical services for their patients. Here, practitioners include psychologists, mental health nurses, social workers, occupational therapies and indigenous mental health workers. Through this approach, the Commonwealth attempted to integrate general practitioner PMHC with mental health services provided by non-physician practitioners (Hickie and Groom 2002). Under Medicare, each patient was eligible for up to 12 non-physician practitioner treatment sessions annually. Overall, Better Outcomes made minor modifications to the existing policy model for PMHC by adding fee items to encourage the provision of general practitioner PMHC, as well as referral pathways to integrate allied/non-physician mental health professionals into the traditionally physician-dominated PMHC system. The Australian model also retained general practitioner autonomy and power within the health system, since general practitioners continued to be the primary source of referrals to the allied practitioners.

A final policy lesson from the Australian experience involves the expansion of the MBS fee schedule to include non-physician mental health professionals. In 2006, the Commonwealth replaced Better Outcomes with the Better Access to Psychiatrists, Psychologists, and General Practitioners program, which Medicare Australia continued to administer and finance. The GP Mental Health Plan component of the Better Access Program (Better Access) replaced the three-step mental health plan in Better Outcomes.
General practitioners adopted the program quickly, partially due to the program’s lack of educational requirements to bill for mental health services (Harrison, Britt, and Charles 2012). More importantly, Better Access introduced MBS fee items to rebate non-physician mental health professionals, predominantly clinical psychologists and mental health counsellors. Under Better Access, these professionals require a physician referral and they must be registered with Medicare Australia, the federal body, to directly bill the MBS or for the patient to receive a rebate for up-front fees (Bassilios et al. 2010). Ultimately, the introduction of allied mental health professionals into the traditionally physician-dominated MBS represents a possibility for incremental, yet potentially transformational, change within the Australian system.

Thus far, Better Access has increased rates of depression management, while decreasing referrals to psychiatrists, who manage the more severe spectrum of mental illness (Harrison, Britt, and Charles, 2012). The Divisions of General Practice continue to manage the ATAPS component of Better Outcomes, and general practitioners retain access to fee items for the delivery of focused psychological strategies (Australian Government 2009). However, Better Access tends to favour greater improvement in access rates and depression management for socio-economically advantaged urban populations (Harris et al. 2009; Bassilios et al. 2010). In contrast, ATAPS demonstrates greater uptake in rural areas where access to general practitioners is limited (Bassilios et al. 2010). Another disadvantage to Better Access is that general practitioners can potentially become nothing more than glorified referrers with limited PMHC involvement. However, recent studies suggest that general practitioners still remain
heavily involved in depression management through the mental health plan fee items attached to the fee-schedule (Harrison, Britt, and Charles 2012).

**Lessons from New Zealand**

In contrast to the incremental and evolutionary Canadian and Australian reforms, New Zealand demonstrates more revolutionary PMHC reform. These differences relate to the recent PMHC initiatives that benefited from New Zealand’s more revolutionary service delivery reforms (including primary care), where both traditional governance structures and remuneration modes were changed. The first policy lesson relates to the expansion of state authority over primary care. For the majority of New Zealand’s history of public health insurance, primary care doctors were largely independent of the government and as such were paid fee-for-service directly by their patients (French, Old, and Healy 2001).

This changed with the election of the left-of-centre Labour – Alliance coalition government in 1999. The coalition was elected on a platform that sought to secure access to a comprehensive range of health services for the majority of New Zealanders, while delivering care through non-commercial, community orientated hospitals (French, Old, and Healy 2001). First, the Labour Party introduced regional governance by creating twenty-one District Health Boards (DHBs) to replace the existing Hospital and Health Services Enterprises (Gauld 2008). Under the newly instated *Public Health and Disability Act 2000*, the DHBs were empowered to hold their own budgets and were delegated administrative authority to purchase and provide services, including primary care, within geographically designated regions. In contrast, Canadian RHAs provide a
limited range of primary care services compared to general practitioners who are the main authority over these services.

A second policy lesson includes the introduction of the New Zealand Ministry of Health’s Primary Health Care Strategy (the Strategy) in 2001. Through the Strategy, the New Zealand Government moved to address increasing gaps in public coverage for primary care services, which were previously paid out-of-pocket by patients, or were financed through government subsidies to general practitioners providing care to vulnerable patient populations (Cumming and Mays 2011). Moreover, the Strategy was a product of the Labour Party’s ideological opposition to private sector delivery of health services, and consequently used it to create Primary Health Organisations (PHOs) – community-based, non-profit organizations – to publicly deliver primary care services to approximately 95% of New Zealanders population (Tenbensel 2008). Part of this restructuring shifted general practitioners from independent contractors to PHO employees, and changed physician service payments from fee-for-service (individual practitioner level) to mostly capitation (system-level funding) with patient rostering (Tenbensel 2008; Cumming and Mays 2011). Consequently, general practitioner service financing shifted from the New Zealand Ministry of Health to the DHBs. The DHBs then administered population and risk-adjusted capitation funding to the PHOs for physician services (Tenbensel 2008).

A final policy lesson includes the New Zealand Ministry of Health’s use of hierarchical authority to achieve primary care reform. This type of authority meant centralizing executive powers and legislation to unilaterally prescribe primary care arrangements. In addition, this authority normalized the alternative primary care payment
mechanisms, specifically capitation (Tenbensel 2008). Further, the government attempted to counter private practice primary care medical dominance by mandating that PHOs be community owned and governed, and that these organizations include non-physician health care professionals—psychologists, physiotherapists and nurses—as practitioners (Gauld 2008; Barnett et al. 2009). Under this policy, general practitioners and other service providers share clinical decision-making.

Such a shift contrasted sharply with the dominant primary care landscape established by Independent Practitioner Associations (IPAs) in the early 1990s. IPAs were organized networks established by fee-for-service private practice general practitioners to exert greater decision-making authority over service delivery. These associations engaged in an arm’s-length contractual relationship with the state to provide primary care services, on a fee-for-service basis, to the New Zealand population. Further, IPAs managed their own budgets for laboratory and pharmaceutical services and they coordinated comprehensive information systems and patient registries (French, Old, and Healy 2001; Gauld 2008).

The Strategy was pursued with minimal general practitioner and IPA input and favoured the community-based model of primary care organization over the IPA’s non-profit, private delivery model (Gauld 2008). However, because the government delegated PHO formation to the practitioner groups, the medical profession’s entrenched institution of dominance continued. In fact, even today, PHOs remain largely controlled by medical practitioners because they evolved from pre-existing IPAs (Gauld 2008; Tenbensel et al. 2011).
Despite the controversial nature of New Zealand primary care reform, DHB and PHO development established an important governance and payment framework for general practitioners delivering PMHC services. The expansion of (mostly) comprehensive coverage of primary health services through the Strategy and the PHOs has meant greater access to mental health services provided by general practitioners. Prior to this reform, publicly financed mental health services were only available in the hospital or community health sector (Cumming and Mays 2011).

Moreover, in enacting system-wide PMHC initiatives, the New Zealand Government has been able to capitalize on significant primary care structural changes and the shift in independent general practitioner remuneration from fee-for-service to a rostered capitated model in which primary care falls under DHB authority. For example, the New Zealand Ministry of Health’s Primary Mental Health Initiative (PMHI), in contrast to Canadian PMHC reform, involved financing initiatives (i.e. 42 projects in all 21 DHBs) at the PHO level rather than at the individual practitioner level (Rodenburg and Dowell 2008). In fact, the financing initiative was designed to “provide additional time for patients with the GP or practice nurse, improved access to psychological therapies, and arrange for improved linkages with health social services” (Rodenburg and Dowell 2008, 247).

Although these initiatives were largely pilot projects, the New Zealand PMHI has since expanded to over 80 projects. Further, this initiative explicitly targeted the 17% of the New Zealand population with mild to moderate mental illness, and also increased policy attention on preventative and health promotion services in mental health care (Dowell et al. 2009). In all, the systemic coordination for the PMHC reforms controlled
by regional (DHB and PHO) governance of PMHC and the system-wide use of alternative payment mechanisms, suggests that the New Zealand reforms are considerably more revolutionary than the highly incremental Canadian PMHC reforms.

**Conclusion**

International comparisons with Australia and New Zealand provide important policy lessons for Canadian PMHC policy. Table 5.1 summarizes these lessons. While the policy lessons cannot be directly imported into provincial PMHC policy contexts, they reveal potential opportunities for Canadian PMHC reform. For instance, the Australian case demonstrates significant progress in removing institutional barriers through targeted PMHC reform that would not alter current Canadian governance arrangements. Alternatively, New Zealand offers a more radical reform option, which for Canadian provinces may not be feasible under the current political administrations. Nevertheless, building on the Australian and New Zealand experiences, Chapter Six will discuss three feasible policy options for Canadian PMHC reform.
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6 REFORM OPTIONS

Introduction

Primary mental health care (PMHC) governance and the mode of physician remuneration are critical structural barriers to improving Canadian PMHC quality. These factors influence provincial health systems’ ability to coordinate mental health care, as well as support interdisciplinary collaborative care, and longer, more involved patient-physician consultations. This chapter translates the policy lessons from previous chapters into feasible policy options for provincial governments to improve PMHC. The advantages and disadvantages of three options are explored below. While these options are not prescriptive, they propose that PMHC change is possible and state how it may be achieved.

Non-Targeted Gradualist Reform

To achieve non-targeted gradualist reform, provincial governments must retain the traditional organization, remuneration, and governance PMHC mechanisms. This option is advantageous to provincial governments because it requires the least political risk and fiscal investment because existing fee-schedules and governance structures are preserved. As a result, it does not require administrative upheaval or structural reform costs. Additionally, the medical profession benefits from the non-targeted gradualist approach since their position as primary PMHC providers and their relationship with the government as independent contractors would not be challenged.

Since the medical profession has been traditionally resistant to change, particularly concerning challenges or changes to their power and privileged position in
the health system, this policy approach would likely be the most acceptable to organized medicine. Consequently, non-targeted gradualist reform is feasible for governments that choose to avoid political upheaval. In fact, this sensitivity to maintaining the status quo relates to past historical decisions and events, namely the Saskatchewan Doctor’s Strike in 1962, which have created a more politically volatile relationship with the medical profession.

Ultimately, gradual non-PMHC targeted reforms lock past policy choices into a dominant policy path. The longer these choices are sustained in the current state, the more resilient they become to additional reforms. Eventually, as health systems evolve, these path-dependent governance structures and remuneration modes hinder quality PMHC improvements by restricting better delivery, organization, and finance.

**Incremental but Highly Targeted Reform**

Incremental PMHC reform currently exists in Canada. The primary example is the British Columbia Full-Service Family Practice Incentive Program (FSFPIP). This type of policy reform is incremental because it involves minimal changes to the existing dominant PMHC policy structure. Although the general practitioner remuneration structure was modified to accommodate more comprehensive PMHC services, the reforms resulted in minor adjustments to the existing private general practitioner model of PMHC delivery. This is problematic because these reforms do not directly or effectively address the institutional barriers of physician remuneration and governance. To expand on the British Columbian approach, it is recommended that governments look to the Australian PMHC reforms for an incremental, but highly targeted policy option.
With the Australian approach, provincial governments would be required to make permanent changes to physician fee-schedules in order to accommodate fee items that target PMHC delivery. To achieve this, governments may provide regulatory oversight or create an administrative body to encourage and oversee fee-item incentives (and their operational features). Typically, such a committee would be composed of ministry and physician representatives. The inclusion of the medical profession is important here, since their political power awards them significant influence over the fee-schedule process. Furthermore, integrating educational requirements into the fee framework is an essential component to better equip physicians to make more accurate diagnoses and more appropriate referrals. To achieve this component, the provincial colleges for physicians and surgeons would be vital actors on the government-appointed committee because the colleges regulate physician education.

In terms of finance, blended payment reforms that accommodate PMHC-specific incentives offer a number of advantages. For example, an analysis of Ontario Health Insurance Plan fee-for-service claims data from the 1992-2008 fiscal years, demonstrated that group-physician practices under blended payment (i.e. enhanced fee-for-service remuneration, which integrates elements of fee-for-service and other alternative remuneration modes, such as salary or capitation) were statistically more likely to treat a greater number of patients, make fewer referrals, and treat more complex patients than the traditional fee-for-service model (Kantarevic, Kralj, and Weinkauf 2011). To reform Canadian PMHC, Dewa et al. (2001) argue that it would be more politically feasible to build on the existing fee-for-service system because the combination of guaranteed income from capitated payments, in addition to the added fee-items, subsidizes the use of
mental health specialists in private primary care practices. Thus, these blended payment models may encourage general practitioners to spend more time coordinating with providers and providing longer consultations (Dewa, Hoch, and Goering 2001).

Next, incremental reforms could expand non-physician mental health professional roles in PMHC delivery. Using the current fee schedule framework, governments could create provisions for private practice psychologists to bill the provincial government for providing psychological services (Rybarczyk et al. 2013; Verhaak, Kamsma, and Van der Niet 2013). The Australian case demonstrates this effectively, whereby psychologists may bill the government for a limited range of mental health fee items. Such a model would work in the Canadian policy context because medical profession support is required given their political influence on health policy. As such, state-funded remuneration of private practice psychologists would likely impose specific service restrictions. For example, billable services would require general practitioner referral, which ensures that the medical profession does not face direct constraints to their monopoly over PMHC organization, finance, and delivery. Additionally, the inclusion of non-physician mental health professionals also requires change to the psychologists’ scope of practice, and the creation of new laws and regulations to publicly insure private psychological services.

The Australian approach also has many significant disadvantages. First, incremental fee-schedule reforms do not address the institutionalized barriers posed by Canadian PMHC governance. As a result, the dominant PMHC policy framework path dependency remains, which means that the barriers to PMHC quality improvement may prevail despite incremental changes to the mode of remuneration. Obviously, improved
PMHC system coordination with other health care sectors may not occur if planning is restricted to the traditional silos of private practice PMHC and regionally delivered secondary and tertiary mental health services. Second, since the removal of fee items can ignite medical profession political opposition, changes to provincial fee-schedules are relatively permanent. A third challenge includes the risk associated with using financial incentives to improve PMHC because incentives may encourage gaming (i.e. taking advantage of the payment model for personal gain) or prove ineffective in improving quality if they are poorly designed. For example, Hurley et al. (2011) demonstrated that incentive payments in Ontario did not produce the anticipated improvements to primary care service quality because physicians were already providing high levels of preventative services prior to the implementation of targeted incentives (Hurley, DeCicca, and Buckley 2011).

Governments may also encounter medical profession opposition should they incrementally include non-physician mental health professionals into provincial medical service fee-schedules. In this case, the medical profession may feel pressured to protect their scope of practice and monopoly on primary care. In effect, physician opposition may prevent governments from expanding the scope of PMHC delivery. As well, the commitment to fund relatively permanent fee-schedules for private psychological services could create additional financial pressure for governments because under the current model RHAs employ a limited range of non-physician mental health professionals.

Therefore, a fee-schedule open to a wide range of providers broadens the number of providers billing for services and poses greater government financial liability. A final
disadvantage is that incremental reform assumes that provinces have a large supply of physicians and non-physician mental health professionals to deliver PMHC services. This is because the underlying mechanism of enhanced fee items and expanded access to PMHC relies on a consistent supply of providers to deliver the services and to respond to incentives. As such, in situations where the supply of mental health professionals is affected by the inability to attract, retain, and finance these professionals, the effectiveness of targeted reforms to PMHC are compromised. General practitioners, who provide a broad range of services, are most affected by provider supply because it influences the amount of time they spend with their patients. Limited time with patients may de-rail any efforts to increase consultation length and collaborative care through incentive programs.

**Revolutionary Governance Reform**

As the most complex and controversial policy option, revolutionary reform to PMHC governance and mode of physician remuneration involves significant changes to the existing PMHC policy framework. This option focuses on PMHC governance structures whereby general practitioners are salaried or capitated employees of a devolved health authority. To employ salaried physicians, the WHRA’s Share Mental Health Care Program temporarily used this approach and it provides a more extensive example of how this option could be achieved in the Canadian policy context.

Addressing the governance to improve PMHC system coordination requires a shift in the historical distribution of power in the principal-agent relationship between the state and the medical profession. This alternative involves remunerating physicians through a
system-level mode of payment, such as capitation, instead of individual modes of payment (i.e. fee-for-service). Through system-level payment, physicians would be state employees. The government could then transfer authority to RHAs for mental health and service allocation and management. Ultimately, this would shift more power to the RHAs as payer and, ideally, would stimulate greater PMHC sector and other hospital and community sector integration. In this scenario, patients would likely be rostered to a specific physician or group practice to ensure better service continuity. This reliance on rostering would require broader primary care reform, because PMHC is directly linked to the primary care governance, organization, delivery, and finance.

Accomplishing this type of reform requires addressing a number of requirements. First, the governing party must be willing to make difficult and politically risky decisions that impact the entire primary care system structure. Along these lines, hierarchical authority is required to coordinate and direct reform from a systems level. Second, given that re-structuring often incurs significant financial expense, strong economic data is required to demonstrate that this shift would be beneficial in relation to costs. Further, the RHAs would require an expanded PMHC role, and, as a consequence, need to be prepared financially and organizationally to take on expanded governance powers. As mentioned above, primary care delivery would also need to shift to a rostered model, whereby patients are assigned or registered to a specific general practitioner; this contrasts with the current way fee-for-service primary care is organized, i.e. patients may seek services from an unlimited number of general practitioners, who may or may not be consistently involved in the patient’s care. Finally, governments must be prepared to face medical profession opposition and would need to ensure that the inevitable political
compromises made to achieve this reform do not conflict with patient best interests and do not undermine the long-term reform objectives.

Despite the list requirements to reform PMHC governance, the primary advantage to this approach is reflected by the New Zealand reforms, which sought to remove key institutional barriers of traditional governance and remuneration structures. The hierarchical authority required to achieve this type of reform affords the potential for better system coordination between physician-delivered PMHC and regionally delivered mental health services. Further, the use of capitation as the primary mode of remuneration may improve continuity of care and encourage greater collaboration between general practitioners and non-physician mental health professionals. For example, capitation provides greater continuity of care since patients are attached to a specific physician, and financial incentive is built into the remuneration mode to provide more preventative services, such as depression screening and suicide risk assessments (Devlin, Sarma and Hogg 2006). Dewa et al. (2001) argues that capitated remuneration offers an opportunity to incentivize shared mental health care. In this context, capitated arrangements encourage physicians to procure psychiatric consultations or non-physician mental health services within their private primary care practices. As such, physicians are motivated to provide these services because they incur greater financial costs if patients on their roster seek services outside of their practice. However, this option requires capitated payments to be high enough to offset the costs incurred by the physician to refer patient care to an alternative practitioner such as a psychiatrist, psychologist, or nurse practitioner (Dewa, Hoch, and Goering 2001).
The New Zealand policy approach also poses severe challenges. First is the significant political risk posed by reform requirements to the entire primary health care sector (delivery, organization, finance, and governance). This may be politically unfavourable to the public and medical profession because entire system reform may impede patient choice, may be viewed as unnecessary, financial wasteful, or, in the case of the medical profession, be perceived as a direct attack on their provider monopoly.

A second disadvantage is the administrative complexity of this change and the necessary time to do so. The New Zealand case exemplifies this challenge: financing primary care services became more complex and inefficient than the traditional fee-for-service payment mode after primary care reforms implemented new modes of physician payment (Gauld 2008). As well, restructuring the system requires large up-front financial costs, while the hierarchical authority required to direct this scale of change may alienate the medical profession, impede professional innovation, or impact morale if physicians are excluded from the decision-making processes.

Capitation requires physicians to accept the financial risks of attracting less healthy or more complex patients, which may entice some physicians to favour the healthier patients into their practices (Devlin, Sarma, and Hogg 2006). As a consequence, the successful application of this PMHC model is problematic since those with mental illness are inclined to have greater co-morbidities and require more time for assessment and treatment. In one sense, the fee-for-service mode financially rewards physicians who treat more complex patients because multiple visits are required. However, the capitated model may perform poorly if it under-compensates physicians who treat patients with
more complex illnesses that are vulnerable to factors beyond the physicians’ control (Robinson 2001).

Finally, governments may not be in the best position to determine PMHC needs since they do not directly provide the treatment or directly interact with patients. In New Zealand, the governance shift actually retained physician control over the system because the provider groups mandated to provide services that were essentially pre-existing physician-controlled practices. This defeated the collaborative and community-based purposes of the reform.

Given the complexity and the economic and political risk posed by this option, it is unlikely that any Canadian jurisdiction would consider this option in the near future. The primary reason is because provincial governments are extremely reluctant to challenge the authority of the medical profession through fundamental changes to governance and remuneration. This fear has structured policy responses to favour the physician-centered PMHC sector.

Conclusion

Three policy options were presented to improve PMHC quality: non-targeted gradualist reform, highly targeted incremental reform, and revolutionary governance reform. To expand beyond the existing dominant PMHC policy framework, of these options, the targeted incremental approach is the most feasible policy option for Canadian provinces. Some reforms include adding mental health fee items to physician fee-schedules, enhancing physician education, including psychologists in the fee-schedule, and creating a province-wide collaborative PMHC practice program. Moreover, the
incremental option is feasible because it expands on the existing policy framework in targeted stages. However, to achieve this option, governments need to commit to a long-term mental health strategy that includes direct improvements to the PMHC sector. This type of commitment requires an influential political actor, such as a Premier or Minister of Health to champion the reform. While the targeted approach will not resolve all PMHC quality issues, it will provide a new institutional framework that accommodates better system coordination, inclusion of non-physician mental health professionals, and longer consultations.
7 CONCLUSIONS & FUTURE DIRECTIONS

Review of Research Objectives

A comparative analysis of provincial PMHC policy reforms demonstrated minimal movement away from the dominant PMHC policy framework; these reforms do not address the institutional barriers of PMHC governance and mode of remuneration. As a result, these barriers may inhibit the capacity to achieve greater system coordination, effective interdisciplinary collaboration, and longer, more involved consultations. However, PMHC reforms in Australia and New Zealand demonstrated feasible policy options to expand the Canadian initiatives.

This final chapter discusses the key research contributions, the methodological, informational, and conceptual limitations of the research, as well as the ways to address these limitations. Finally, the chapter provides a detailed research agenda for future development, including an outline of the next steps to improve the quality of information on physician remuneration and PMHC governance. Ultimately, improving information quality in this area will achieve greater recommendation applicability to real governmental health policy contexts.

Research Contributions and Application of Results

The thesis provides two key original research contributions. The first contribution is the use of historical institutionalism to develop a conceptual framework that depicts the dominant PMHC policy features in the Canadian health system. Currently, no other research in health systems has attempted to identify the dominant institutions and ideas of
PMHC policy structures in order to explain the implications of policy path dependency and the power dynamics on PMHC quality. The significance of this contribution is the capacity of the theoretical framework to identify the key institutional barriers (i.e., physician remuneration and PMHC governance) that prevent revolutionary PHMC sector reform. By identifying these barriers through the lens of historical institutionalism, provincial and territorial governments can develop more effective policies.

Finally, the policy lessons derived from the comparative case analysis provides a larger commentary on the Canadian primary care sector, which involves a broad continuum of services beyond mental health care. Since these services are largely dependent on mostly fee-for-service, private practice physician delivery, the organization and finance of these services are similarly influenced by dominant remuneration and governance structures. Consequently, any efforts to improve the quality of primary care services will inexorably encounter institutional resistance from the dominant PMHC policy framework.

**Research Limitations**

Policy research inevitably involves a number of limitations and tradeoffs with respect to the research methods selected and the information collected. First, the selection of the comparative case study method as the chief analytical tool to evaluate PMHC governance and physician remuneration reform to improve PMHC implies a trade off between a broader analysis of a policy problem involving multiple cases and a more detailed and in-depth analysis of a single case. Here, one limitation is the loss of some context-specific case details that may only be appropriately addressed in single-case
analyses. In addition, the comparative case method is also limited in its capacity to establish clear causal linkages between remuneration policy and PMHC quality, which occurs because of different combinations of economic, political, and social factors that are extremely difficult to isolate. This problem translates into a limited capacity to evaluate the impact of a policy on a particular health outcome or health sector. Finally, the policy lessons of the comparative case method cannot be generalized to the entire Canadian context. While the theoretical framework and comparative analysis are designed around common features of PMHC sectors in Canadian provinces, constitutional designation of provincial responsibility for health care means that PMHC policies vary across jurisdictions, thereby limiting the capacity to generalize policy conclusions.

The benchmarking method used in chapter four to evaluate PMHC governance and the mode of physician remuneration also contains limitations. First, the design of the benchmarking approach for mode and governance is oversimplified with respect to the complex reality of governance, remuneration, and PMHC policy. Furthermore, the lack of comparable pan-Canadian data on PMHC limited outcome measure development. This meant that the benchmarking approach relied on indirect measures of policy adherence. However, the policy lessons were intended to balance this restriction. A second limitation with the benchmarking approach includes the difficulty to define “best practice” for PMHC quality and remuneration policy, since the process of defining the benchmarking criteria involves both subjective interpretation and academic literature analysis.

It should also be noted that access to relevant PMHC policy information from provincial governments and comparative international jurisdictions was restricted to
articles accessed through the Internet and inter-library loans. In fact, access to policy information varied between the jurisdictions examined; for example, British Columbia, New Zealand, and Australia provided the most policy material, while Manitoba and Saskatchewan provided the least. As a result, the final collection of relevant policy documents in this thesis is likely incomplete. Additionally, the reliance on government policy documents indicates the information retrieved was subject to publishing organization biases. To address this limitation, each article was thoroughly examined for its validity, accurate representation, and additional academic sources were consulted for confirmation.

In this thesis, historical institutionalism served a critical theoretical purpose to identify and evaluate the key variables of the dominant institutional PMHC framework. This was achieved by applying the concepts of institutions, ideas, path dependency, and power dynamics to identify the framework variables and to define policy reform options. Despite the value that historical institutionalism provides, this theory also has limitations. Historical institutionalism tends to mask or de-value incremental policy change since it emphasizes policy changes through disruptive critical junctures (Peters, Pierre, and King 2005). Consequently, historical institutionalism may over-emphasize dramatic shifts in policy, rather than the potential for incremental movement or even what might be mistaken for “policy drift” to produce significantly positive policy reform over time. In addition, the path-dependency component of historical institutionalism is criticized for its inability to provide explanations for specific linkages between causal variables, or its inability to estimate the size of those linkages (Kay 2005). This means that path dependency may lack sufficient explanatory power with respect to the incremental
changes that are the primary focus of the thesis. Finally, change velocity is another important element missing from the historical institutionalism framework because change is often depicted in a mechanical manner and may not accurately represent how policy changes occur in real time.

**Future Research Agenda**

The policy lessons derived from the PMHC governance and physician remuneration reform comparative analysis represent a small piece of a much larger puzzle. Consequently, many areas for future health systems and policy research could enhance and refine the information and conclusions presented here. First, theoretical revisions to the conceptual framework could be achieved by interviewing key policy stakeholders, such as provincial governments, medical associations, regional health authorities, and individual practitioners. Actually, input from these stakeholders could strengthen the theoretical claims in the conceptual framework and refine the benchmarking policy indices criteria. Paired with the information collected from the policy document analysis, stronger conclusions and potentially new causal linkages may be achieved with respect to the impact of governance and physician remuneration on PMHC quality.

A second future research recommendation is a greater focus on the aspects of governance structures of physician remuneration in PMHC. Despite the relevance of governance in remuneration structures and their impact on successful reform, the literature in this area remains sparse. Expanding research in this area is important given that many provincial and territorial health systems have invested significant financial and
political resources to reform the primary care sector. Policy change cannot occur without enhancing the evidentiary linkages of governance to PMHC quality.

Third, it is necessary to develop a greater understanding of the overlap between the RHA, non-physician mental health professional, and physician services in PMHC and how this overlap influences PMHC and interdisciplinary care team accountability. In this context, more research is needed on the political, social and economic implications of including non-physician mental health providers into first-contact care realm. In particular, this research should provide more clarity with respect to the costs and benefits of enhancing RHA responsibility for a larger proportion of Canadian PMHC.

Finally, the policy benchmarking approach used in Chapter Four would be enhanced by creating a set of pan-Canadian outcome measures that are capable of quantitatively capturing the impact of reform on PMHC quality. To achieve this, data PMHC-level data collection is required. While there have been numerous attempts to develop a set of quality indicators to measure PMHC quality, a pan-Canadian data set is required and their resulting indicators must be more sensitive PMHC and physician remuneration policy fluctuations. This problem highlights the complexity in collecting data on PMHC because quality improvement cannot be easily isolated or reduced to a single measure.


Mulvale, Gillian, Julia Abelson, and Paula Goering. 2007. “Mental health service delivery in Ontario, Canada: How do policy legacies shape prospects for reform?” *Health*


### APPENDIX A – British Columbia

<table>
<thead>
<tr>
<th>Date</th>
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| 1998 | British Columbia Medical Services Commission - Communiqué Volume 3 Number 1  
Revitalizing and Rebalancing British Columbia’s Mental Health System: The 1998 Mental Health Plan  
The BC Early Intervention Study: Report of Findings |
| 1999 | Report on the Use of Provincial Health Goals in Regional Health Service Plans |
| 2000 | BC Medical Association: Obtaining Effective Medical Input into Regional-Decision-Making  
British Columbia’s Mental Health Reform Inpatient/Outpatient Best Practices Guidelines  
Early Psychosis: A Guide for Physicians  
Early Identification of Psychosis: A Primer  
Physician’s Newsletter, Issue 2 Volume 24 Winter 2000 |
| 2001 | A New Era for Patient-Centered Health Care: Building a Sustainable, Accountable Structure for Delivery of High-Quality Patient Services  
British Columbia Medical Association: Turning the Tide – Saving Medicare for Canadians Part II  
Physician’s Newsletter Issue 2 Volume 26 Winter 2001  
Policy and Practice – A Report on the Use of British Columbia’s Health Goals by the BC Government |
| 2002 | British Columbia Medical Association: Ensuring Excellence: Renewing British Columbia’s Primary Care System  
British Columbia Medical Association: Presentation to the Royal Commission on the Future of Health-Care in Canada: Vision for Sustaining Medicare  
British Columbia Medical Association – Regionalizing Health Care Budgets in British Columbia  
British Columbia Ministry of Health Planning 2001/2002 – Annual Service Plan Report  
British Columbia’s Provincial Depression Strategy Phase 1 Report October 2002  
Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities  
The Picture of Health: How We are Modernizing British Columbia’s Health Care System |
British Columbia Ministry of Health Services 2002/2003 – Annual Service Plan Report  
Development of a Mental Health and Addictions Information Plan for Mental Health Literacy 2003-2005 |
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| 2004 | Expanded Chronic Care Model: Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model  
Review of British Columbia Health Professions’ Quality Assurance Program |
<p>| 2007 | Physician’s Newsletter January 2007                                                             |                                                                                                    |
| 2007 | Physician’s Newsletter June 2007                                                                |                                                                                                    |
| 2007 | Planning Guidelines for Mental Health &amp; Addictions Services for Children, Youth &amp; Adults with Developmental Disability |
| 2007 | Primary Health Care Charter: A Collaborative Approach                                           |                                                                                                    |
| 2008 | Physician’s Newsletter April 2008                                                               |                                                                                                    |
| 2008 | Physician’s Newsletter November 2008                                                             |                                                                                                    |
| 2009 | General Practice Services Committee 2008-2009 Annual Report                                    |                                                                                                    |</p>
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<td>Consensus Decision of the Alternative Payments Committee</td>
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<td>Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia</td>
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<td>Investing in Prevention Improving Health and Creating Sustainability: The Provincial Health Officer’s Special Report</td>
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<td>British Columbia Medical Association: Multi-Disciplinary Primary Care</td>
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<td>Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia -- Monitoring Progress First Annual Report 2011</td>
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## APPENDIX B – Manitoba

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<td>1994</td>
<td>The Utilization of Medical Services for Mental Health Disorders, Manitoba: 1991-1992</td>
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<td>1996</td>
<td>Needs-Based Planning for Generalist Physicians</td>
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| 1997  | A Planning Framework to Promote, Preserve and Protect the Health of Manitobans  
Manitoba Health Annual Report 1996/1997  
A Needs-Based Funding Methodology for Regional Health Authorities: A Proposed Framework |
| 1999  | Achieving Accountability (Finance Health Winnipeg Community & Long Term Care Authority Winnipeg Hospital)  
Manitoba Budget Address 1999  
Manitoba Health Annual Report 1998/1999 |
| 2000  | Brandon Regional Health Authority – 2000/2001 Annual Report  
Manitoba Budget Address 2000  
Manitoba Health Annual Report 1999/2000 |
| 2001  | Brandon Regional Health Authority – 2001/2002 Annual Report  
Do Some Physician Groups See Sicker Patients than Others? Implications for Primary Care Policy in Manitoba  
Manitoba Budget Address 2001  
Manitoba Health Annual Report 2000/2001  
Winnipeg Regional Health Authority – 2001/2002 Annual Report |
| 2002  | Brandon Regional Health Authority – 2002/2003 Annual Report  
Manitoba Health Annual Report 2001/2002  
Winnipeg Regional Health Authority – 2002/2003 Annual Report |
| 2003  | An Examination of RHA Governance  
Brandon Regional Health Authority – 2003/2004 Annual Report  
Manitoba Budget Address 2003  
Manitoba Health Annual Report 2002/2003  
Winnipeg Regional Health Authority – 2003/2004 Annual Report |
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<td>Working for Better Health Care Sooner: Report to Manitobans on Health Care Services</td>
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<td>Composite Measures/Indices of Health and Health System Performance</td>
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<td>Report of the Manitoba Regional Health Authority External Review Committee</td>
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<td>Winnipeg Regional Health Authority – Aspire: Health and Wellness News for You and Your Family: Spring</td>
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| 2008 | Winnipeg Regional Health Authority – Aspire: Health and Wellness News for You and Your Family: Summer 2008  
Winnipeg Regional Health Authority – 2008/2009 Annual Report |
| 2009 | Achieving Health System Accountability 2009: Getting There Together  
Brandon Regional Health Authority – 2009 Annual Report  
Brandon Regional Health Authority – Community Health Assessment 2009  
Manitoba Budget Address 2009  
Manitoba Health and Healthy Living 2008-2009 Annual Report  
Manitoba Physicians’ Manual 2009  
Winnipeg Regional Health Authority – 2008/2009 Annual Report |
| 2010 | Brandon Regional Health Authority – 2010 Annual Report  
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Physician Integrated Network Baseline Evaluation: Linking Electronic Medical Records and Administrative Data  
Public Expectations of the Health Care System: Community Health Advisory Councils  
Winnipeg Regional Health Authority – Public Expectations of the Health Care System: Community Health Advisory Councils  
Winnipeg Regional Health Authority – 2009/2010 Annual Report |
| 2011 | Brandon Regional Health Authority – 2011 Annual Report  
Manitoba Health Annual Report 2010-2011  
Manitoba Budget Address 2011  
Rising to the Challenge: A Strategic Plan for the Mental Health and Well-Being of Manitobans 2011 |
| 2012 | Winnipeg Regional Health Authority: Shared Mental Health Care Program Evaluation Report |
## APPENDIX C - Saskatchewan

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<td>Healthier Places to Live, Work, and Play: A Population Health Promotion Strategy for Saskatchewan</td>
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Speech from the Throne 2005 |
| 2006 | 2006/2007 Saskatchewan Provincial Budget Performance Plan: Saskatchewan Health  
Medical Services Branch – Annual Statistics Report 2006/2007  
Saskatchewan Health 2006/2007 Annual Report  
Saskatchewan Health’s Primary Health Care in Saskatchewan: Moving Forward – SAHO’s Response  
SMA Agreement with the Ministry of Health  
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Speech from the Throne 2006 |
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Ministry of Health 2007/2008 Annual Report  
Speech from the Throne 2007 |
Medical Services Branch – Annual Statistics Report 2008/2009  
Ministry of Health 2008/2009 Annual Report  
Speech from the Throne 2008 |
For Patient’s Sake: Patient First Review Commissioner’s Report to the Saskatchewan Minister of Health  
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The Need for More-Effective Patient- and Family-Centered Care: Report on the Patient Experience Component of the Saskatchewan Patient First Review  
The Need for Transformation in Health Care Administration: The Administrative Component of the Saskatchewan Patient First Review |
| 2010 | 2010/2011 Saskatchewan Provincial Budget Performance Plan: Saskatchewan Health  
Medical Services Branch – Annual Statistics Report 2010/2011  
Leading Collaboration Among Providers of Primary Health Care  
Ministry of Health 2010/2011 Annual Report  
Speech from the Throne 2010 |
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Medical Services Branch – Annual Statistics Report 2011/2012  
Ministry of Health 2011/2012 Annual Report  
October 2011 Saskatchewan Ministry of Health Payment Schedule for Insured Services  
October 2011 Physician Newsletter  
Saskatchewan Ministry of Health Payment Schedule for Insured Services – April 2011  
SMA Agreement with the Saskatchewan Ministry of Health  
SMA Letter of Understanding with the Saskatchewan Ministry of Health |
| 2012 | April 2012 Physician Newsletter  
April 2012 Saskatchewan Ministry of Health Payment Schedule for Insured Services  
Family Physician Comprehensive Care Program – Program Details  
October 2012 Physician Newsletter  
October 2012 Saskatchewan Ministry of Health Payment Schedule for Insured Services  
Patient Centered, Community Designed, and Team Delivered: A Framework for Achieving a High-Performing Primary Health Care System in Saskatchewan  
Saskatchewan Ministry of Health Policy on Physician Visits |