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A DISCOURSE ANALYSIS OF ONTARIO'S FAMILY HEALTH TEAMS

by

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DISSERTATION

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Abstract

Inspired by critical social work practice, this study engages in a discourse analysis of Ontario's Family Health Team (FHT) model. The purpose for this study is threefold; namely, a) to deepen our understanding of health discourses promoted by Ontario's FHT model; b) to explore how Ontario's FHT model compares to Haggerty, Burge, Lévesque, Gass, Pineault, Beaulieu, & Santor's (2007) conceptual model of PHC; and c) to promote critical reflection in order to help inform decisions on how to improve quality of care and enhance health equity in FHTs. This study is guided using the overarching question: What health care practices and organizational structures are encouraged by the FHT model?

Discourse analysis guides the investigation using Gee's (2001a) combination of saying, doing, and being. Two data sources inform this study: MOHLTC documents and in-depth interviews with seven policy informants and twenty-nine FHT leaders. Two key findings are presented in this dissertation: foundational PHC attributes shaping FHTs and inadequate performance indicators. Foundational PHC attributes examines and describes the four key PHC attributes that underpin the FHT model. These include: first-contact accessibility, accommodation accessibility, comprehensiveness of services, and interdisciplinary team. The second key finding is inadequate performance indicators and reveals that measures being used to evaluate FHT success are posing challenges to FHT health care practices, FHT structures, and health outcomes. This study demonstrates that performance indicators are inadequate because they are: a) valuing quantity; b) volume is influencing health care practices in FHTs; c) inaccurate measurement is shaping FHT organizations, and d) the volume emphasis is encouraging acuity in health outcomes.

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Table of Contents

Abstract.....	i
Acknowledgements.....	ii
List of Tables.....	x
List of Figures.....	xi
Glossary.....	xii
Chapter 1 – Background to Study.....	1
Statement of Purpose and Significance.....	6
Conclusion.....	8
Chapter 2 – Literature Review.....	11
Primary Health Care.....	12
PHC Models.....	15
Conceptual Model: Attributes of PHC.....	18
Clinical Practice Attributes.....	18
Structural Dimensions.....	19
Person-Oriented Dimensions.....	20
Community-Oriented Dimensions.....	21
System Performance.....	22
Equity in Health.....	23
Health Discourses.....	30
Health Discourses Shaping PHC.....	32

Biomedical Discourse.....	33
Informing PHC.....	35
Equity in Health.....	35
Biopsychosocial Discourse.....	39
Informing PHC.....	40
Equity in Health.....	42
Health Promotion Discourse.....	45
Informing PHC.....	47
Equity in Health.....	50
Social Determinants of Health Discourse.....	52
Informing PHC.....	55
Equity in Health.....	57
Holism Discourse.....	59
Informing PHC.....	62
Equity in Health.....	64
Political Economy Discourse.....	66
Informing PHC.....	69
Equity in Health.....	70
Conclusion	74
Chapter 3 – Methodology.....	75
Purpose.....	75

Research Design.....	75
Research Questions.....	75
Discourse Analysis.....	77
Introduction.....	77
Saying, Doing, Being.....	78
Context.....	79
Descriptive – Critical.....	80
Appropriateness of Discourse Analysis for this Research.....	81
Sampling.....	83
MOHLTC Documents.....	84
In-Depth Qualitative Interviews.....	84
Policy Informants.....	85
FHT Leaders.....	86
Combined Sample.....	89
Data Collection.....	90
Data Analysis.....	91
Research Ethics.....	93
Limitations and Contributions.....	94
Conclusions.....	96
Chapter 4 – Context of Ontario’s FHTs.....	98
Background.....	98
1995-2003: Harris Conservative Government.....	102

Family Health Networks (FHNs).....	105
Ontario Family Health Network Agency.....	107
Primary Health Care Transition Fund.....	107
Family Health Groups (FHGs).....	109
2002 – 2003: Harris to McGuinty – Anticipating a Change.....	109
2003 – 2011: McGuinty Liberal Government	111
Emergence of FHTs.....	111
FHTs: A Political Priority Project.....	112
FHT Funding.....	113
Changing Leadership within the MOHLTC (Approx. 2007 – 2010).....	114
Federal Funding: Health Accord (2004 – 2014).....	115
Changing Economic Times.....	116
Political Influence.....	117
Conclusion.....	118
Chapter 5 – Findings.....	119
Organization of Finding.....	119
Discourse Analysis.....	119
PHC Framework.....	119
Deciding on the Salient Findings.....	123
Foundational PHC Attributes of FHT Model.....	124
First-Contact Accessibility.....	125
Saying: Valuing Congruency.....	125

Doing: Patient Enrolment.....	126
Being: Emphasizing Physicians.....	127
Accommodation Accessibility.....	130
Saying: Valuing Congruency.....	130
Doing: Advanced Access.....	130
Being: Emphasizing Physicians.....	133
Comprehensiveness of Services.....	134
Saying: Valuing Congruency.....	134
Doing: Encouraging Prevention.....	135
Being: Emphasizing Physicians.....	138
Interdisciplinary Team.....	139
Saying: Valuing Congruency	139
Doing: Teamwork Being New.....	140
Being: “The Right Fit for the FHT”	143
Being: Visionaries Making it Work.....	146
Summary.....	148
Inadequate Indicators.....	151
Saying: Valuing Quantity.....	151
Doing: Volume Influencing Practice.....	155
Being: Inaccurate Measurement Shaping FHTs.....	160
Health Outcomes: Volume Emphasis Encouraging Acuity.....	163
Summary.....	165

Conclusion.....	166
Chapter 6 – Discussion and Recommendations.....	168
Health Discourses.....	171
Health Discourses and PHC.....	172
Health Discourse and FHTs.....	173
Summary.....	176
Equity in Health.....	177
Congruency with Equity in Health.....	178
Incongruency with Equity in Health.....	178
Strengthening Congruency with Equity in Health.....	181
Summary.....	182
Contextual Factors.....	183
Recommendations.....	185
Policy and Decision Makers.....	185
FHT Leaders.....	186
Educators.....	187
Researchers.....	187
Relevance to Social Work.....	188
Conclusion.....	189
Appendices.....	191
Appendix A – MOHLTC Documents Included in Study.....	191

Appendix B – Study Sample.....	192
Appendix C – Letter of Invitation to Policy Informants.....	194
Appendix D – Letter of Invitation to FHT Leaders.....	195
Appendix E – Interview Guide for Policy Informants.....	196
Appendix F – Interview Guide for FHT Leaders.....	197
Appendix G – Consent Form for In-Person Interviews.....	198
Appendix H – Consent Form for Telephone Interviews.....	199
Appendix I – Definitions of PHC Attributes (Haggerty et al., 2007, p. 340).....	200
References.....	202

List of Tables

Table 2.1: Summary of Six Influential Health Discourses.....	32
Table 3.1: Discourse Analysis: Key Attributes Guiding Study.....	80
Table 3.2: Sample Overview.....	90
Table 5.1: PHC Attributes Emerging in Data According to Level of Discourses and Across Data Sources.....	122
Table 5.2: Foundational PHC Attributes of FHT Model.....	125

List of Figures

Figure 3.1: Discourses Informed from a Combination of Saying, Doing, Being..... 79

Glossary

Discourse: A “dance” that exists in the abstract as a coordinated pattern of words, deeds, values, beliefs, symbols, tools, objects, times, and places” (Gee, 2011a, p. 36).

Discourse Analysis: Is a qualitative methodology useful to investigate meaning in interactions between and across people and systems (Shaw & Bailey, 2009); meaning emerges from the combination of saying (informing), doing (action), and being (identity).

Equity in Health: Refers to fairness and inclusion; a right to health for all in the pursuit of physical, emotional, mental, and spiritual wellbeing (Wallace, 2008).

Family Health Teams (FHTs): An interdisciplinary model of primary health care initiated in Ontario in 2005.

Health Policy: “A course of action or inaction chosen by public authorities to address an issue that deals with human health” (Westhues, 2006, p. 8).

Health Practice: Health care delivery by any number of health professionals such as (but not exclusive to): social work, physicians, nurses, pharmacists, mental health therapists, occupational therapists, and physiotherapists.

Primary Care (PC): Typically refers to the “diagnosis, treatment and management of health problems, with services delivered by physicians” (Cook & Kachala, 2004, p. 7); although, primary care may be administered by a health professional other than physicians such as nurse practitioners.

Primary Health Care (PHC): “Incorporates primary care, but also recognizes and addresses the broader determinants of health including population health, sickness prevention and health promotion, with services provided by physicians and other professionals in partnership and often in multidisciplinary teams” (Cook & Kachala, 2004, p. 7).

Chapter 1 – Background to Study

This dissertation is informed, guided, and inspired by social work practice, knowledge, and values. The ideas and inspiration leading to this study began while I was in direct social work practice health care. I have had the opportunity to work in various sectors of the health care system including: an HIV-focused health clinic, several grassroots community health agencies, a residential mental health setting, and a tertiary care hospital. These experiences provided me with a broad understanding of the scope of the health care system, the complexities influencing health care practices, and the commitment that so many health care professionals have in caring for others.

It was during my ten years as a social worker in Winnipeg's inner-city tertiary care hospital that I began to think deeply about the ideas that stimulated this study. My social work lens led me to examine the various external forces that were shaping my practice and the health care experiences of the individuals and families I worked with. I began to think about the assumptions within the health care system that assisted and challenged me in my social work practice. At first, I began to think of ways that health care practices and the structures in my immediate practice setting might be changed to better meet the diverse health needs of the individuals and families with whom we as a health care team worked. I saw how I was able to influence positive change in my immediate work environment and have a transformative impact even within a medical setting. It was also during this time that I began to think of ways that the health care system might be able to better meet people's health needs, and how I might be able to influence that on a larger scale.

During this same time period, primary health care (PHC) was gaining increased national attention. PHC initiatives were emerging and as a result, I began to think about what this might mean for the Health care system in terms of underlying assumptions. I wondered if this might make health care become more person-centered and perhaps even more inclusive of the socio-environmental and economic factors interconnected to the reasons why people sought health care. However, I knew from my own practice experience that health care is informed by diverse opinions, assumptions, beliefs, and at times, competing interests. I anticipated that PHC reform would be challenging because of this. It is a culmination of these experiences and ideas that led to my interest in exploring PHC. I moved from Manitoba to Ontario to pursue my doctoral studies with a budding interest in PHC. At the same time, Family Health Teams (FHTs) had emerged and were gaining significant public attention as Ontario's new model of PHC. This intersection guided my curiosity and interests toward the FHT model and resulted with the development of this study.

One of the main reasons that I chose to conduct this study is to deepen our understanding of the FHT model. My use of the word "deepen" is inspired by Blommaert's (2005) description of "deep structure" which suggests that "true meaning" can be obtained by examining the core components of a structure. Although meaning is developed in a variety of different ways besides "deep structure" – for example, through interactions – this study considers an investigation into the "deep structure" of the FHT model an important endeavor. Blommaert's (2005) message inspires this investigation to examine core assumptions and attributes of PHC in an attempt to gain an understanding

of meanings promoted by the FHT model. In this study the word “deepen” refers to the examination of core assumptions and attributes in hopes to get closer to a “true meaning”. As well, this study is largely inspired by critical social work practice and has used the lens of critical reflection provided by critical social work practice and applied it to Ontario’s FHT model.

What I suspected when I embarked on this study was that the implementation of the FHT model has likely been challenging for policy and decision-makers, health care practitioners, and leaders of FHTs. The reason for this is because PHC is informed by beliefs and assumptions that are different from other parts of the health care system. I suspected that PHC likely draws upon diverse assumptions (or health discourses) in order to be able to be inclusive of health care practices that address a broad scope of individual, population, and community health needs. I also suspected that by bringing different perspectives together in the form of interdisciplinary teams, this meant that diverse assumptions and different beliefs about health and health care practices were being introduced to an area of the health care system in a way that it hadn’t been before. By undertaking this study, one of my aims has been to help illustrate some of the assumptions that guide PHC in the hopes that this will better prepare policy and decision makers, health care practitioners, and FHT leaders for diverse ways of thinking about health. By doing so, this study hopes to contribute to future decisions about the FHT model so that there is greater inclusion of health care practices and organizational structures that support quality care and greater health equity.

This study is developed to answer the following overarching question: What health care practices and organizational structures are encouraged by the FHT model? Guided

by discourse analysis, four more specific questions are addressed, namely: a) What contextual factors are influential in shaping the FHT model?; b) What are the health discourses informing the FHT model?; c) How does the FHT model compare to Haggerty, Burge, Lévesque, Gass, Pineault, Beaulieu, & Santor's (2007) framework of PHC?; and d) How does the FHT model compare with Wallace's (2008) model of equity in health? This study is timely and adds to the body of PHC knowledge during a period of increasing attention being directed towards PHC.

There has been a trend involving a shift from solo-physician-based primary care (PC) towards greater inclusion of interdisciplinary teams within PHC. Cook and Kachala (2004) help to make the distinction between PC and PHC:

Primary care typically includes the diagnosis, treatment and management of health problems, with services delivered by physicians. Primary health care incorporates primary care, but also recognizes and addresses the broader determinants of health including population health, sickness prevention and health promotion, with services provided by physicians and other professionals in partnership and often in multi-disciplinary teams.

(p. 7)

Based on Cook and Kachala's (2004) description, PHC is inclusive of PC but broadens inclusion of additional attributes that shape health care processes and structures.

Frankish, Moulton, Rootman, Cole, and Gray (2006) describe how PHC is informed by a

complex and sophisticated philosophy intended to improve individual and population health outcomes; some of these benefits have been demonstrated (Starfield & Shi, 2007; Starfield, Shi, & Macinko, 2005). Starfield (2004) – a long-time advocate of PC and PHC – sees PHC as a locus for health care that can aid in addressing the intersections of social, economic, psychological, and biological factors that shape health outcomes, also areas of importance to social work. However, there is no one model of PHC. Diversity between PHC models can emerge given that there is no universal framework guiding the implementation of PHC models in Canada (McPherson, Kothari, & Sibbald, 2010). Furthermore, even though PHC models are intended to be shaped with core values, goals, and health care processes such as described by Cook and Kachala (2004), the form a PHC model may be influenced by external interests such as broader policy decisions (Hutchison, Abelson, & Lavis, 2001).

A PHC model may be grounded with goals and priorities of how health care is to be delivered; however, competing interests from the broader political, policy, and health care environment may impact what materializes in PHC practices and structures. For example, Hutchison et al. (2001) describe how policy documents may suggest a desire to shift PC models to PHC models by promoting inclusion of broader service integration, prevention services, health promotion, and interdisciplinary teams. However, attaining these goals set out in policy documents have been challenging because “these objectives have largely been derivative of the overriding goals of cost control and access. At best, quality of care has played third fiddle” (p. 119-120). Along with these competing interests, another reason that the implementation of PHC models is challenging is because its complex philosophy described by Frankish et al. (2006) is unlike the philosophy

informing other health care systems that are currently in place (Romanow, 2002; WHO, 2008).

The implementation of new PHC models grounded in a philosophy unlike other areas of the health care system is challenging. For example, Romanow (2002) states, “Primary health care goes against the grain. It goes against entrenched practices in the prevailing culture of our health care system” (Romanow, 2002, p. 119). Furthermore, the WHO (2008) states, “health systems do not spontaneously gravitate towards PHC values” (p. 11). Thus, greater inclusion of PHC models in the health care system is more than just adding new health care practices and structures. PHC is informed by values and a complex philosophy that differs from the dominant health care system.

As health care systems shift from PC to PHC, one of the impediments to implementation of PHC in Canada is that “Primary care reform proposals have typically addressed issues of managerial effectiveness and efficiency rather than core social values” (Hutchison et al., 2001, p. 126). Hutchison et al. (2001) and Romanow (2002) suggest the importance of undertaking an examination of foundational assumptions underpinning PHC in order to facilitate PHC implementation. This study contributes to the larger conversation about PHC by examining some of these competing interests that may influence the shape of a PHC model.

Statement of Purpose and Significance

This study helps to identify the health care practices and organizational structures that are promoted by the FHT model. There are three purposes for conducting this study. First, this study aims to deepen our understanding of health discourses promoted by Ontario’s FHT model. A second purpose of this study is to explore how Ontario’s FHT

model compares to Haggerty et al.'s (2007) conceptual model of PHC. A third purpose of this study is to promote critical reflection in order to help inform decisions on how to improve quality of care and enhance health equity in FHTs. In this study, when I refer to FHTs, I am referring to the entire organization comprised of both the physician group and interdisciplinary health providers.

With Ontario's FHTs being a recently implemented model, this study is timely. Considering Bell's (2010) statement that tells us that "policies are rarely fully formed when implemented" (p.10), it is worthwhile to undertake this study given that the FHT model is still in its infancy. Two salient findings are presented in this study. First, this study provides knowledge on the foundational PHC attributes being promoted by the FHT model and how they are influencing health care practices and organizational structures. Second, the study provides evidence that performance indicators being used to evaluate FHT success are presenting challenges to health care practices, organizational structures, and health outcomes. Thus, the study provides knowledge for policy and decision makers that can be used to evaluate the strengths and challenges of the FHT model. As well, it provides knowledge about areas of concerns that can be used policy and decision makers to make changes to the FHT model.

This research also provides knowledge useful for operationalized FHTs. During the course of the study and as I travelled and spoke with FHT leaders from across Ontario, FHT leaders were curious about the successes and challenges of their FHT counterparts. This question was asked of me frequently. FHT leaders spoke about the busy process of developing a new FHT, and of wanting to know more about some of the challenges that

their counterparts were experiencing because of the FHT model. This study responds in part by providing FHT leaders with knowledge gained from a collective FHT experience.

Conclusion

This chapter described the rationale leading up to the study and illustrated how this study is informed, guided, and inspired by social work practice, knowledge, and values. It highlighted three purposes of the study, namely: a) to deepen our understanding of health discourses promoted by Ontario's FHT model; b) to explore how Ontario's FHT model compares to Haggerty et al.'s (2007) conceptual model of PHC; and c) to promote critical reflection in order to help inform decisions on how to improve quality of care and enhance health equity in FHTs. This chapter described how the aim of this study is to answer the overarching question: What health care practices and organizational structures are encouraged by the FHT model? This chapter also described how the overarching question will be answered in four key ways, namely: a) identifying contextual factors that are influential in shaping the FHT model; b) examining influential health discourses informing the FHT model; c) comparing the FHT model with Haggerty et al.'s (2007) model of PHC; and d) applying Wallace's (2008) model of equity in health to help illustrate ways that the FHT model can achieve greater health equity. Further, this chapter provided an introduction as to why a study examining the conceptual underpinnings of Ontario's FHTs is important. This dissertation is organized as follows:

Chapter 2 – Literature review provides an overview of PHC, examples of various PHC models, and an examination of Haggerty et al.'s (2007) conceptual model of PHC. Wallace's (2008) model of equity in health is presented because equity is an important

value underpinning PHC; and improving equity in health outcomes is important to PHC. The literature review explores the six health discourses that appear to inform Haggerty et al.'s (2007) conceptual model of PHC: biomedical, biopsychosocial, social determinants of health (SDOH), health promotion, holism, and political economy. Haggerty et al.'s (2007) model of PHC and Wallace's (2007) model of equity in health are then applied to the six health discourses. Applying Haggerty et al. (2007) to health discourses will demonstrate that a broad scope of health discourses inform PHC. Also, applying Wallace's (2008) model to health discourses will demonstrate ways that PHC can strive for greater equity in health.

Chapter 3 – The methodology used to examine the Ontario FHT model is explained. This chapter begins by providing an overview of this study's purposes, and exploratory design. The chapter also provides an overview of discourse analysis and how discourse analysis was used to guide the research by way of an examination of meanings that emerge from a combination of saying (informing), doing (action), and being (identity). Further, the importance of context in shaping this approach to discourse analysis is reviewed. This chapter also provides an overview of the study sample, data collection methods, the five phases of data analysis. Lastly, ethical considerations are reviewed, followed by limitations and contributions of this study.

Chapter 4 – This chapter highlights key historical, economic, and political factors that have been influential in shaping the FHT model. Findings are presented from the research data: Ontario Ministry of Health and Long-Term Care (MOHLTC) documents,

interviews with policy informants, and interviews with FHT leaders. This chapter also draws upon the literature to provide a comprehensive overview of relevant contextual factors influencing the FHT model.

Chapter 5 – An analysis of Ontario’s FHT model is presented in this chapter. Organization and presentation of research findings were aided by the use of a discourse analysis framework inspired by Gee (2011a, 2011b) and Haggerty et al.’s (2007) model of PHC. The two most salient findings are explored.. First, four foundational PHC attributes shaping FHTs are elaborated, 1: first-contact accessibility, accommodation accessibility, comprehensiveness of services, and interdisciplinary team. Inadequate performance indicators is the second salient finding that is explored, and this section presents evidence demonstrating that the MOHLTC is using indicators that lead practitioners to focus on quantity of service rather than quality or equity of access. .

Chapter 6 – This chapter discusses the findings, provides recommendations for policy and decision makers, FHT leaders, pedagogy, and researchers. It concludes with a discussion of the implications of this research for social work practice.

Chapter 2 – Literature Review

A comprehensive review of the literature was conducted prior to the start of the study, and then additional terms were searched during the process of the study. Key words used in the searches included: primary care, primary health care, primary care models, health discourses, epistemology, biomedicine, biopsychosocial, health promotion, holism, political economy, equity, health equity, and health inequities. The purpose of this review was to identify what the literature said about health discourses and equity in relation to PHC. The data bases searched were Scholars Portal, Medline, PsychINFO, and Sociological Abstracts. A search was also conducted of multiple universities' book stacks by perusing the sections that contained books related to the keywords searched..

This chapter helps to provide a foundational understanding of PHC and the assumptions that guide health care practices and organizational structures. The literature review is organized first, by providing an overview of PHC and PHC models, and presents Haggerty et al.'s (2007) model as an example of one conceptual framework that demonstrates the scope of attributes included in PHC. Wallace's (2008) model of equity in health is examined for two main reasons, namely, because equity is a core value that guides the practice of both PHC and social work. Wallace's (2008) model helps to explore ways that greater equity in health can be achieved. Lastly, Haggerty et al.'s (2007) and Wallace's (2008) models are applied to six discourses that shape PHC. This chapter aims to explore which are evident in Haggerty et al.'s ideal model of PHC. By deepening our understanding of health discourses in PHC, and examining ways that PHC

may be able to promote greater equity in health, this chapter hopes to foster a critical reflection that will be used to guide decisions about health care practices and organizational structures in PHC.

Primary Health Care

PHC is a conceptual model that includes both beliefs and processes that shape how health care is structured (Thomas-MacLean, Tarlier, Fortin, Ackroyd-Stolarz, & Stewart, 2008). Although PC and PHC are concepts that are sometimes used interchangeably, they are characterized differently. Starfield (1998) defines PC as the “level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon...conditions, and co-ordinates or integrates care provided elsewhere by others” (p. 8-9).

There appears to be agreement that PC refers typically to family physician services – or another medical provider such as a nurse practitioner – whereby care is delivered to individuals (Aggarwal, 2009; JAMA, n.d.; Marriot & Mable, 2000). PHC is considered to be a broader concept that takes a more expansive population view of health and services that often includes interdisciplinary team care (Aggarwal, 2009; Marriot & Mable, 2000). According to the National Forum of Health (1988), PHC refers to “The care provided at the first level of contact with the health care system, the point at which health services are mobilized and coordinated to promote health, prevent illness, care for common illness, and manage health problems” (p. 22). Frankish et al. (2006) describe how this definition of PHC “includes a focus on a primary (medical) care model, usually

provided by family physicians, *and* a broader concept that encompasses a range of health/social services provided through multidisciplinary teams” (p. 173).

Although both PC and PHC share the philosophical underpinnings of equity and justice (Aggarwal, 2009; Ramsden, McKay, & Crowe, 2011), PC focuses on treatment whereas PHC broadens its approach to include health promotion and prevention along with treatment. Frankish et al. (2006) describe how the shift from PC solo practice models to PHC means shifting to team based models of care. Ramsden et al. (2011) take an even broader view and state that a key difference between PC and PHC is “that primary health care involves the community in all the various aspects of health and its subsequent action” (Ramsden et al., 2011, p. 33) along with interprofessional approaches to care. Health Canada (n.d.) agrees, stating that “[PHC] refers to an approach to health and a spectrum of services beyond the traditional health care system” (n.p.). Some of the PHC providers suggested by Frankish et al. (2006) include: “chiropractors, dentists, dieticians, family physicians, health educators, midwives, nurses, nurse practitioners, optometrists, pharmacists, physiotherapists, psychologists, and social workers” (p. 173).

Although there are slight variations in defining PHC, there are four main features, namely: “first-contact access for each new need; long-term person-(not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere” (Starfield et al., 2005, p. 458). Aggarwal (2009) agrees that the common features of PHC include: “first-contact care, accessibility, comprehensiveness and coordination of care” (p.16). According to Thomas-MacLean et al. (2008), the main cornerstones of a PHC model are “access, equity, essentiality, appropriate technology, multisectoral collaboration, and community participation and empowerment” (p. 1).

Similarly, the WHO (2008) describe key features of PHC as “person-centredness, comprehensiveness and integration... continuity of care, with a regular point of entry into the health system, so that it becomes possible to build an enduring relationship of trust between people and their health-care providers” (p. 42). According to the WHO (2008), these features are “essential in ensuring improved health and social outcomes” (p. 41). Aggarwal (2009) also describes PHC as “an integral part of the overall social and economic development of the country;...it brings care closer to where people live and work; its services are organized and adapted to the needs of a population;...[and] it involves teamwork and interdisciplinary collaboration” (p. 17).

How PHC is understood has evolved over time. The first use of the term *primary care* is believed to “date back to about 1920, when the Dawson Report was released in the United Kingdom” (Starfield et al., 2005, p. 457). Starfield et al. (2005) state that this report was the first that talked about PC centers, which eventually became the core of the United Kingdom’s regionalized health services. In the United States, it was in the 1960s and 1970s that PC was included in medical curricula to prepare generalist physicians for practice, reflecting that physicians were the historical pillar of PC (Donaldson, Yordy, Lohr, & Vanselow, 1996; Starfield et al., 2005). In 1978, the Declaration of Alma-Ata was adopted, the first international declaration highlighting the importance of PHC and equity for individual and collective health (Lawn, Rohde, Rifkin, Were, Paul, & Chopra, 2008).

With the Alma-Ata, the WHO cemented the importance of PHC and broadened a focus from health services to the larger context of “the relationship between health and social and economic development” (Bhatia & Rifkin, 2010, p. 1). , Romanow (2002)

emphasized the importance of a PHC model in Canada and suggested that PHC is informed by beliefs and processes that differ from the acute care philosophy that largely underpins Canadian health care. Ramsden et al. (2011) agree with Romanow (2002) when they describe how PHC takes “away the almost overwhelming focus on hospitals and medical treatments, breaking down the barriers that too frequently exist between health care provided, and putting the focus on consistent efforts to prevent illness and injury and improve[d] health” (Ramsden et al., 2011, p. 34). The implementation of PHC is challenging for the healthcare system because of differing assumptions and health care practices (Romanow, 2002). Health Canada (n.d.) agrees that the beliefs and processes of PHC are unique within the health care system: “Primary health care refers to an approach to health and a spectrum of services beyond the traditional health care system” (Health Canada, n.d.). As a result PHC “is situated within shifting paradigms [or discourses] of health and illness, particularly in Canada” (Thomas-MacLean et al., 2008, p. 2).

PHC Models

A variety of PHC models exist and based on an extensive review of the literature, Cook and Kachala (2004) suggested that diverse models are required in order to meet pluralistic community and provider preferences. Cook and Kachala (2004) provide an overview of different PHC models. First, they describe professional models of care which are designed “to deliver medical services to patients who seek these services” (p. 18). Key characteristics of the professional models of PHC include: physicians are the main providers of care; care is mainly preventative, diagnostic, or curative; physicians hold responsibility and do not report to a regional or local entity; there is no community involvement; and funding is linked to physician compensation (Cook & Kachala, 2004).

According to Cook and Kachala (2004), walk-in medical clinics are the dominant professional model in Canada. However, the University of Ottawa (2011) suggests that the walk-in model is neither PC nor PHC because it does not meet the basic criteria of PHC in that “they do not offer continuity of care; they are not comprehensive or family-oriented” (n.p). A less prominent professional model is the health service organizations (HSOs) that can be found in Ontario, England, Denmark, Netherlands, and the United States (Cook & Kachala, 2004).

Community PHC models are intended to meet population health care needs and include a variety of medical, health, social, and community services delivered by a team of health professionals; the community approach may be integrated or non-integrated with other aspects of the health care system (Cook & Kachala, 2004). According to Cook and Kachala (2004), PHC centers in Canada vary from province to province. Further, Cook and Kachala (2004) describe how PHC models may be top-down government directed, or PHC models may be locally designed.

In Ontario, CHCs are an interdisciplinary model that includes physicians, nurse practitioners, social workers and other health professionals (University of Ottawa, 2011). Hutchison et al. (2001) describe how Ontario’s CHCs are community-governed, globally funded organizations, with salaried physicians. The aim of CHCs is to improve health care access for socially disadvantaged and vulnerable populations (Hutchison et al., 2001). CHCs increased in numbers between 1987 and 1992, going from eleven to forty-nine during that time period. However, additional program growth slowed dramatically since then (Hutchison et al., 2001). Currently, 101 CHCs exist in Ontario (MOHLTC,

n.d.). At time of Hutchison's (2001) publication, 56 CHCs were providing PHC to approximately 2 percent of the Ontario population (Hutchison et al., 2001).

In Ontario the scope of professional and community PHC models include: walk-in clinics, Family Health Networks (FHNs), Family Health Groups (FHGs), Health Service Organizations (HSOs), CHCs, and FHTs (Canadian Institute for Health Information, 2003; Cook & Kachala, 2004; University of Ottawa, 2011). FHNs refer to "groups of family physicians who work together with other health professionals to coordinate patient care and also to provide a better work environment for themselves" (University of Ottawa, 2011). McPherson et al. (2010) provide a distinction between Ontario's different types of PHC models and state that PHC reform in Ontario began in the 1970s with the introduction of CHCs and HSOs. They explain:

FHNs, FHGs, FHTs and FHOs were established in the early and mid-2000s. As of January 2010, 34% of the Ontario population was enrolled with a FHN or FHO (capitation-based models) and 32% was enrolled in a FHG (fee-for-service-based model). CHCs serve 3% of the population...while FHTs (an interdisciplinary model, most of whose physicians are remunerated through a FHN or FHO payment model) serve 16%. There are several notable differences among these models, including physician payment schemes, composition and degree of multidisciplinary within the team, and priorities, such as populations served and according to which principles. (p. 7)

Although there may be some difference among PHC models, the examination of key attributes assist to provide a deeper understanding of PHC.

Conceptual Model: Attributes of PHC

Although various conceptual models of health care and PHC exist (Aday, 2001; Donabedian, 1966; Hogg, Rowan, Russell, Geneau, & Muldoon, 2008; Lamarche, Beaulieu, Pineault, Contandriopoulos, Denis, & Haggerty, 2003; Starfield, 1992; Watson, Broemeling, & Wong, 2009), Haggerty et al.'s (2007) comprehensive model will be explored in order to identify attributes that are informing PHC. This model was generated using a Delphi process with 26 Canadian PHC experts (Haggerty et al., 2007). The model identifies, defines, and organizes twenty-five attributes of PHC into five categories: clinical practice attributes, structural dimensions, person-oriented dimensions, community-oriented dimensions, and system performance (Appendix A).

Clinical practice attributes.

Clinical practice attributes include: first-contact accessibility, accommodation accessibility, comprehensiveness of services, informational continuity, management continuity, and technical quality of clinical care. First-contact accessibility refers to “the ease with which a person can obtain needed care (including advice and support) from the practitioner of choice within a time frame appropriate to the urgency of the problem” (Haggerty et al., 2007, p. 340). Also informing clinical practice attributes is accommodation accessibility which refers to how resources within PHC are organized to facilitate contact with health care providers and services (Haggerty et al., 2007).

Comprehensiveness of services also informs clinical practice attributes and refers to direct and indirect provision of services including: health promotion, prevention, diagnosis and treatment of common conditions, referral to other clinicians, management of chronic conditions, rehabilitation, palliative care and, in some models, social services” (Haggerty et al., 2007, p. 340). Informational continuity is the fourth attribute informing clinical practice attributes and refers to the degree that information about past care informs current care (Haggerty et al., 2007). Management continuity is another attribute informing clinical practice attributes and refers to “the delivery of services by different clinicians in a timely and complementary manner such that care is connected and coherent” (p. 340). Technical quality of care is another clinical practice attribute and refers to the degree to which clinical procedures reflect current research evidence and/or meet commonly accepted standards for technical content or skill.

Structural dimensions.

Structural dimension attributes include: clinical information management, multidisciplinary team, quality improvement process, and system integration. Clinical information management refers to the inclusion of methods and systems “to capture, update, retrieve, and monitor patient data in a timely, pertinent, and confidential manner” (p. 340). Multidisciplinary team is also an attribute informing structural dimensions of PHC that refers to the inclusion of a variety of health practitioners to provide collaborative team care (Haggerty et al., 2007). Quality improvement process is the third structural dimension attribute and refers to “the institutionalization of policies and procedures that provide feedback about structures and practices and that lead to improvements in clinical quality of care and provide assurance of safety” (p. 340).

System integration is the fourth structural dimensions attribute and is defined as “the extent to which the health care unit organization has established and maintains linkages with other parts of the health care and social service system to facilitate transfer of care and coordinate concurrent care between different health care organization” (Haggerty et al., 2007, p. 340).

Person-oriented dimensions.

Person-oriented dimensions of Haggerty et al.’s (2007) model of PHC include: advocacy, relational continuity, cultural sensitivity, family-centered care, interpersonal communication, respectfulness, and whole-person care. Advocacy is “the extent to which clinicians represent the best interests of individual patients and patient groups in matters of health (including broad determinants) and health care” (Haggerty et al., 2007, p. 340). Relational continuity is another person-oriented dimensions attribute and refers to the inclusion of a therapeutic relationship between one or more clinicians and a patient, spanning over multiple health events and resulting with the accumulation of knowledge used to inform care consistent with a person’s needs (Haggerty et al., 2007).

Cultural sensitivity is another attribute of person-oriented dimensions and refers to “the extent that to which a clinician integrates cultural considerations into communication, assessment, diagnosis, and treatment planning” (Haggerty et al., 2007, p. 340). Family-centered care is the fourth attribute shaping person-oriented dimensions and encourages the clinician to consider the family and understand its influence on health. Further, family-centered care also encourages clinicians to partner with a person’s family in the provision of health care. Interpersonal communication is another attribute of person-centered care and refers to “the ability of the clinician to elicit and

understand patient concerns, explain health care issues, and engage in shared decision making” (Haggerty et al., 2007, p. 340).

Respectfulness is the sixth attribute informing person-oriented dimensions and makes reference to the extent that health care providers meet the expectations about interpersonal engagement, demonstrate respect, dignity, and adequate privacy (Haggerty et al., 2007). Whole-person care is the last attribute informing person-oriented dimensions and refers to “the extent to which a clinician elicits and considers the physical, emotional, and social aspects of a patient’s health and considers the community context in their care” (p. 340).

Community-oriented dimensions.

Community-oriented dimensions include: client/community participation, equity, intersectoral team, and population orientation. Client/community participation informs community-oriented dimensions of primary health care and refers to “the involvement of clients and community members in decisions regarding the structure of the practice and services provided” (Haggerty et al., 2007, p. 340). This may take the form of advisory committees or governance structures for example (Haggerty et al., 2007). Equity informs community-oriented dimensions by attending to “the extent to which access to health care and quality services are provided on the basis of health needs, without systematic differences on the basis of individual or social characteristics” (Haggerty et al., 2007, p. 340). The third attribute informing community-oriented dimensions is intersectoral team and refers to the collaboration between primary health care practitioners and with those from non-health sectors (Haggerty et al., 2007). The final attribute informing community-oriented dimensions includes population orientation and refers to “the extent

to which the primary care clinicians assess and respond to the health needs of the population they serve” (Haggerty et al., 2007, p. 340). A population may be defined geographically, by social characteristics, or based on a particular patient population (Haggerty et al., 2007).

System performance.

Lastly, system performance includes: accountability, availability, and efficiency/productivity (Haggerty et al., 2007). Accountability is an attribute shaping system performance and refers to “the extent to which the responsibilities of professionals and governance structures are defined, their performance is monitored, and appropriate information on results is made available to stakeholders” (Haggerty et al., 2007, p. 340). Availability is another attribute shaping system performance and refers to the “fit between the number and type of human and physical resources and the volume and types of care required by the catchment population served in a defined period of time” (Haggerty et al., 2007, p. 340). Efficiency/productivity is the final attribute informing system performance and strives to achieve “desired results with the most cost-effective use of resources” (Haggerty et al., 2007, p. 340). Of the identified twenty-five attributes of PHC, the following five attributes are considered specific to PHC: “first-contact accessibility, relational continuity, family-centered care, population orientation, and intersectoral team work” (p. 341).

Haggerty et al.’s (2007) model also provides a foundation in which to further conceptualize differences between PC and PHC. Using the previous definitions of PC (Aggarwal, 2009; Cook & Kachala, 2004; Starfield, 1998) attributes (Haggerty et al., 2007) that appear to most inform PC are: first-contact accessibility, comprehensiveness

of services, and relational continuity. Starfield's (1998) definition also suggests that the attribute system integration is important in PC considering that PC is responsible for the co-ordination of care, for example by referrals to different parts of the health care system.

What is presented above is an example of one conceptual model of PHC. An analysis of health discourses informing PHC provides a more in-depth understanding of the beliefs and processes of PHC, which will be used to explore Haggerty et al.'s (2007) model in greater depth.

Equity in Health

The concept equity is examined and will be used to theorize the six health discourses that inform Haggerty et al.'s (2007) model of PHC. The reason for this is twofold. First, equity is important for social work to consider given that it is one of the main values underpinning the profession (Payne, 2005). Although social work as a profession does not materialize in the same way everywhere (Payne, 2006), its underlying values tend to be congruent from one place to the next – which encourages this sort of value-based exploration. Second, equity is also important to Ontario's FHT model because it is a philosophical underpinning of PHC (Aggarwal, 2009; Crooks & Andrews, 2009; Ramsden et al., 2011). According to the WHO (2008), the value of equity has been embraced by the PHC movement and has become central to “widely shared social expectations for health” (p. 18). A more in depth understanding of health discourses is facilitated by exploring their compatibility with a shared social work and PHC value – equity. Including equity in the analysis aims to demonstrate how social work and PHC converge in this foundational value. By doing so, this analysis hopes to demonstrate how social work and PHC together can promote greater health equity.

The concept of equity is a normative ethical value, which means fairness. It is a dynamic concept (WHO, 2009), is linked to the ethical principle of distributive justice, and is very much allied with human rights principles (Braveman & Gruskin, 2008; Taylor, 1992). Recent definitions of equity in health characterize it as attending to the differences or disparities observed between various populations and subpopulations (Last, 2006; Rashid, Amuwo, Skillen, Melanson, & Wagner, 2008). This is consistent with Starfield (2007a) who inspired by the International Society for Equity in Health (ISEqH) defines equity in health “as the absence of systematic and potentially remediable differences in one or more aspects of health between groups of people characterized socially, geographically, or demographically” (p. 1355). Starfield’s (2007a) definition parallel’s the WHO (2009) which sees equity in health as a guide to target differences that are “judged to be avoidable by reasonable action” (p. 3). Braveman (2006) agrees that equity in health focuses on the potentially avertable differences in health and explains that a focus on equity in health strives to “eliminate health disparities strongly associated with social disadvantage [and] can be thought of as striving for equal opportunities for all social groups [in order] to be as healthy as possible” (p. 181). Wallace (2008) offers a definition of equity in health rooted in fairness and social justice, which means that: “all human beings are free to enjoy the right to health and pursuit of physical, emotional, mental, and spiritual well-being—consistent with how any diverse groups may define it and elect to pursue it (p. 2). Wallace’s (2007) definition conceptualizes health broadly as an individual, collective, and social phenomenon. Although concepts of health disparities, health inequities, health equity, as well as equity in health are related (Braveman, 2006), I will use the term “equity in health” in order to

be consistent with Wallace (2008). The reason why Wallace's (2007) model of equity in health has been selected for this analysis is because the thirteen guiding principles help to operationalize equity in a way that fits with PHC.

Equity in health is striving for the eradication of health disparities and better health outcomes (Starfield, 2007b; Wallace, 2008). Wallace's (2008) model is one way to demonstrate how to achieve greater health equity using the following thirteen principles as a guide: a drive for a major shift towards equity; new models of health care and training; new theories, perspectives, and identities; evidence-based approaches; transdisciplinary teams and community-based participatory research; collaboration; cultural competence and cultural appropriateness; health literacy and linguistic appropriateness; the right to health; social justice and recognition of forces in the social context; support for the most vulnerable; repair damage and restore trust; and redistribution of wealth and access to opportunity.

The first principle is broad and calls for a shift away from stratified thinking of hierarchies and towards "relationship[s] of equality, freedom, justice, and the conditions for all [to reach] their full human potential" (Wallace, 2008, p. 7). This strengths-based approach encourages interpersonal relationships that reflect a non-hierarchical state of equality at all levels of human interaction (Taylor, 1992; Wallace, 2008). This is important because "unequal societies have higher rates of violence and discrimination, lower levels of civic trust and involvement in community life" (Keleher, MacDougall, & Murphy, 2007, p. 5). Equity in health assumes that there is a systems-based impact and that all interpersonal relationships inform all social institutions.

Wallace's (2008) second principle strives to increase prevention strategies in health care practice and training. The intent is not to eliminate other health care approaches but to position prevention in parity with other models of care (Levine, Foster, Fullilove, Fullilove, Briggs, Hull, Husaini, & Hennekens, 2001; Wallace, 2008). Achieving prevention parity means greater inclusion of a broader scope of health discourses (Wallace, 2008). The reason is because prevention shifts an emphasis away from the dominant curative approaches, thus drawing on a different set of assumptions.

Wallace's (2008) third principle is theories, perspectives, and identities. The third principle encourages the inclusion of a variety of theories so that we can choose the most appropriate theory and strategies so that we can meet diverse health needs (Wallace, 2008). The emphasis is to move away from a reductionist individual deficit-oriented perspective and instead encourage theories that help promote linkages between individuals and the social setting. The third principle supports a broad scope of theories and perspectives that span: biology, behaviour, social, environment, and structural aspects of health in order to address the upstream mechanisms of society as well as the downstream mechanisms of human biology, disease, disabilities, and array of clinical issues that people cope with (Diderichsen, Evans, & Whitehead, 2001).

Wallace's (2008) fourth principle advocates evidence-based approaches. Evidence is valued to guide decision making about policies, programs, interventions as well as social structures and environments. Multiple sources of evidence are encouraged and multiple approaches to acquiring evidence are valued: "The goal is to arrive at a menu of evidence-based options for specific health challenges" (p. 16).

Wallace's (2008) fifth principle is transdisciplinary teams. The fifth principle considers the inclusion of multiple team perspectives as a way to enhance research, knowledge development, and action. This requires providing an environment that supports the comingling of different assumptions and opinions: "Ideally, professionals and community members enjoy a mutual respect and recognition, as well as free-flowing dialogue among equals" (Wallace, 2008, p. 17). Team-based approaches that are inclusive of diverse knowledge are seen as an asset to problem solving (Brownson, Baker, Leet, & Gillespie, 2003; Walker, 2008; Wallace, 2008).

Global collaboration is Wallace's (2008) sixth principle which recognizes the interdependence across the global community which has been fostered by technology, the world economy, politics, and culture (Wallace, 2008). Globalization is awareness of "what affects one affects all" (p. 19) and "the resulting process of learning to work collaboratively and share and disperse resources" (p. 19).

Wallace's (2008) seventh principle is cultural competence and cultural appropriateness. According to Betancourt, Green, Carrillo, and Park (2005), cultural competence is "a strategy to improve quality and eliminate racial/ethnic disparities in health" (as cited in Wallace, 2008, p. 20). This requires attitudes, knowledge, and skills that embrace differences in research and health care practices. Cultural competence and cultural appropriateness calls for knowledge and strategies aimed at racism, discrimination, and oppression (Wallace, 2008, p. 20).

Wallace's (2008) eighth principle is health literacy and linguistic appropriateness. The eighth principle is considered essential for all health practitioners, educators, and prevention specialists in order to facilitate development and dissemination of effective

health messages (Perez-Rivera & Langston-Davis, 2008; Wallace, 2008). “*Health promotion* is a process of enabling people to increase control over their health, thereby also improving it; *health education* involves a multiplicity of activities where the communication of vital health information to people is at the core of all activities” (Zarcadoolas, Pleasant, & Green, 2006; In Wallace, 2008, p. 22). *Health communication* takes a broader scope that involves mass, multimedia, technologies, and communication skills “to educate or inform an individual or public about a health issue and to keep that issue on the public agenda” (Zarcadoolas et al., 2006; In Wallace, 2008, p. 22).

Ensuring the right to health is Wallace’s (2008) ninth principle. The ninth principle promotes flexibility and diversity in defining health and health care practices. This principle refers to the “right to determine what constitutes health” (p. 23) and a right to access health resources and services. Equity in health strives to remove obstacles for people “such as the poor, disadvantaged racial/ethnic groups, women, or persons who are not heterosexual – who have faced more obstacles to realizing their rights to health” (Braveman, 2006, p. 181). Access refers to the larger forces that make it difficult for someone to obtain necessary resources, as well as barriers that are immediate and more tangible. For example, in some instances cost is cited as a significant barrier to accessing of health care (McClelland, 2000). Access to health services are considered “fundamental to a well-functioning economy” (WHO, 2009, p. 5).

Social justice and influence of social context is Wallace’s (2008) tenth principle. According to Drucker (2006) social justice strives for fairness in social structures. This includes governments, policies, political forces, and underlying guiding ideologies (Hofrichter, 2006). Social justice is important for social work. Social workers who

consciously incorporate social justice into their practice do so in a manner that will “attempt to address immediate crisis and emotional pain while keeping in mind the bigger picture of oppressive policies, practice and social relations” (Baines, 2007, p. 5).

Supporting the most vulnerable is Wallace’s (2008) eleventh principle. According to Levy and Sidel (2006), those that are the most vulnerable tend to be “defined by racial or ethnic status, socioeconomic position, age, gender, sexual orientation, or other perceived population or group characteristics” (In Wallace, 2008, p. 26). Vulnerable populations “tend to be negatively stereotyped and stigmatized” (p. 26) and be “targets of hate and violence” (Levy & Sidel, 2006, in Wallace, 2008, p. 26). Those that may be considered vulnerable extends beyond those characteristics listed above. For example, people with disabilities, those who are incarcerated, as well as people displaced from their homes are taken into consideration (Wallace, 2008). The most vulnerable in a population are those who experience the greatest social injustices (Wallace, 2008).

Wallace’s (2008) twelfth principle is repairing the damage and building trust. The twelfth principle responds to the negative consequences that have been experienced by vulnerable population and “subject to domination, oppression, and discrimination” (Wallace, 2008, p. 28). The twelfth principle responds to adverse health consequences, health disparities, and inequitable access to health services (Levy and Sidel, 2006). The twelfth principle aims to improve socio-environmental factors such as environments, economic conditions, social contexts, access to health and social services, and eliminating barriers restricting health (LaVeist, 2005).

The twelfth principle also considers trust in health care to be important (Shore, 2007; Wallace, 2008). According to Shore (2007), trust inherently includes two distinct

elements. The first element is trust in the knowledge, skills, and competencies of those upon whom we rely in health care. The second element refers to the belief that those one relies upon for health care have the individual's best interests at the forefront without compromise by any competing motive that would cause risk or harm to the person receiving care (Shore, 2007; Wallace, 2008). According to Blendon (2007), leadership is important for providing a long-term vision while taking "the steps necessary to build trust" (In Wallace, 2008, p. 32).

The final guiding principle of Wallace's (2008) model of equity in health is "a drive to redistribute wealth and access to opportunity" (Wallace, 2008, p. 33). Income has a robust impact on health, this principle advocates for policies that promote the redistribution of income and resources (Braveman, 2006; Wallace, 2008). This is consistent with the approach to distributive justice that is the prevailing view of social justice (Powers & Faden, 2006). Wallace's (2008) model provides a framework to help theorize health discourses to in order to determine what health discourses promote equity in health. Six health discourses that will be examined are: biomedical, biopsychosocial, SDOH, health promotion, political economy, and holism.

Health Discourses

Examining health discourses provides insight into some of the assumptions shaping PHC (Table 2.1). According to Gee (2011a), "discourse" refers to the combination and integration of "language, actions, interactions, ways of thinking, believing, valuing, and using various symbols, tools, and objects" (p. 29). The following definition of discourse is used as a guide: "A Discourse is a "dance" that exists in the abstract as a coordinated

pattern of words, deeds, values, beliefs, symbols, tools, objects, times, and places” (Gee, 2011a, p. 36).

There are three rationales for an examination of discourses. First, discourses are influential because they guide theory-making, methods of research, and practice (Payne, 2005). Examining health through the lens of its defining discourse helps to identify assumptions guiding health care practices and organizational structures from a particular perspective. Second, is because it introduces us to alternative viewpoints. This kind of examination prompts a critical reflection that helps us to better understand our own assumptions that guide our practices, and even more important, it helps bring awareness to what is not there (Rossiter, 2005). A third rationale is because this type of critical reflection leads to critical action (Adams, Dominelli, & Payne, 2009). For the purpose of this dissertation, critical action refers to the inclusion of health practices and structures that promote greater equity in health.

The way health discourses manifest themselves in praxis may vary from how they are described in theory. Here they are presented as distinct from one another, which is beneficial for theorizing and understanding health discourses. However, many factors influence how discourses are shaped in praxis: political, government, cultural, and organizational preferences. Despite the potential variation, they nevertheless describe the prevailing features that inform theory and practice. The six health discourses that are examined are: biomedical, biopsychosocial, SDOH, health promotion, political economy, and holism. This is not an exhaustive list of all health discourses; yet these are influential in shaping health care practices and organizational structures of Haggerty et al.’s (2007) model of PHC. Haggerty et al.’s (2007) model is used to theorize health discourses to

help discern the assumptions guiding attributes of PHC. Adding Wallace's (2007) model to the analysis assists to illustrate ways that health discourses help to inform equity in health. The aim in using this combination is to promote a critical reflection on the health discourses that inform PHC attributes in order to prompt the critical action of increasing greater inclusion of health practices that most support health equity.

Health Discourses Shaping PHC

Table 2.1: Summary of Six Influential Health Discourses

Health Discourse	Assumptions about Health
Biomedical	<ul style="list-style-type: none"> • Disease focus • Patients recipients of knowledge, treatment, and technologies • Professional care providers, physician dominant • Institutional medical settings • Excels in acute, emergent, and conditions with single cause
Biopsychosocial	<ul style="list-style-type: none"> • Medical and social perspective • Biological, psychological, and environmental influences • Strengths-based, systems-thinking • Person-centered • Professional care providers, interdisciplinary • Rehabilitation emphasis
Health Promotion	<ul style="list-style-type: none"> • Personal behaviours, physical, and social environments • Micro and macro level view • Increasing control over and improving health • Prevention emphasis: individual, social, environmental, community • Interventions include but extend beyond health care system
SDOH	<ul style="list-style-type: none"> • Socio-environmental perspective • Micro and macro level view • Social, political, and environmental factors • Horizontal and vertical structures • Materialist, neo-materialist, and social comparison approaches • Interventions address inequity and contextual forces in order to achieve individual and societal health
Holism	<ul style="list-style-type: none"> • Emphasis on wellness and positive state of being • Strives for balance and harmony • Physical, mental, emotional, nutritional, environmental, social, and spiritual

	<ul style="list-style-type: none"> • Relational emphasis • Teamwork, including person/community
Political Economy	<ul style="list-style-type: none"> • Social structures and political economy • Structural view • Macro level structures are viewed as distinct from people • Poor health related to socio-economic factors • Welfare state emphasis

Biomedical Discourse

Biomedical discourse is the most pervasive of the health discourses: it is the current centerpiece of contemporary Western medicine (Longino & Murphy, 1995) and is “the dominant paradigm among health care workers and researchers” (Raphael, 2006, p. 126). Biomedical discourse reflects a binary view of health because it is defined in terms of the presence or absence of disease. Disease is “a discrete entity that can be discovered, treated, and cured” (Logino & Murphy, 1995, p. 2) and are defined using naturalistic indicators like blood pressure and heart rates (Gordon, 1988). Starfield (2004) agrees that here health is viewed as “the absence of any one of a wide range of anatomic, physiological, mental, or behavioural deviations from an unspecified ideal” (p. 77). Thus, the presumption is that illness has uniform qualities independent of the person.

The biomedical discourse excels in emergency care, treating infectious diseases, traumatic or acute injuries, or conditions that have a single, specific cause (Cohen, 1998). Health and illness are approached rationally according to the belief that, by doing everything correctly, sickness can then be avoided (Kirmayer, 1988). In terms of mental health, the biomedical discourse considers mental health issues in a way that recognizes physiological explanations, like inadequate biochemical levels.

In clinical settings, the biomedical discourse diagnosis and clinical interventions rely on technology and medical specialists (Longino & Murphy, 1995). As well, clinical interventions take on aggressive forms and emphasize short term results (Davis-Floyd, 2001). Interventions are universally prescribed and directed towards disease by way of professionalized providers of care with little room included for prevention. From this perspective, scientific knowledge and medical professionals are considered the legitimate sources of knowledge, with physicians considered the ultimate informants.

In practice, biomedicine attends to health needs within an institutional setting. The most innovative of scientific findings and technology are often situated within acute care hospitals. As biomedicine flourished, so did the rapid increase in the number of hospitals. It is important to recognize that although biomedical discourse drives contemporary hospital functioning, hospitals are often nevertheless organized in a way that attends to needs that exist beyond the scope of discourse. The interdisciplinary approach often adopted within the hospital setting means that a variety of professions and services can be provided to take care of one's needs, including those that fall outside the physiological realm. Certainly the auxiliary professions and services develop their clinical practices and interventions with strong influence from biomedical discourse; however, their presence suggests that the locus of biomedicine offers some flexibility, albeit slight. For example, many hospitals include a spiritual care department with spiritual leaders available to meet with patients for guidance and support. Also, it is common to find a chapel or spiritual worship centre within a hospital site. In my past clinical practice, the hospital where I was employed staffed Indigenous elders and had an Aboriginal services department. These examples show some organizational recognition

of the importance of faith, difference, and culture in relation to health. Although biomedical discourse may be navigating practice, organizations may make room for additional components, which they offer as complementary services. These types of services do not challenge or alter biomedical discourse. However, they do demonstrate how the biomedical discourse in practice may allow health care some room to encompass more than biology alone.

Informing PHC.

In PHC, the biomedical discourse is reflected in clinical practice attributes. For example, the biomedical discourse influences the attribute of comprehensiveness of services by way of directing care at the level of individuals who are recipients of knowledge, treatment, and technologies. The biomedical discourse guides some strategies included in comprehensiveness of care; for example, monitoring of blood pressure and heart rates, and treatment of existing diseases (Gordon, 1988; Haggerty et al., 2007). Frankish et al. (2006) provide an example of this: “Most primary care interventions are limited to the most basic provision of curative...services, which are reactive, episodic and brief” (p. 180). Given that the emphasis on treatment of disease, the inclusion of prevention strategies considered important to comprehensiveness of care (Haggerty et al., 2007) is minimal.

Equity in health.

Biomedical discourse does not provide room for different views of health based on how “diverse groups may...elect to pursue it” (Wallace, 2008, p. 2). Health is understood solely as an individual phenomenon unlike Wallace’s (2008) model that considers health as an individual, collective, and social experience. Unlike Wallace

(2008), the biomedical discourse promotes a curative response aimed at the body and disease; there is no attention to prevention strategies with acute-care approaches taking precedence.

Wallace's (2008) model of equity in health relies on a variety of theories and approaches; whereas, a biomedical approach is much more narrow in scope. As well, the biomedical discourse differs from Wallace (2008) because it emphasizes individual perspectives that exclude a person's social environment. Although Wallace (2008) considers the biomedical discourse's "downstream into the mechanisms of human biology" (Diderichsen et al., 2001; as cited in Wallace, 2008, p. 10) approach, Wallace would consider it limited because of the absence of an upstream approach that looks towards the mechanisms of society (Diderichsen et al., 2001).

Like Wallace's (2008) model, biomedical discourse values evidence based approaches; however, what considered evidence based from the perspective is more narrow than what Wallace (2008) advocates for. Similar to Wallace's (2008) model, in practice biomedicine relies on individual practitioners; however, it is limited in the implementation of transdisciplinary teams. The micro approach of biomedical discourse in education, research, and clinical practice ignores the linkages among the individual, society, and institutions (Wright, 2000). Thus, Wallace's (2008) principle of global collaboration is limited. Unlike Wallace's (2008) model, strategies that focus on health literacy and linguistic appropriateness appear to be limited. However, there may be some inclusion of health literacy and linguistic appropriateness in relation to the immediate interactions between provider and patient.

In the promotion of a standardized view of human beings, biomedical discourse ignores the complex differences between individuals and diverges from Wallace (2008); it does not highlight cultural competence or cultural awareness. “By treating variations between genders and races as something fixed in the body, medical theorists helped to reinforce the perception that social inequities were a straightforward reflection of the natural order of things” (Epstein, 2007, p. 34). Thus, this standardized view can even contribute to inequalities and oppressive social institutions. An example of this is the negative impact that biomedicine has had on those who are not viewed as part of the dominant culture. According to Bishop (2005), “objectivity...is a denial of identity” and he views this as “the ultimate victory of colonization” (p. 129). Prior (2007) furthers this assertion by stating that the epistemology guiding knowledge production in biomedicine plays a part in sustaining social inequities and he believes the conventions of objectivist scientific medical research to be the emulation of colonization. Biomedicine’s standardized approaches to and assumptions about health are based on Eurocentric values and can have ill effects that perpetuate social inequities and inequities in health. One example of this is how those excluded from the dominant culture tend to experience poorer states of health. Biomedicine’s “failure to recognize... [culture] has contributed significantly to the profound disparity in health status between African Americans and the White population” (Airhihenbuw, 1995, p. 91).

Wallace’s (2008) model highlights the importance of ensuring the right to health. The biomedical discourse appears to be somewhat in agreement with Wallace (2008) particularly when it comes to access of available technology, diagnostic equipment, and acute care facilities. However, the scope does not extend to broader considerations such

as contexts or elements impeding access to health care of vulnerable populations. Unlike Wallace (2008), the biomedical discourse is not inclusive of social justice; focus is on the physiology of the individual and ignores social context. Furthermore, the normative view of biomedical discourse means that differences between people are not recognized, negating the ability to attend to those who are considered most vulnerable in society. With a lens aimed solely at physiology, repairing the damage of those socially excluded is not a priority of biomedical discourse. However, biomedicine agrees with Wallace (2008) and attempts to build trust by way of emphasizing rigor and expertise.

Lastly, Wallace's (2008) principle of redistribution of wealth and access to opportunities is not included in the biomedical discourse. In fact, by focusing solely on physiology and ignoring all outside context, biomedical discourse depoliticizes medical encounters. Systemic and structural issues are often transformed into problems of the individual and are to be solved accordingly (Treichler, Cartwright, & Penley, 1998). According to Baldwin (2008), biomedicine can even avoid "vexing political choices" (p. 36) such as targeting controversial health issues that are intertwined with multifaceted social structures and institutions, such as HIV. By putting money into biomedical research, it gives the impression that something is being done without having to make difficult political choices or challenge social structures (Baldwin, 2008).

Thus, there may be some traces of coherence with Wallace's (2008) model of equity in health; however, biomedical discourse for the most part is not coherent as there is no recognition of the role of social processes and structures that shape health. Most importantly, approaches that are guided solely by biomedical discourse can further contribute to social inequities because of its limited coherence with equity in health.

Biopsychosocial Discourse

Biopsychosocial discourse views health as inseparable from biological, psychological, and environmental contexts. It has been influential and adopted by the WHO to describe health and health status at both the individual and population levels. Biopsychosocial discourse approaches health in a manner that integrates medical and social perspectives. The assumption is that by combining a biological explanation of health and disease with a social model of health and wellbeing, it will be able to conceive of and address a more complete experience of health. Biopsychosocial discourse assumes itself to be a “person-centred model that moves beyond the often-oppositional standpoints of the medical vs social models” (p. 11).

The biopsychosocial discourse conceptualizes health in terms of the abilities, physiology, body functioning, activities of daily living, and participation in one’s external world. On the other hand, it also refers to personal and environmental factors that define health (College of Occupational Therapists, 2004). Biopsychosocial discourse assumes it necessary to consider biologically based health conditions and contextual factors such as environmental conditions to have a complete understanding of individual and population wellbeing. Although the biopsychosocial discourse may not take into account all of the influences contributing to an individual’s health, the scope of health and wellness extends beyond the context of hospital and clinical contexts. It aims to respond to existing health issues, encourage rehabilitation, and also emphasizes prevention.

Functional capacity is a guiding concept and refers to “an umbrella term for body functions, structures, activity and participation” (WHO in College of Occupational Therapists, 2004, p. 10). According to Bickenbach et al. (2003), body functions and

structures, activities, and participation in the external world are the necessary elements for functionality and impediment in functioning is what distinguishes disability from well-being. “Disability is an overall or umbrella term denoting a decrement in functioning at one or more of these levels, that is, an impairment, activity limitation or participation restrictions” (p. 296). As well, mental health is explicitly included within this view and attended to in assessment and strategy development. How participation is viewed is based on societal norms and determined “by reference to roles ‘expected of an individual without disability in that culture or society’” (WHO in Edwards, 2005, p. 41).

The biopsychosocial discourse provides a descriptive view of health, diagnosis, and disability (Üstün, Chatterji, & Andrews, 2002), yet provides a foundation for practice models that use standardized frameworks. Collaborative interdisciplinary health-professionals are considered to be important. As well, the biopsychosocial discourse places a heavy emphasis on rehabilitation, which it assumes will be achieved in an interdisciplinary professionalized manner. Social work practice is historically influenced by biopsychosocial discourse and aims to determine the physical, psychosocial, and environmental issues that may be contributing to health outcomes (Barrow, 2006). Social work practice has a focus of helping people to “resolve problems in person-situation interactions” (Compton & Galloway, 1989, p. 19) grounded in a biopsychosocial perspective (Collins, 2005).

Informing PHC.

The biopsychosocial discourse has been influential in shaping PHC. For example, the inclusion of rehabilitation and palliative care in comprehensiveness of services suggests a presence of the biopsychosocial discourse in clinical practice attributes of

Haggerty et al.'s (2007) model. As a result, a broad focus is included to take a person's functionality and environment into consideration. As well, the biopsychosocial discourse informs structural dimensions of Haggerty et al.'s (2008) model by encouraging collaborative multidisciplinary team approaches in health care. Consistent with structural dimensions of PHC, Sargeant, Loney, and Murphy (2008) state: "Effective primary health care requires teams of diverse health professionals and institutional and community resources to address patients' needs and the broader call for health promotion and illness prevention" (p. 233).

Congruent with the biopsychosocial discourse, Haggerty et al.'s (2007) attribute of system integration encourages collaboration with diverse health and social services, and an amalgamation of various factors – physiological and social – are taken into consideration in care. Thus, the concept of PHC views health in a way that combines the medical and social views of health. "There is recognition of psychosocial factors in the process and outcome of health problems" (Evans & Trotter, 2009, p. 319).

Person-oriented dimensions of Haggerty et al.'s (2007) model are strongly influenced by the biopsychosocial discourse of health (Ransom, 1984; Thomas-MacLean et al., 2008; WHO, 1978) especially since the biopsychosocial discourse itself is considered person-centred (College of Occupational Therapists, 2004). Starfield (2004) describes how person-oriented dimensions of PHC extend beyond the physiological and include "the phenomena of vulnerability and resilience" (p. 78). Congruent with the biopsychosocial discourse, PHC takes into consideration the interconnectedness of relationships that informs a person's world, yet the individual person is considered at the center of the system (Rogers & Sheaff, 2000; Suter, Oelke, Adair, & Armitage, 2009).

Relationships have long been a key factor and considered a central tenet of effective PHC (Rosser & Schultz, 2007). Continuity of care refers to the importance of the therapeutic relationship in PHC; there is strong evidence that suggests individual satisfaction and better health outcomes are linked with continuity of care and ongoing relationships with PHC providers (Rosser & Schultz, 2007, Starfield et al., 2005). Furthermore, if person-oriented dimensions are emphasized in accountability measures, then the biopsychosocial may become more prominent in shaping a particular PHC model. Although influential in shaping person-oriented dimensions of PHC, the WHO (2008) indicate that one challenge is that “few health providers have been trained for person-centred care” (p. 47).

Equity in health.

The biopsychosocial discourse has some areas that converge with Wallace’s (2008) model and also areas that could be strengthened. Like Wallace (2008), the biopsychosocial discourse views health as an individual, collective, and social phenomenon. Biopsychosocial discourse agrees with Wallace (2008) given that it is grounded by a strengths-based foundation. Furthermore, the biopsychosocial discourse promotes the inclusion of multiple approaches to health in that strategies target both biological and social realms and come from multiple sources. Given the comingling of the medical and social views of health, there is more potential for biopsychosocial discourse to diversify its theoretical approaches than what currently exists. However, views of health predominantly take a downstream view that considers “human biology and the clinical issues of how people cope with disease and disabilities” (Diderichsen et al., 2001; as cited in Wallace, 2008, p. 10) with a limited view upstream to broader contributing factors. In order to gain a more complete understanding of the absolute

condition - as endorsed by Wallace's (2008) model - further inclusion of the influence of the mechanisms of society is advocated.

The biopsychosocial discourse supports Wallace's (2008) principle of evidence-based knowledge and approaches and takes a wider understanding of what constitutes evidence-based than the biomedical discourse. Also, biopsychosocial discourse agrees with Wallace (2008) and supports inclusion of transdisciplinary teams; multiple perspectives are considered valuable in research, theory, and practice. Health care professionals of varying backgrounds are considered central in biopsychosocial discourse; however, one area that may enhance congruency is with an even greater inclusion of non-professional people or those outside of the health sector: "Many of us would argue that the removal of obstacles on a more complex social level ought instead to be handled by people in the political echelons of society" (Nordenfelt, 2006, p. 1465). The biopsychosocial discourse displays moderate congruency with global collaboration. However, greater inclusion of equity in health (Wallace, 2008) can be achieved by increasing intersectoral collaboration within and beyond the health sector.

Biopsychosocial discourse has some coherence with Wallace's (2008) principle of cultural competence and cultural appropriateness. Like Wallace (2008), understanding a person's culture and how this impacts on their health situation is an essential component of biopsychosocial discourse. However, it does not appear that biopsychosocial discourse goes as far as Wallace's (2008) model that strives to "eliminate racial/ethnic disparities in health" (Betancourt et al., 2005; as cited in Wallace, 2008, p. 20). The biopsychosocial discourse somewhat supports Wallace's (2008) principle of social justice and influence of social context. For example, the biopsychosocial discourse brings attention to some of

the external limiters that may influence a person's capacity for healthy functioning, such as inaccessible housing. In this way, biopsychosocial discourse converges with Wallace (2008) by ensuring the right to health when advocating the removal of immediate barriers restricting accessibility. However, the lens likely does not extend to the wider macro level influencers although there may be some varying perspectives on this. Scherer, McAnaney, and Sax (2006) imply that biopsychosocial discourse attends to structural issues when they state that it "spans the functional to the political and places health simply as one element in the dynamic relationship between the person and their environment" (p. 1467). However, the biopsychosocial discourse often actualizes in an individualized therapeutic manner whereby intervention occurs with the person at hand. Thus, the view of social context may at times be limited. For example, in the case of the ICF "the classification remains in the broad context of health and does not cover circumstances that are not health-related, such as those brought about by socioeconomic factors" (WHO, 2007b, p. 7). Thus, inequities, structural and social process are overlooked since they do not fit into this definition.

The biopsychosocial discourse agrees with Wallace (2008) and aims to support the most vulnerable. For example, biopsychosocial discourse has evolved from the disabilities discourse "which has done much to give voice to those oppressed in society as a result of their health conditions" and is "therefore significant for [those] who labor for social justice" (Barrow, 2006, p. 71). Furthermore, the biopsychosocial discourse is minimally to moderately coherent with the redistribution of wealth and access to opportunity. At the micro level, biopsychosocial promotes functionality and advocates for the reduction of barriers in one's social environment that impede on health and access

to health care. However, congruence is limited with the lack of attention given to the larger context. For example, oppressive forces and structures that may inhibit one's ability to flourish and sustain health are often viewed as personal factors.

Health Promotion Discourse

The health promotion discourse is broad and is commonly conceived as both a process and a goal: "Health promotion is the process of enabling people to increase the control over, and to improve, their health" (WHO, 1986; cited in Keleher et al., 2007, p. 8). The health promotion discourse embraces a "positive, multidimensional view of health that focuses on the whole...person or the community. It recognizes the role of broad determinants...in creating/maintaining health and quality of life" (Frankish, 2006, p. 176). Prevention is emphasized because there is concern "with health problems before they develop or worsen, not only after they appear" (p. 176).

The health promotion discourse is about assisting people to take control of the factors influencing their health; in order to be effective, "practitioners need a solid understanding of people's experiences of everyday life, of the social factors that contribute to those experiences, including the systemic influences" (Keleher, 2007a, p. 16). Health is "seen as a resource for everyday life, not the objective of living" (WHO, 1986; as cited in Keleher, 2007a, p. 16) and is a concept that considers the social, environmental and personal resources (Keleher, 2007b). The health promotion discourse is explicit that it is guided by values such as: rights, respect, equity, and social justice (Keleher et al., 2007). Frankish et al. (2006) agree and state that the health promotion discourse "places a premium on social justice, diversity, fairness, and removal of barriers

to equitable participation in aspects of society that influence health and quality of life, including access to health services” (p. 176).

Health promotion has been criticized for being broad, vague, and poorly articulated (Naidoo & Wills, 2009; Seedhouse, 1997; Tannahill, 1985). Contemporary health promotion encourages strategies that attend to micro, meso, and macro levels with an aim to get to the root of the cause. As well, an intention is to help people recognize the impact that their decisions have on health consequences (Kehler et al., 2007). For example, health education aims at increasing knowledge and skills in order to help motivate healthy behavioral changes (Grandes, Sanchez, Cortada, Balague, Calderon, Arrazola, Vergara, & Millan, 2008). This approach emphasizes a lifestyle orientation of health promotion where individual responsibility for health is reinforced (Jackson & Riley, 2007; Pederson, 2007).

Health promotion discourse assumes primary, secondary, and tertiary prevention strategies are a priority for health outcomes. Primary prevention activities focus on preventing injury and disease through measures such as immunizations. Primary prevention also includes health education strategies aimed at eliminating lifestyle risk factors such as poor diet, smoking, and lack of physical activity (Calloway, 2007; Feinstein, 2005). Secondary prevention refers to the early detection of problems to avert the progression to a more serious of state, like cervical cancer and cholesterol screenings. Tertiary prevention measures are designed to restore health after there has been a major health event such as a stroke with the intent to prevent the condition from worsening (Calloway, 2007; Feinstein, 2005). health care

At the macro level, health promotion discourse attends to the structural and socio-environmental contributors of health. For example, “health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health” (Nutbeam, 1998; as cited in Keleher, 2007a, p. 16). At this level, health promotion discourse takes a broad view of health and believes that the foundations for health start with peace, shelter, adequate food supply, stable environments, economic resources, and sustainable resources (Keleher et al., 2007; WHO, 1978; Nutbeam, 1998).

Health promotion discourse promotes single level strategies that target individuals – primarily encouraging behavioural change – as well as including multi-level strategies that have a wider and more sustainable impact. Along with promoting multi-level approaches, health promotion discourse advocates for intersectoral activities within and beyond the health sector (Keleher, 2007a; Lin & Fawkes, 2007).

Informing PHC.

Frankish et al. (2006) advocate for greater inclusion of the health promotion discourse in PHC and suggest “[PHC] is natural entry-point to reorient a health system towards health promotion” (p. 173). Yet, Frankish et al. (2006) advocate for a greater clarification of health promotion in PHC because “many people associated with [PHC] continue to understand the term ‘health promotion’ differently” (p. 173).

One way that the health promotion discourse may shape approaches in PHC is by “enabling or ‘empowering’ people to address factors that affect their health....by

‘increasing their ‘control’ over these factors...by helping them to obtain access to needed resources, or by helping them develop personal and collective capacities” (p. 174). The emphasis on the “removal of barriers to equitable participation in aspects of society that influence health and quality of life, including access to health services” (p. 176) implies that the health promotion discourse is influential in informing two clinical practice attributes in Haggerty et al.’s (2007) model of PHC: first-contact accessibility and accommodation accessibility. The health promotion discourse also encourages prevention strategies and health education that would shape the clinical practice attributes of Haggerty et al.’s (2007) model of PHC, with focus on risk categories and the promotion of healthy behaviors. As well, comprehensiveness of services is explicit in identifying the inclusion of health promotion (Haggerty et al., 2007).

The health promotion discourse also advocates for multidisciplinary team approaches, also an important attribute included in the structural dimensions of Haggerty et al.’s (2007) model of PHC. Frankish et al. (2006) describes how this means that physicians, a range of health care providers, and even those outside the formal health care sector work together and “participate in broad planning and development at the community and policy level” (Frankish et al. (p. 179).

The health promotion discourse also shapes community oriented dimensions of Haggerty et al.’s (2007) model of PHC. For example, the health promotion discourse advocates for community and civic participation in a range of activities that can influence health (Frankish, 2006). Thus, client/community participation – one attribute informing community-oriented dimensions of PHC (Haggerty et al., 2007) – appear to be congruent with the health promotion discourse. As well, health promotion assists to inform

population orientation view that encourages the inclusion of upstream approaches to care. Also, the health promotion discourse is “concerned with removing disparities in health and access to its determinants for disadvantaged/at-risk populations” (Frankish, 2006, p. 176); thus, the health promotion discourse appears to be influential in shaping equity - another attribute informing community-oriented dimensions of primary health care.

Intersectoral collaboration is a community-oriented dimension of Haggerty et al.’s (2007) model of PHC that converges with health promotion: “partnerships and coalitions are essential to address social and economic factors that mediate health status differences, and to generate community-based solutions to health problems” (Frankish et al., 2006, p. 178). Frankish et al. (2006) advocate for greater inclusion of the health promotion discourse in shaping system performance attributes of PHC and suggest inclusion of “incentives, rewards and standards for engaging in quality health promotion practices” (p. 178) in primary health care. They also encourage the inclusion of “establishing formal responsibility for health promotion within management...[and] incorporating health promotion action into performance and accreditation agreements” (p. 178) also suggesting a role for the health promotion discourse in shaping system performance attributes. The health promotion discourse appears to have a significant role in shaping a model of PHC like the one provided by Haggerty et al. (2007) model of PHC. However, Frankish et al. (2006) indicate that the current state is not as expansive as it may seem. For example, they state that health promotion approaches in PHC currently target the individual for change “rather than the social and environmental conditions that underlie the disease or condition” (p. 180).

Equity in health.

The health promotion discourse is grounded by values of equity and respect (Keleher et al., 2007). Similar to Wallace's (2008) model, diverse theoretical positions to guide health care practice are considered important. However, this does present differing opinions on what constitutes the best approaches to health. For example, there are strong advocates for individualized behavioural approaches as well as socio-environmental approaches to health promotion (Keleher et al., 2007).

Like Wallace (2008), health promotion advocates for direct action to address both upstream and downstream factors: "Thinking in upstream-downstream terms enables planning to develop multiple levels of action" (Keleher, 2007b, p. 30). Currently, strategies that target individualized lifestyle changes are most dominant in health care, yet the aim of health promotion discourse is to be inclusive of a wide array of multi-level prevention strategies. Similar to Wallace's (2008) model, the health promotion discourse values evidence based approaches and strives to develop and rely on accessible evidence to inform the most effective approaches to health (Keleher et al., 2007; Raphael, 2002). Health promotion values interventions that are based on an accumulation of knowledge and sound theoretical principles (Keleher, 2007b). In order for health care strategies and interventions to be effective, evidence-based must be shaped in accordance to a particular context in order to determine what strategies work best given the circumstances (Grandes et al., 2008; Keleher, 2007b).

Although the health promotion discourse has been largely informed and implemented by nursing, there is a value placed on the co-construction of knowledge, transdisciplinary teams, multi-level strategies, and intersectoral collaboration. For

example, health promotion encourages the development of partnerships and “collaborative ways of working to find evidence about how the determinants of health are played out” (Keleher et al., 2007, p. 9). Informed by a systems-based perspective, health promotion encourages partnerships: “The incorporation of strong and sustainable partnerships is a core skill for equity-focused, integrated health promotion and for health development” (Keleher, 2007b, p. 40). As well, Wallace’s (2008) principle of global collaborations is emerges in the Bangkok Charter (WHO, 2005), which identifies the need to place health promotion within the context of global development and “a wider social development agenda” (Keleher, 2007a, p. 21).

The health promotion discourse is moderately supports Wallace’s (2008) principle of cultural competency and cultural appropriateness. From a health promotion perspective, “a concept of health can be refined or changed to guide the development of a project or program but it must always be culturally appropriate and agreed by stakeholders” (Keleher et al., 2007, p. 7). Thus, recognition that there are multiple ways of viewing health is evident and the discourse encourages discussion amongst those involved to clarify how health is understood within that particular context. However, coherency with cultural competency and cultural appropriateness requires approaches that look beyond the immediate. Keleher et al. (2007) provide an example of the importance of culture in shaping interventions such as with the inclusion of “Aboriginal people’s knowledge and wisdom” (p. 5). “The starting point for health promotion needs to be in the causes, which are much further back than those soft-target culprits of lifestyle and behaviours” (p. 5); yet, , Keleher et al. (2007) describe how the dominant health promotion approaches have failed to “engage with Aboriginal health issues” (p. 10).

Much of the health promotion discourse has been based on expert-led models which may be promoting a dominant culture that at times may be inconsistent with additional cultural needs. Greater inclusion of local culture of the individual or community in terms of guiding values, knowledge, and preferred health care practices are considered important .

Like Wallace's (2008) model, health literacy and linguistic appropriateness are core foundations in health promotion discourse. As well, health promotion discourse recognizes health as a fundamental right, yet, the extent to which barriers restricting access to health care are addressed vary depending on what health care practices and strategies are implemented (Keleher et al., 2007). Health promotion agrees with Wallace (2008) and values social justice (Health Promotion Forum of New Zealand, 2004); however, attention to supporting the most vulnerable is influenced by the type of practice intervention. For example, micro level strategies aimed at encouraging lifestyle changes do not attend to the needs of those most vulnerable; yet, when the scope is broadened to include meso and macro level socio-environmental approaches, needs of the most vulnerable are included. Clearly, the health promotion discourse has the potential to increase equity in health but this is dependent on what health care strategies and interventions are included in practice.

Social Determinants of Health Discourse

Social determinants of health (SDOH) discourse considers the greatest threats to physiological health to be from interactions between political, sociological, environmental, psychological, and biological factors. These determinants offer “a window into both the micro-level processes by which social structures lead to individual health or illness and the macro-level processes by which power relationships and political

ideology shape the quality of these social structures” (Raphael, 2006, p. 132). Among the factors shaping health are: poverty, income inequality, gender inequality, racial inequality, sexual inequality, housing and living conditions, education, food security, employment and working conditions, social inclusion and exclusion, early childhood care, and (recently) globalization (Marmot & Wilkinson, 2006; Raphael, 2008b).

The SDOH discourse assumes a socio-environmental perspective of health. Social, political, and economic forces are perceived as having the greatest influences on health, which is assumed to be socially produced. Although health outcomes are largely determined using physiological indicators, wellbeing also takes into account social and economic needs. From this perspective, “the most distal factor is the social structure of society, variously labeled general socioeconomic, cultural, and environmental conditions, social structures, social context, and social, economic, and cultural characteristics of a society” (Graham, 2004, p. 106). Furthermore, attention is given to the health gradient whereby “the higher the social position, the better the health” (Marmot, 2006, p. 2). Although there are various determinants of health, Raphael (2006) considers income especially important as it is the “determinant of the quality of early life, education, employment and working conditions, and food security” (p. 118). Income’s overall impact on health is pervasive: “Income also is a determinant of the quality of housing, need for a social safety net, the experience of social exclusion, and the experience of unemployment and employment insecurity across the lifespan” (p. 118). All of these factors are viewed as integral components of health within the SDOH discourse.

SDOH discourse considers horizontal social structures important, this refers to “the more immediate factors that shape health and wellbeing” (Raphael, 2006, p. 124).

Examples include workplace conditions, family environments, household environment, educational resources, and recreational activities (Raphael, 2006). Vertical structures – the complex macro level societal components such as political, economic, and social forces at all governmental levels (Raphael, 2006) – are also considered to be important. SDOH, considers the following three ways of viewing health particularly important: materialist, neo-materialist, and social comparison approaches. The materialist approach assumes that key to understanding and promoting health is to attend to the conditions of living, in the sense that “individuals experience varying degrees of positive and negative exposures over their lives that accumulate to produce adult health outcomes” (Raphael, 2006, p. 121). Material conditions shape social environments, relationships, and individual development including physically, developmentally, and educationally (Raphael, 2006). “To understand the material influences on health...we need to look for factors other than infections. The neo-materialist approach assumes that living conditions and social infrastructures – including those that determine how economic and social resources are distributed – account for individual health outcomes and differences in health levels between larger populations (Raphael, 2006). Finally, the social comparison approach assumes that social hierarchies impact on health. The social comparison approach assumes that perceptions and experiences of social inequality lead to stress and negative health outcomes (Raphael, 2006). Although each of these three contrasting approaches to health “differ in style and complexity,” they all “represent health as the outcome of a web of social influences” (Graham, 2004, p. 106).

The SDOH discourse emphasizes a need to address inequity and contextual forces in order to achieve individual and societal health. Woolf, Johnson, and Phillips

(2007) argue, “for more than 100 years, the national death rate has declined at a rate that has remained remarkably constant (1% per year)... Addressing these social determinants of health might do more to save lives than the incremental advancements in the technology of care that consume the bulk of societal investments in health” (p. 679). In other words, the route to health according to the SDOH discourse depends on properly attending to social factors and structures. Yet, there does appear to be some ambiguity within the SDOH discourse regarding appropriate interventions once biological health issues have materialized: “While it is well established that social determinants of health are excellent predictors of illness and disease, we know little about how these same health determinants lead to recovery from illness” (Raphael, 2006, p. 131).

Informing PHC.

The SDOH discourse may be influential in shaping person-oriented dimensions of Haggerty et al.’s (2007) model of PHC given that the social aspects of a person’s health and consideration of community context is considered important. Thomas-MacLean et al. (2008) describe how “individual, family, community and population experiences of health and illness” (p. 2) are considered important in shaping beliefs and processes underpinning person-oriented dimensions of PHC. SDOH encourages Haggerty et al.’s (2007) person-oriented dimensions to address horizontal structures and “the more immediate factors that shape health and wellbeing” (Raphael, 2006, p. 124) like household environment, education, recreational activities, and family environment (Raphael, 2006). Also, there is potential that whole person care is informed by SDOH by taking into consideration material conditions shaping social environments, relationships, and individual development (Raphael, 2006).

SDOH informs community-oriented dimensions of Haggerty et al.'s model of PHC. Namely, Thomas-MacLean et al. (2008) state that PHC is community-based given that it: "a) is universally accessible to individuals, families, groups, communities and populations; b) is driven by community participation in identifying health issues; c) involves community participation in decision-making regarding appropriate solutions; and d) is sustainable by the community" (p. 2). Numerous studies highlight the importance of PHC for improving individual and population based health outcomes (Aggarwal, 2009; Atun, 2004; Macinko, Starfield, & Shi, 2003; Starfield & Shi, 2002). In fact, Starfield et al. (2005) describe how PHC has been "associated with reductions in the adverse effects of income inequality on health" (p. 470) and has contributed to the reduction of "disparities in health across racial and socioeconomic groups" (p. 470). health care

It appears that community-oriented dimensions of Haggerty et al.'s (2007) model of PHC are largely informed by a socio-environmental view. Similar to the SDOH discourse, PHC maintains a focus on individual as well as community and population health and wellbeing (Greenhalgh, 2007). The emphasis on social inclusion through client/community participation, equity, and population orientation appears to be associated with the SDOH. Also, community-oriented dimensions of Haggerty et al.'s (2007) model are influenced by SDOH when shaped in relation to a neo-materialist approach inclusive of living conditions and social infrastructures (Raphael, 2006). Thomas-MacLean et al. (2008) also state that although the focus of PHC is on "the health of individuals, families, and communities, PHC is equally concerned with addressing the

overall social and economic development of communities, thereby targeting the social determinants of health” (p. 2).

Equity in health.

Like Wallace’s (2008) model, SDOH has a central focus on a variety of social, structural, and institutional forces that shape health. SDOH discourse has helped to name and identify health disparities and differences between populations and subpopulations. As well, SDOH discourse “is represented in a way of launching a going attack on the social causes of ill health and of disparities in health” (Graham, 2004, p. 102).

SDOH discourse is largely coherent with Wallace (2008) in the models of health care and training that it promotes. SDOH views health broadly and encourages inclusion of a range of different health practices. Particular emphasis is on the development and implementation of healthy policy, as well as on diverse clinical interventions. However, SDOH discourse does not provide guidance on a particular model of practice. Instead, various models can be aligned with a SDOH perspective as long as there is a structural component (beyond the individual) woven into practice. Prevention strategies are encouraged, particularly social and environmental conditions that lead to negative physiological outcomes. In coherence with equity in health, the SDOH discourse moves away from reductionist approaches and focuses on the upstream to “the mechanisms of society” (Diderichsen et al., 2001; as cited in Wallace, 2008, p. 10). There is variable attendance to the “downstream...mechanisms of human biology and the clinical issues of how people cope with disease and disabilities” (Diderichsen et al., 2001; as cited in Wallace, 2008, p. 10) thus at times detracting from an absolute picture of the whole condition that is promoted by an equity in health model.

The SDOH discourse has contributed significantly to the evidence for determinants of health. Given the broadness of SDOH discourse, it is implied that transdisciplinary teams are valued. Knowledge is seen as emerging from a variety of perspectives, which is coherent with a model of equity in health. SDOH discourse is also coherent with global collaboration. Although collaboration within and beyond the immediate health system is considered necessary, the primary focus of the SDOH discourse is on collaboration with sectors outside of the current health system.

The SDOH discourse is aimed at targeting racism, discrimination, and oppression thus, is coherent with Wallace's (2008) principle of cultural competence and cultural appropriateness. As well, the SDOH discourse may at times be coherent with health literacy and linguistic appropriateness, yet this is not made explicit because little guidance is provided on practice interventions. However, the SDOH discourse is coherent with ensuring the right to health because it brings attention to the obstacles that the most vulnerable of the population experience in the pursuit of health and health care. The SDOH discourse brings attention to social and contextual barriers that impede access. As well, the SDOH discourse is coherent with social justice and recognizes the influence of social context. One of the tenets of the SDOH discourse is that societal injustice is innately related to profound health differences and problems. According to Raphael (2006), "issues of health equity and the role played by social determinants of health that lead to such inequity are rooted in concepts of social justice" (p. 130).

Coherent with Wallace's (2008) model, SDOH discourse attends to wider social processes and structures. For example, consideration of a health gradient has led to the examination of the accompanying "social cost in terms of diminished labor productivity,

social exclusion, rising incidence in crime, and the erosion of civil society” (Kawachi, Kennedy, & Wilkinson, 1999, p. xi). Health determinants include, but are not limited to: food supply, inequity, income distribution, housing, workplace environment, racialization, education, and early life. “These prerequisites of health are concerned with structural aspects of society and the organization and distribution of economic and social resources” (Raphael, 2004, p. 5).

SDOH discourse is also coherent with Wallace (2008) in its support for the most vulnerable; this is a priority area for SDOH. SDOH support Wallace’s (2008) directive to repair the damage of those most excluded, the SDOH discourse explicitly calls attention to the “negative consequences experienced by those subject to domination, oppression, and discrimination” (Wallace, 2008, p. 28). However, coherence to the building of trust – by way of attending to relationships and leadership – does not appear to be made explicit by the SDOH discourse. Lastly, SDOH discourse is coherent with Wallace’s (2008) principle of redistribution of wealth and access to opportunity. SDOH strives to achieve this through “a counterbalancing of market forces with a polis of communal responsibility associated with the welfare state” (Raphael, 2009, p. 4). Furthermore, the SDOH discourse also promotes the equitable distribution of goods and services deemed necessary for health.

Holism Discourse

Holism sees a system as a whole where all properties cannot be resolved or explained solely by its parts; the system establishes how components perform, while parts influence one another and simultaneously impact the whole. Holism and health are related concepts: both healing and health come from the root word hale which means to

make whole. Holism refers to “a view of the human being as part of her or his community, which is part of its local environment, which is part of its society and culture, which is part of the system of cultures and societies in the human family – which is part of the global environment” (Laszlo, 2002, p. 137).

The holism discourse views health as an overall emphasis on wellness and positive state of being, not just the absence of disease. Health is considered to be one part of a person’s entire entity. Holism strives for balance and harmony; when a concerning health issue arises, the focus is on healing as opposed to curing. According to Airhihenbuwa (1995), healing focuses on “the *ultimate* cause of an illness: who or what caused it, and why” (p. 51). This means that no one explanation is considered sufficient to explain a malady. The holism discourse assumes a view of health that aims to address “mental, emotional, nutritional, environmental, and spiritual elements” (Cohen, 1998, p. xii) imbalances. Johnson (2003) also describes how holism assumes that healing extends beyond the biological and is concerned about quality of one’s life: “healing is the process of expanding awareness – opening one’s eyes to the unknown, deepening one’s relationships, rededicating one’s life to what one loves and cares about, participating fully on one’s behalf, connecting with others on the journey, and finding meaning, purpose... [and] joy” (p. 354). Individuals are considered central in their own healing process, not passive recipients of treatment and knowledge: “It is the individual...that does the healing” in conjunction with “the wide variety of...modalities available” (p. 354).

Holism that is historically rooted within an Indigenous epistemology views health as a balance between the four dimensions of the physical, spiritual, mental, and emotional. A person cannot be readily compartmentalized, “instead, the individual views

self and views others as holistic” (Lowe, 2002, p. 6). From this perspective, a dynamic relational process between all individuals, the earth, the universe, and the spirit world is assumed to be necessary in order to achieve personal growth and balance. “Healing grows out of a change in the patient’s relationship to his or her self, or it grows through a relationship with the healer and the spirits the healer calls forth” (Mehl-Madrona, 1997, p. 145). Overall, holism assumes that spirituality is an essential component of one’s wellbeing. What transpires in the physical body is considered to be reflective of the state of mind or spirit of the person; in order to achieve wellness, healing transpires from the inside out. Addressing the spiritual, psychological, and energy states of a person are assumed essential from a holistic perspective.

Holism places a great deal of importance on the relational process. Holistic health healers assume it is necessary to engage with the individual in depth. Often, “the most commonly asked question in holistic health [being] ‘What’s going on in your life?’” (Davis-Floyd, 2001, p. S20). This means that in the clinical setting, holistic healers will take a very detailed history of the person and attempt to respond to each individual’s needs with this history in mind: “Each interaction with a person is filled with the potential for growth, understanding, and touching one another in a deep and significant way” (Johnson, 2003, p. 355). According to Davis-Floyd (2001), “if the body is an energy field, then as they interact the energy fields of client and practitioner can merge” (p. S17). Both the client and healer are considered to be active participants in the process. “In the holistic practice, ‘diagnosis and healing from the inside out’ can refer to the information that arises from deep inside both patient and physician – a phenomenon explained at its core by their essential unity” (p. S18). Despite the relational component

of holism discourse, the Western standpoint of holism appears to maintain an element of individuality in the approach to wellness: “A basic tenet of holistic healing is that ultimately, individuals must take responsibility for their own health and wellbeing” (p. S18). Davis-Floyd (2001) states that “no one can really heal anyone else; individuals must decide for themselves if they want to be healed, and if so, they must take action to achieve that goal – give up smoking, exercise, eat right, maybe even give up a lucrative job that makes them unhappy or a relationship that is harmful to their health” (p. S18).

In practice, no one approach is assumed by all holistic healers. Some practitioners focus on one particular mode of healing, while others may employ more of an eclectic approach to healing (Davis-Floyd, 2001). The major fields of holistic health practice include mind-body interventions, bioelectromagnetic applications, alternative systems of medical practice, manual healing methods, pharmacological and biological treatments, herbal medicines, and diet and nutrition (Cohen, 1998). Possible modes of intervention include psychotherapy, imagery, yoga, art therapy, prayer, electroacupuncture, nerve stimulation, Ayurveda, community based healings, homeopathic medicine, chiropractic, massage, traditional herbal remedies, vitamins, macrobiotic diet, and ceremonial practices to name but a few (Davis-Floyd, 2001). While this is not an exhaustive list, it does provide an understanding of the wide array of mechanisms that may be adopted in the healing process from a holism perspective.

Informing PHC.

According to Goldstein, Sutherland, Jaffe, and Wilson (1987) and Strandberg, Ovhed, Borgquist, and Wilhelmsson (2007), the holism discourse has been influential in shaping PHC. The holism discourse guides PHC to take into account a broad range of

people's needs, inclusive of psychological, physical, and social factors (Strandberg et al., 2007). This emerges by way of whole-person care, one attribute informing person-oriented dimensions of PHC. Haggerty et al.'s (2007) attribute of whole-person care includes a broad range of physical, emotional, and social factors impacting on health.

However, Strandberg et al. (2007) suggest that in relation to PHC, "the word holistic should really be spelt 'wholistic' to avoid confusion with complementary and alternative medicine" (p.7). Thus, this signifies that in PHC the holism discourse may not necessarily refer to the broad range of complementary and alternative medicines that is sometimes associated with a Western view of holism. Yet, Strandberg et al. (2007) indicate that the holism discourse guides the provision of effective care, which "has to do with biomedical conditions, culture and context conditions, medico-psychological and social conditions" (p. 6). According to this description, the holism discourse also informs cultural sensitivity – another attribute shaping person-oriented dimensions of PHC (Haggerty et al., 2007). PHC physicians and nurses have pointed to holism for providing an overall understanding of a person "which include patients' social contexts as well as their body and soul" (Strandberg et al., 2007, p. 3). Additionally, relational continuity – another attribute informing person-oriented dimensions of PHC (Haggerty et al., 2007) – is informed by the holism discourse (Mercer & Howie, 2006; Sandberg et al., 2007).

Although, the extent to which holism is included in PHC is influenced by the organization context. For example, Strandberg et al. (2007) state "the organisation of primary care affects the conditions for using a holistic view" (p. 4). Strandberg et al. (2007) advocate for greater inclusion of multidisciplinary teams – one attribute informing Haggerty et al.'s (2007) structural dimensions of PHC. For example, Strandberg et al.

(2007) describe how health care practitioners from diverse professional backgrounds helps to promote a understanding of a person seeking care: “Teamwork is another factor of importance for understanding the patient’s whole situation [and]...makes it possible to elucidate the patient’s situation from different professional angles” (p. 4).

However, Lutschini (2005) raises concerns that the holism discourse informs health systems - including PHC - in a way that signals that Aboriginal and Western societies are homogeneous. For example, Lutschini (2005) describes how in the literature, Aboriginal holistic health is presented in a way that is considered “consistent with comprehensive [PHC]” (p. 5). According to Lutschini (2005), holism discourse when rooted in an Indigenous perspective shapes PHC differently than what is presented from the Western perspective above. For example, how PHC is shaped would be determined by way of Aboriginal community control and decision-making.

Equity in health.

There appears to be varying congruence of the holism discourse with Wallace’s (2008) model of equity in health. When holism is rooted in Indigenous epistemologies, it appears to support Wallace’s (2008) model. For example, holism informed by an Indigenous epistemology encourages interpersonal relationships that reflect a non-hierarchical state of equality at all levels of human interaction. As well, health is viewed broadly and does not assume only one theoretical stance in the pursuit of health and wellbeing. Furthermore, holism that is informed by Indigenous epistemology takes into consideration the whole condition of health at all levels, and across time; knowledge deeply rooted in history is valued. Also, holism informed by Indigenous epistemology values transdisciplinary teams and global collaboration in the broadest terms – it is

inclusive of all peoples. When informed by Indigenous epistemology, holism promotes cultural competence and cultural appropriateness; it is coherent and challenges the dominant structures by its very nature of being. In order to maintain and hold onto one's Indigenous beliefs one must challenge existing structures and social processes at all levels. Battiste (2000) describes how these various struggles and challenges occur at all levels and "cannot...be reduced to...one-dimensional solutions. Interventions and transformative strategies must be correspondingly complex, and they must be able to engage with and react to the multiple circumstances and shapes of oppression, exploitation, assimilation, colonization, racism, genderism, ageism, and the many other strategies of marginalization" (p. xxi). The holism discourse as influenced by Indigenous epistemology consistently challenges dominant structures and social processes, particularly those that continue to perpetuate colonization and oppression.

The Western view of holism also promotes a broad view of health and advocates for a wide array of approaches promoted by Wallace's (2008). Western-based holism discourse appears to take into account not only the whole person but also their environmental context. However, in health care practice, it appears to pay little attention to the structural or social processes related to health and wellbeing. One potential shortcoming of the contemporary Western holism perspective is that it perceives sickness/illness as the result of personal disharmony, and this can have a tendency to place the fault of the sickness or illness with the individual. Thus, Western holism mainly takes a downstream approach to health (Diderichsen et al., 2001).

It is unclear the extent to which the Western-based holism discourse is congruent with Wallace's (2008) principles of evidence-based approaches or transdisciplinary

teams. However, it does appear congruent with global collaboration particularly since it largely values systems-oriented strategies and takes into consideration the interconnectedness of one's social world. This discourse of holism is moderately congruent with Wallace's (2008) principle of cultural competence and cultural appropriateness; it is attended to at the micro level but not consistently at the micro and macro levels. Furthermore, the Western view of holism is only marginally congruent with social justice and the influence of social context. Immediate social and structural forces impacting on an individual's health and wellbeing may be taken into consideration; however, broader forces are often neglected. There is minimal congruence with Wallace's (2008) principle of repairing of damage experienced by those excluded. Considering that holism emphasizes relationships and interconnectedness, it appears that it would encourage congruency with the building of trust. However, there appears to be no attention given to Wallace's (2008) principle of redistribution of wealth and access to opportunity in Western-based holism.

Political Economy Discourse

Political economy discourse provides a structural approach to health by viewing politics and economies as interrelated and influential in health outcomes. Political economy discourse "is about the relationships among the state, economy, and civil society" (Raphael & Bryant, 2006). The assumptions that the political economy discourse makes about health are as much political as they are social. Health is viewed as a reaction to a society's political economy. Political economy considers good health to be a state of physical and emotional wellbeing which includes "access to and control over the basic material and non-material resources that sustain and promote life at a high level

of satisfaction” (Baer, Singer, & Johnsen, 1986, p. 95). To achieve this, the political economy discourse advocates for universal access to a broad range of health care services (Lupton, 2006).

Political economy discourse generally does not challenge the biological approach to health and considers biomedical health care essential to cure acute conditions, injuries, and chronic illnesses (Armstrong et al., 2001); however, it recognizes a need for a broader scope of interventions. The political economy discourse does have a concern about the influence of capitalism on shaping health care and considers this to be problematic (Lupton, 2006; Navarro & Muntaner, 2004). It is assumed that “capitalism produces health needs which are treated in such a way as to obscure their origins and demands the consumption of commodities to secure the healing process, which in turn supports the capitalist system of production” (Lupton, 2006, p. 10). The political economy discourse approaches health care institutions and professionals with scepticism, because they are viewed as significant sources of power and contributors to inequity (Baer et al., 1986; Navarro & Muntaner, 2004). Health care institutions are not considered to be the main route to achieving health (Williams, Deber, Baranek, & Gildiner, 2001).

The political economy discourse assumes that larger structures of society are a required focal point in order to understand and improve health. Materialist explanations are considered important and are defined “as those which refer to experiences arising as a consequence of social structure and organization, over which the individual has no control” (Bartley, 2004, p. 96). For example, political economy discourse provides a recognition that the AIDS crisis extends far beyond a medical issue because it has social,

racial, political, economic, and cultural dimensions (Carlson, 1996). As well, political economy discourse recognizes inequities between populations and sees “marginalized groups, such as women, people from non-English-speaking backgrounds, non-whites, the aged, the unemployed and members of the working class, tend to endure greater social and economic disadvantage than those from privileged groups, have restricted access to health care services and suffer poor health as a result” (Lupton, 2006, p. 9).

Furthermore, the political economy discourse seems to recognize a tension between agency and state. Macro level structures are viewed as distinct from people with causes of poor health seen as diffuse and most often related to socio-economic factors resulting from capitalist production such as “over-processed foods treated with chemicals, pollution, stress, alienation and occupational hazards” (p. 10). Structures such as the mode of production are viewed as social constructions that contain power and impact on health outcomes and accessing of health care. Yet the political economy discourse does not delimit agency, it suggests that there exists an element of individual autonomy in navigating and engaging in the world, albeit in a restricted way. What appears to be absent from the political economy discourse is an awareness of the individual experiences of health and health care since the primary focus is on population and societal levels of analysis. Thus, this discourse does not appear to attend to the individual’s need for immediate attention. According to Lupton (2006), the political economy discourse views the ill person as being “reduced to ‘a specimen of societal processes’” (p. 11). By placing its main focus on broader structural forces, the political economy discourse largely overlooks individual health experiences.

Informing PHC.

The political economy discourse assists in providing some explanation as to how the broader context might shape a conceptual model of PHC when actualized. The political economy discourse encourages an exploration to understand PHC and the broader health system as a “dynamic complex social, political and economic phenomenon” (p.862). For example, Félix-Bortolotti (2009) states that the political economy discourse provides a perspective that assists in understanding conflicts related to: PHC organizational structures, health care providers, intersectoral partnerships, management, and policy and decision-makers.

Félix-Bortolotti (2009) describes how PHC models take on different forms based on political and economic priorities. The political economy discourse provides a lens to explore the influence of contextual forces that shape and may account for differences in PHC models. For example, Félix-Bortolotti (2009) states that “each country health care systems is circumscribed and embedded in a dense, complex institutional, legal and structural arrangement also complicated by an intense political process deeply entrenched in the nation state and their regional government” (p. 862).

The political economy discourse also provides a lens to evaluate PHC – a sub-system of the health care system - in relation to the larger health system (Félix-Bortolotti, 2009). In order to understand PHC, the political economy discourse considers it necessary to gain an understanding of the whole. Félix-Bortolotti (2009) describes how PHC cannot be understood separate from the rest of the health care system. However, this is considered a challenging feat because of the specialized and compartmentalized nature of health care that poses challenges to the integration of services and intersectoral

collaborations (Félix-Bortolotti, 2009). What the political economy discourse offers is a way to understand challenges that might emerge in the implementation of PHC attributes – such as structural dimensions’ system integration (Haggerty et al., 2007) – by gaining an understanding of the whole health care system.

Sandy, Bodenheimer, Pawlson, and Starfield (2009) advocate for the healthcare system to become more balanced between tertiary care and PHC. Guided by the political economy discourse, Sandy et al. (2009) advocate for action in PHC around five key areas: reimbursement, clinical workforce, medical education, practice infrastructure, and health system performance measurement. First, health care reimbursement is to be realigned with a population health value “as opposed to the current system that rewards technical procedural volume” (p. 1141). Second, Sandy et al. (2009) encourage development of clinician-to-population ratios in PHC which requires a government and economic commitment. Third, Sandy et al. (2009) encourage medical education curriculum to have greater inclusion of knowledge about the SDOH. Fourth, Sandy et al. (2009) advocate for government to increase monetary and technical support for PHC. Fifth, Sandy et al. (2009) advocate for key performance indicators that “track both the “health” of the nation’s primary care system” (p. 1142) and the health of the population. Political economy discourse provides a lens that helps demonstrate the role of political and economic structures in shaping PHC models.

Equity in health.

The political economy discourse is largely coherent with Wallace’s (2008) model because it focuses on the structural factors that are considered central to health disparities. Health is viewed broadly from the political economy discourse. There may

be some coherence to Wallace's (2008) model in health care and training. Yet, even though the political economy discourse values biological based knowledge, its main focus is on broad social, economic, and political structures. Thus, its aim is not to provide guidance on health care practice and intervention strategies. Political economy discourse illuminates underlying oppressive and restrictive forces associated with health and health care. Thus, targeting structures is viewed as preventative measures in the alleviation of health inequities.

Although the political economy discourse has a primary focus on inequities, there does not appear to be a wide array of theories, perspectives, and identities that are promoted thus limiting coherence to Wallace's (2008) model. Coherent with equity in health, the political economy discourse directs its attention upstream to structural mechanisms yet there is little attendance to the downstream clinical issues and how people cope with illness and disability (Diderichsen et al., 2001) thus limiting understanding of the absolute condition.

It is unclear the extent to which the political economy discourse is coherent with Wallace's (2008) evidence-based principle. However, it does appear that political economy discourse supports transdisciplinary teams in research, knowledge development, and action implementation as advocated by Wallace (2008). To target factors that cross multiple social, economic, and political systems, expertise and knowledge from various backgrounds is considered necessary. Political economy discourse is also congruent with global collaboration in that it sees the integration of world economies, politics, culture, and social issues as intertwined with the pursuit of health. Political economy discourse

agrees with Wallace (2008) in the recognition that health inequities cannot be successfully reduced without broad intersectoral action.

Political economy discourse is congruent with Wallace's (2008) principle of cultural competence and cultural appropriateness. Racism, discrimination, and oppression in knowledge and strategies are considered necessary targets for intervention. One example of this is presented by Quinonez (2004) who, upon examination of dentistry needs of Nunavut, identified the impact of institutionalized experiences of racialization on dentistry issues. Quinonez (2004) describes how racialization and the effects of colonization must be included in health care in order to meet dentistry issues in Nunavut.

The political economy discourse does not appear congruent with Wallace's (2008) principle of health literacy and linguistic appropriateness because it does not provide guidance on practice strategies like health promotion, health education, and health communication. However, political economy discourse is congruent with Wallace's (2008) principle of ensuring the right to health. The goal of political economy discourse is to reshape macro structures and in doing so, alter those that contribute to ill health and act as barriers in realizing rights to health. There is "a strong commitment to identifying how these structures can be changed to promote health and wellbeing" (Raphael, Bryant, & Rioux, 2006, p. 5). It does this in part by calling for a mass social movement in the dominant contemporary health arenas. To address issues of structural inequity, one desire of political economy is "to change dependency upon medical technology, decommodify medicine, challenge the vested interests of drug companies, insurance companies and the medical profession, and redirect resources toward ameliorating the

social and environmental causes of ill health” (Lupton, 2006, p. 9). Thus, attendance is on restructuring the broad structures as opposed to the immediate elements of access.

Political economy discourse is also congruent with Wallace’s (2008) principle of social justice and recognizing the influence of social context. Attention is given to those who have been marginalized in society and by illuminating the political and structural conditions that contribute to inequity and ill health. It adheres to the value of social justice by recognizing the dominant perspectives that influence health and health care are those that are also considered to be contributors to social inequities.

Like Wallace (2008), the political economy discourse supports the most vulnerable by advocating for change at those macro level structures that contribute to inequities.

However, there is little attendance to how this might emerge in micro level strategies.

The political economy discourse is also congruent with Wallace’s (2008) principle of repairing the damage experienced by those most excluded; this is a primary goal of political economy discourse. It is unclear the extent that political economy discourse attends to the building of trust, also endorsed by a model of equity in health. In the example provided of Quinonez (2004), the importance of relationships was highlighted as a necessary component to repairing the damage of colonization. However, political economy discourse does not often provide explicit direction regarding relationships and leadership issues. Lastly, the political economy discourse is congruent with the redistribution of wealth and access to opportunity described by Wallace (2008). This too is a central concern of the political economy discourse which aims to overhaul economic, political, and social structures that are considered oppressive.

Conclusion

This chapter provided a review of the literature exploring PHC and presenting Haggerty et al.'s (2007) conceptual model of PHC. Wallace's (2008) model of equity in health was then reviewed. Following was an analysis of six health discourses - biomedical, biopsychosocial, health promotion, SDOH, holism and political economy discourses – which assists to uncover some of the beliefs and processes shaping PHC. Wallace's (2008) model of equity was then used to demonstrate how health discourses differ in their promotion of health equity. The aim of this analysis was to demonstrate that a broad span of health discourses is required to support an “ideal” model of PHC like the one provided by Haggerty et al.'s (2007). This analysis also aimed to initiate critical reflection about the health discourses that may or may not be included in PHC, and provide a tool that can help assist in the inclusion of health practices and structures that can lead to greater health equity.

Chapter 3 – Methodology

This chapter begins with a review of the aim of this research including the purpose and the research questions guiding the study. Following is a brief discussion regarding discourse analysis and how it is used to guide this study. This chapter then reviews the process of data collection and details the two key data sources: MOHLTC documents and in-depth qualitative interviews with policy informants and FHT leaders. Following, a review of the five phases of data analysis is provided. This chapter also includes ethical considerations as well as an overview of the limitations and contributions related to this study.

Purpose

There are three main purposes guiding this study; namely: a) to deepen our understanding of health discourses promoted by Ontario's FHT model; b) to explore how Ontario's FHT model compares to Haggerty et al.'s (2007) conceptual model of PHC; and c) to promote critical reflection in order to help inform decisions on how to improve quality of care and enhance health equity in FHTs.

Research Design

This study is informed by a qualitative design consistent with an exploratory approach (Miles & Huberman, 1994). The design is compatible with the aim of this study because it helps to gain a rich understanding of a naturally occurring event (Miles & Huberman, 1994). The aim of this study is not to test theory even though findings may be useful for initial or future development of theory. An exploratory design is appropriate because it will help to achieve the three identified purposes particularly

because descriptive designs aim to make a complex thing understandable by reducing it to the component parts (Miles & Huberman, 1994). This is consistent with the first two purpose statements because this study aims to examine the component parts of the FHT model by identifying: health discourses (core assumptions and beliefs about health), PHC attributes shaping the FHT model, and health care practices and organizational structures being promoted by the FHT model. Thus, this design assists to guide an investigation of the component parts of the FHT model.

Although largely descriptive, this study is also informed with a critical perspective that comes from critical social work practice (Adams, Dominelli, & Payne, 2009; Rossiter, 2005). The use of a critical perspective in the design assists to achieve the third purpose statement. The descriptive framework assists to identify the component parts that inform the FHT model whereas the critical influence promotes critical reflection on the component parts. Like critical social work practice, this study is grounded by the assumption that the examination of different perspectives is valuable. This study is guided by the assumption that examining different perspectives leads to critical thought which then will lead to critical action (Adams, Dominelli, & Payne, 2009). This helps to achieve the third purpose of the study which aims to promote critical reflection on the component parts of the FHT model with the goal that this reflection will help inform decisions on how to improve quality of care and enhance health equity in FHTs.

Research Questions

The overarching question guiding this study is:

- What health care practices and organizational structures are encouraged by the FHT model?

The overarching question will be answered using the following sub-questions:

- What contextual factors are influential in shaping the FHT model?
- What are the health discourses informing the FHT model?
- How does the FHT model compare to Haggerty et al.'s (2007) framework of PHC?
- How does the FHT model compare with Wallace's (2008) model of equity in health?

Discourse Analysis

Discourse definition: “a “dance” that exists in the abstract as a coordinated pattern of words, deeds, values, beliefs, symbols, tools, objects, times, and places” (Gee, 2011a, p. 36).

Introduction

Discourse analysis is used in the study of social life, and offers a method of investigating meanings in interactions and culture (Shaw & Bailey, 2009). Although various approaches to discourse analysis exist, this chapter presents how discourse analysis guided the investigation of this research study. Discourse analysis guiding this investigation is most influenced by the work of Gee (2011a, 2011b) and Fairclough (1989); what follows is a synopsis of the ideas which informed my approach to discourse analysis in this study (Table 3.1).

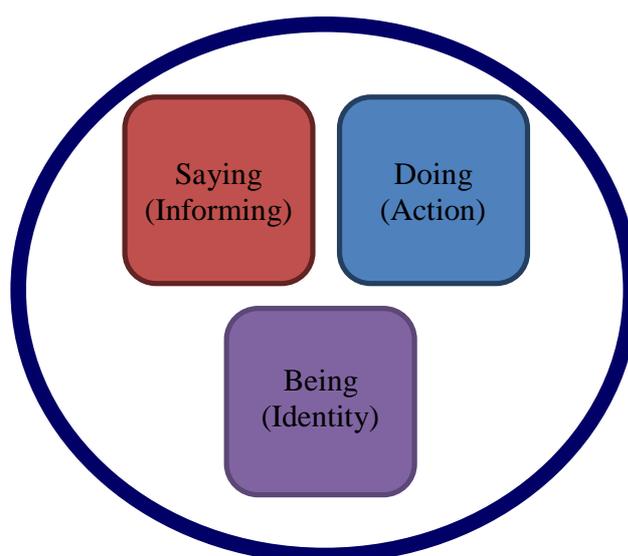
Saying, Doing, Being

Discourse analysis sees meaning about the world emerging from a combination of saying, doing, and being – all interconnected and involved in the forming of discourses (Gee, 2011a; Gee, 2011b). Discourse is being used in this study to refer to the combination and integration of “language, actions, interactions, ways of thinking, believing, valuing, and using various symbols, tools, and objects” (p. 29). Discourse is defined as “a “dance” that exists in the abstract as a coordinated pattern of words, deeds, values, beliefs, symbols, tools, objects, times, and places” (Gee, 2011a, p. 36). This situates values, beliefs, and goals as expressions of the larger conversations that then emerge within discourses (Gee, 2011b). Although I use the term “discourse” – non-capitalized – my use of discourse in this research study parallels what Gee (2011a) refers to as the “D” Discourse.

According to Gee (2011a, 2011b), meaning emerges from a combination of saying (informing), doing (action), and being (identity). Further, Gee (2011a) states, “there are important connections among saying (informing), doing (action), and being (identity)” (p. 2). As well, “A Discourse is a characteristic way of saying, doing, and being” (p. 30) whereby saying (informing) refers to oral or written “utterance” which can be from individuals as well as institutions (Gee, 2011a). Doing (action) refers to a “*socially situated practice or activity* that the utterance helps to constitute” (Gee, 2011a, p. 30). A practice or activity refers to “a socially recognized and institutionally or culturally supported endeavour” (p. 17) and adherence to practices are often linked with the distribution of social goods (Gee, 2011a). Lastly, being (identity) refers to a “*socially situated identity*” (p. 30) which Gee (2011a) uses to refer to the identities that individuals

take on in different contexts (such as professional identities). However, for the purpose of this study, being (identity) will be used more broadly to refer to the FHT organizational structure identity. According to Gee (2011a), the combination of saying, doing, and being is important because the utterance only has meaning “if and when it communicates a *who* and a *what*” (p. 30). Inspired by Gee (2011a, 2011b), discourse analysis guides this research study in the examination of discourses that emerge from the combination of saying (informing), doing (action), and being (identity) (Figure 3.1).

Figure 3.1: Discourses Informed From a Combination of Saying, Doing, and Being



Context

Additionally, discourse analysis views context as important in shaping what meanings emerge (Fairclough, 1989; Gee, 2011a). According to Fairclough (1989), social conditions are central in the shaping of discourses, “which can be specified as social conditions of production and social conditions of interpretation” (p. 25).

According to Fairclough (1992), “the context in which the discursive event is produced is

comprised of a nexus of practices produced as a result of a particular historical, political, institutional, economic, and social environment” (cited in Smith, 2007, p. 62). Ife (2001) reminds us that understanding context is important because we then come to know how discourses have come to be, thus providing knowledge on how current discourses have been shaped, which also suggests that future change is possible where necessary. Inspired by Fairclough (1989, 1992) and Gee (2011a), discourse analysis shapes this research in the identification of the context influencing discourses.

Table 3.1: Discourse Analysis: Key Attributes Guiding Study

<p>Saying (informing): an oral or written communication; <i>utterance</i></p> <p>Doing (action): socially situated activity or practice; <i>what</i> (ex. health care practices)</p> <p>Being (identity): socially situated identity; <i>who</i> (ex. FHT organizational structure)</p> <p>Context: influential historical, political, and economic factors</p>

Descriptive – Critical

The approach of this study is largely descriptive yet influenced by inclusion of a critical perspective. Although descriptive and critical approaches to discourse analysis are often represented as mutually exclusive, my approach to discourse analysis has been inspired by Gee (2011a) who sees that there is some overlap between the two: “when we use language, social goods and their distribution are always at stake [thus] language is always “political” in a deep sense” (p. 7). Gee (2011a) also reminds us of the power of language in that it is used to make “certain forms of knowledge and belief relevant or privileged...that is to build privilege or prestige for one sign system or way of knowing over another” (p. 20). Also, congruent with one goal of critical discourse

analysis is that discourses are considered to be shaped and shaped by social practices (Smith, 2007). Exploring how equity in health is included and attended to by the emerging health discourses shaping Ontario's FHTs does require some degree of critical evaluation – although, this is not to be confused with critical discourse analysis.

Appropriateness of Discourse Analysis for this Research

Discourse analysis is an appropriate approach to guide this investigation for several reasons. First, greater inclusion of discourse analysis has been advocated for conducting research in health; for example, White (2004) stated, “there is a very important role for discourse analysis in the health field” (p. 8), and Shaw and Bailey (2009) argued that it can add to the deepening of knowledge for PHC. Discourse analysis is an appropriate theoretical and analytical foundation to examine policy issues particularly since “[d]iscourses are always embedded in a medley of social institutions” (Gee, 2011a, p. 35) like those that shape health care. In fact, discourse analysis is considered to be a valuable methodology to discern constructions of meaning in health policy (Smith, 2007) and direct health care practice (White, 2004).

Rossiter (2005) also advocates for discourse analysis as it fosters critical reflection and allows us to “situate our failures and successes in accounts of the complex determinants of practice so that we can acknowledge practice as historically, materially and discursively produced, rather than simple outcomes of theories, practitioners and agencies...” (n.p.). In doing so, Ife (2001) and Fook (1999) indicate that discourses posing challenges can be changed. This is an important site for investigation because discourses are “by no means, just statements” and “beliefs” (Gee, 2011a, p. 57) considering that they distinctively shape “mind, body, and social practice” (p. 57).

Hence, discourse analysis provides a methodology that is appropriate to provide in depth knowledge of Ontario's FHTs.

Discourse analysis also illustrates how meanings and context are interrelated, which is important when health care decisions are often complex and linked with political and economic realities. Furthermore, Gee (2011a) states that: "[d]iscourses are always defined in relationships of complicity and contestation with other [d]iscourses, and so they change when other [d]iscourses in a society emerge or die" (p. 38). Given that Ontario's FHTs are recently implemented, it is an optimal time to embark on a discourse analysis as this may be a time when there is tension between discourses, or it may be a time when new discourses are emerging. Further, the use of Gee's (2011a, 2011b) approach to discourse analysis is appropriate for an additional key reason: Gee's (2011a, 2011b) approach to discourse analysis hones in on the two pillars of PHC described by Donabedian (1966).

Gee's (2011a, 2011b) approach to discourse analysis guides examination of health care practices (doing) and FHT organizational structure (being). Donabedian's (1966) influential work is grounded in the belief that PHC is comprised of both processes and structures. The use of discourse analysis in this study assists to explore both processes and structures of PHC. For example, "doing" facilitates an exploration of health care processes that underpin FHTs. Also, "being" facilitates an exploration of the FHT structure. Thus, the combination of saying, doing, and being is an effective approach to examine two key pillars informing PHC. Thus, Gee's (2011a, 2011b) approach to discourse analysis informs this study in a way that hones in on the foundational elements that comprise PHC. Hence, discourse analysis assists in the exploration of the

underpinnings informing FHTs, which can then be used to deepen our understanding and hopefully lead to FHTs that deliver more effective PHC.

Sampling

Two data sources comprise the sample: MOHLTC documents and in-depth qualitative interviews. An overview of the sample will be provided in greater depth following a brief description of sampling strategies used in this study.

Sampling in this study included: a) purposive, b) stratified purposive, and c) snowball sampling strategies (Miles & Huberman, 1994). A description of how sampling strategies guided data collection for the MOHLTC documents and in-depth qualitative interviews is provided in greater detail below. However, a general description of each of the three sampling strategies will first be provided.

Purposive sampling is commonly used in qualitative studies and means that the sample is not obtained randomly; instead, a boundary is set that helps guide sample inclusion (Miles & Huberman, 1994). Stratified purposive sampling means that the sample is not obtained randomly and that the aim is to obtain representation from prespecified subgroups (Miles & Huberman, 1994). Stratified purposive sampling helps to facilitate comparisons between different subgroups (Miles & Huberman, 1994). Examples of subgroups that will be described in greater detail below are: geographical region and year of FHT approval. Lastly, snowball sampling “identifies cases of interest from people who know people who know what cases are information-rich” (Miles & Huberman, 1994, p. 28). Following is an explanation of sampling for each of the data sources included in this study: MOHLTC documents and in-depth qualitative interviews.

MOHLTC Documents

The first data source included in this study is MOHLTC documents. Twenty-six key documents prepared by the MOHLTC for the purpose of providing information to FHTs were reviewed (Appendix A). These twenty-six MOHLTC documents were purposively selected for the study because they have been made available to FHTs for the intention of assisting newly emerging FHTs. These guide documents serve as information for FHTs that are provided by the MOHLTC in order to assist approved FHTs in their development. All documents that were listed as FHT guides on the MOHLTC website were included in this study. Documents were retrieved from the MOHLTC website on August 31, 2010. Prior to writing up research findings in January 2012, the documents being used in this study were cross-checked with the MOHLTC website to determine if any updated versions of the documents had been released. The intention was to ensure that the most current MOHLTC information was included in the study. Documents retrieved in August 2010 were consistent with the FHT guide documents that were on the MOHLTC website in January 2012. Any new MOHLTC FHT documents that were added to the MOHLTC website after January 2012 were excluded from this study. Given that these documents are aimed at providing newly forming FHTs with foundational guidance, it was determined that these documents would provide useful data.

In-depth Qualitative Interviews

In-depth qualitative interviews took place with two groups of stakeholders: key policy informants and FHT leaders (Appendix B). Purposeful and snowball sampling was implemented and considered useful for this study because it means that participants

“can purposefully inform and understanding of the research problem and central phenomenon in the study” (Creswell, 2007, p. 125).

Policy informants.

In-depth qualitative interviews took place with **seven** policy informants. Policy informants include MOHLTC policy and decision-makers who have directly shaped or implemented FHT policy, or those outside of the MOHLTC who have influenced the development of FHT policy as a consultant. An initial list of policy informants was identified from key MOHLTC documents. Email addresses of these policy informants were then obtained using publicly available information found on the Internet. Information about the study and request for participation was sent to these individuals by email. Policy informants included in this study were those who voluntarily replied to the initial email and indicated interest in participating. Following completion of each of the policy informant interviews, participants were asked if there were other people who they thought should be included in this study. People identified by participants were then sent information about the study and request for participation by email, and then included in this study if they voluntarily replied to the email and indicated interest in participating. One policy informant was identified at a conference when speaking on their involvement in shaping FHT policy. An invitation to participate was sent to thirteen policy informants and 7 accepted the invitation. Interviews with policy informants occurred between November 4, 2010 and December 16, 2010 – simultaneously with the interviews with FHT leaders.

FHT leaders.

In-depth qualitative interviews took place with **twenty-nine** FHT leaders. The sample of FHT leaders consists of those within leadership positions including: physicians, executive directors, and clinical leaders. Purposeful and snowball sampling were used in recruiting these participants. I generated a master email list for FHT leaders using three methods. First, a contact list was provided by one policy informant that contained email information for 167 FHT leaders. Second, the master email list was added to using publicly available information retrieved from the Internet. Third, additional email contact information was obtained by calling FHTs directly and after identifying myself as a doctoral student doing research on FHTs requesting the email address for the FHT executive director and lead physician.

The FHT leader sample was guided by stratified purposive sampling in that data collection strived to collect equitable representation from two prespecified subgroups: the year that the FHT application was approved (or wave) and the geographical location of the FHT. Initially, emails inviting participation were sent out to those leaders for whom I had direct contact information. As the study continued, I became increasingly purposive in sending out invitations to FHTs in order to get representation from the two subgroups. For example, I received quick responses from FHTs that were approved in the first wave indicating interest to participate. Once I had approximately five interviews scheduled per wave subgroup, then I no longer actively recruited from those within the subgroup. What this means is that after there were ample interviews scheduled from the wave one FHTs, invitations to participate were sent to wave two, three, and four FHTs. The initial aim of this study was to obtain a sample that included an equal number of

participants from each of the first four waves (or time periods) FHTs were approved by the MOHLTC: April 2005, December 2005, April 2006, and December 2009. The reason for this was it was thought that participants from each of the four waves may have different insights and experiences based on the time period that their FHT was approved; it was intended that the culmination of insights reflecting the varying time periods would provide an overall understanding of the FHT model as opposed to the experiences of FHTs during one particular time period.

Although the intention at the outset was to get a sample with an equal number of participants from each of the four waves, this was not possible. The researcher was able to recruit participants representative of waves one to three; however, there is only one participant from wave four FHT (Appendix B). It became apparent early on in the interviews that an extensive amount of work for the leaders is necessary between the time that a FHT is approved by the MOHLTC and the time that the FHT becomes operational. Leaders from wave four FHTs that declined participation indicated one of three reasons: the FHT had not yet become operationalized, the FHT was only recently operational and leaders declined because it was not operational long enough to reflect upon, and also, FHT leaders from wave four indicated that they were just too busy trying to get the FHT operational to participate.

Further, purposeful sampling was used to recruit FHT leaders in a way to promote geographical representation from five regions of Ontario: northeast, northwest, southeast, southwest, and central (greater Toronto area). Approaching the sample of FHT leaders in this manner “ensure[s] that appropriate numbers of elements are drawn from homogeneous subsets of [this] group” (Rubin & Babbie, 2008, p. 354). The reason for

purposeful sampling was to facilitate inclusion of diversity in experiences based on when the FHT emerged or where the FHT is geographically located. For example, insights and experiences from FHTs located in the two northern regions may be different than those located in the southern regions. Once an equitable sample from the FHT waves and various geographical locations was achieved, recruitment ceased.

Invitation to participate was sent to ninety-three FHT leaders – executive directors and physicians – requesting participation from them or someone who holds a leadership position in the FHT. Additionally, one FHT leader who holds a clinical manager leadership position was identified at a conference and then emailed an invitation to participate in the study. Criteria for inclusion into the study were those within the FHT who are in a leadership position. The researcher believed that FHT leaders would have insight into the framework of beliefs and processes that were shaping the FHT. Further, the majority of the leaders were involved early on in the FHT development including at the time of FHT application submission, or early on in the operationalization of the FHT. Thus, FHT leaders could provide in-depth knowledge on their broad experiences. Furthermore, FHT leaders are in a position where they are exposed to policy documents and decisions, thus, could add their reflections in a way that could help bridge program policy and the operationalized FHTs.

Snowball sampling was also used for this sample. Although FHT leaders were not asked to suggest additional potential participants – as were the policy informants' sample – four FHT leaders invited other leaders within the same FHT to participate in the interview. For example, two interviews – FHT leader interview 10 and FHT leader interview 12 – were conducted with both the FHT executive director and physician

together. FHT leader interview 15 was conducted with three leaders from the same FHT present: the executive director, lead physician, and clinical leader. Further, FHT leader interview 23 was conducted with the FHT executive director and clinical leader together. The FHT leader that was contacted by this researcher initiated these multiple interviews.

Snowball sampling also influenced two additional interviews. For example, the physician from interview 10 suggested that I also interview the executive director from the same FHT. The interview with the executive director from this same FHT is interview 12. Further, the executive director from interview 16 recommended that I interview one of the physicians from the same FHT. The physician was interviewed immediately following the executive director and is documented as interview 17.

Combined sample.

The total number of participants included in the sample – policy informants and FHT leaders combined – is thirty-six.). Individual interviews were conducted with twenty-seven individual participants. Four small focus group interviews were conducted: three groups of two participants and one group of three participants. Although each these groups were comprised of a small number of participants, I am intentionally using the term “focus groups” because what distinguishes focus groups from other types of group research is that data is generated as a result of the interactions among participants (Morgan, 1996). This was the case in the four focus groups for this study: data were collected that would not have otherwise emerged without the interactions among the FHT leader participants. Within the combined sample of **thirty-six participants**, twenty-nine were FHT leaders and seven were policy informants.

Table 3.2: Sample Overview

Sample Overview	FHT Wave	FHT Geographical Location
Policy informants (n=7)	wave 1 (n=9)	SW (n=6)
Physicians (n=10)	wave 2 (n=7)	SE (n=5)
Executive directors (n=15)	wave 3 (n=7)	NW (n=4)
Clinical leaders (n=4)	wave 4 (n=1)	NE (n=4)
		Central (n=5)
Total Sample: (N=36)		
Policy (n=7)		
FHT leaders (n=29)		

Data Collection

The use of multiple strategies in data collection was used to foster a comprehensive examination of various levels of analysis. According to Chreim, Williams, and Hinings (2007), “The macro and micro streams of research have developed in parallel rather than interactively” (p. 1518). This research seeks to follow the recommended calls to integrate data focused at these intersecting levels (Barley & Tolbert, 1997; Chreim et al., 2007). Furthermore, triangulation – or the use of multiple strategies – “can contribute towards the comprehensiveness of a study” (Casey & Murphy, 2009, 42) and adds to the trustworthiness (or validity) of the findings (Cresswell, 2007). By using multiple data sources, I have gathered multiple perspectives from a variety of sources “so that as complete a picture as possible...can be built and the varied dimensions revealed” (p. 42).

The researcher, Rachele Ashcroft, conducted all interviews. Invitational letters were sent to policy informants (Appendix C) and FHT leaders (Appendix D) via email requesting participation in the study. Policy informants and FHT leaders were asked to contact the researcher by email or telephone if willing to participate in the study. Interviews were then scheduled at a time and location convenient for the participants.

Thirty-one interviews were conducted with the duration of interviews being approximately 45 minutes - 1.5 hours in length. Twenty-three of the interviews were done in person, and the remaining eight interviews were conducted by telephone.

Before each interview, written consent was obtained from each of the participants. Participation was voluntary. I used a semi-structured interview guide to provide consistency (Appendix E, Appendix F). Field notes were used to capture observations and nonverbal information during the interviews. Audiotapes for each interview were transcribed and analyzed. Transcription was done by both the researcher as well as by a professional transcriber. Once transcription was completed, the transcribed document was reviewed to ensure accuracy with the audio-recorded interview. Further, each participant was sent via email a copy of the transcribed document and was encouraged to make or suggest any changes that they felt were necessary. This was done to ensure that data was captured accurately; as well, participants were able to delete any information that they felt might compromise their confidentiality upon publication of findings.

Data Analysis

There were five phases of the data analysis process. Prior to starting data collection, I looked at context by reviewing MOHLTC documents in order to help inform the interviews. This was important to provide me with a basic understanding of context prior to data collection. Data analysis occurred once all data were collected following the five phases of the analysis process described below.

Phase one of the analysis was where open coding was applied to the data. Open coding was useful for reduction of data. Given that a vast amount of data had been

collected from all data sources, the aim of phase one was to break the data into manageable pieces using broad categories (Creswell, 2003).

Phase two of data the analysis applied the prespecified (Miles & Huberman, 1994) discourse analysis framework of saying, doing, and being. The second phase of data analysis was looking for health discourses in the three areas of saying, doing, and being (Gee, 2011a). The category saying (informing) looked at data where attributes of PHC were talked about, the category doing (action) looked at data on health care practices implemented in FHTs, and the category being looked at data that referred to FHTs' organizational structures. Phase two of the data analysis was challenging because health discourses overlap, health discourses are abstract and at times difficult to discern, and participants do not actively use the language of "discourses". Gee (2011a) tells us that discourses are an abstract world constructed by academics and theorists to make sense of the world. What this means is that the language of "discourses" is not as prevalent in health practice settings. Some health discourses were clearly identifiable in the data; for example, when participants named the influence of SDOH on FHT priorities. However, this was not the case for all health discourses which added to the challenge of this level of analysis. It was because of these challenges that I decided to return to the literature to look for a conceptual framework and decided to use the Haggerty et al. (2007) PHC lexicon.

Phases three and four of data analysis utilized Haggerty et al.'s (2007) model of PHC. Phase three used Haggerty et al.'s (2007) framework of PHC to theorize health discourses. Haggerty et al.'s (2007) model was selected because it provided an example of a detailed conceptual model that fit as a "bridge" that could make health discourses

more visible in the data and help to achieve the purposes of the study. The data guided my exploration of the literature, which according to Miles and Huberman (1994) reflects an inductive approach whereby the conceptual framework emerges “in the course of the study” (p. 17). Phase four then applied Haggerty et al.’s (2007) model to the data. Phase four resulted in a very detailed analysis which is not included in its totality within the dissertation because of the resulting length. However, it was an influential necessary step in the identification and presentation of core study findings. Phase five of data analysis applied Wallace’s (2007) model of health equity principles in order to see how the FHT model promoted health equity in relation to the data. Data analysis was supported using the computer software program QSR NVivo.

Research Ethics

Research Ethics Board approval was obtained for this study. Participants were provided with the consent form by email at time that the interview was confirmed. This gave them the opportunity to review the informed consent form prior to the interview. Participants were asked if they had any questions or concerns before proceeding with the interview. Signed consent was obtained from all participants; two consent forms were used: one for in-person interviews (Appendix G) and one for telephone interviews (Appendix H). The signed consent forms are kept in a locked drawer. Research data is stored in a password protected computer. The data will be retained until the time that all academic exploration of the data and subsequent writing is exhausted. After this time, the electronic audio files of the interviews and transcriptions will be deleted.

Care has been taken to avoid contextualizing the report of the results in a way that would identify participants. Identifying information – such as individual names, FHT

names, identifying community names, or other details as determined by the participant – have been removed from the data and replaced with pseudonyms. Further, a code has been assigned to each participant and is used on documents in place of identifying information – policy informants have been assigned the code “PI” followed by a number indicating their interview number. FHT leaders have been assigned as “L” followed by a number to indicating their interview number. In the case of those FHT leaders who participated in one of the multiple interviews, they are also assigned a sub-number 1, 2, or 3 based on who began speaking first in the interview. For example, FHT leader interview 10 is coded as: L10.1 and L10.2. Another example is the FHT leader interview 15 which has three participants involved in the same interview and has been coded as: L15.1, L15.2, and L15.3.

Participants were also emailed a copy of their transcript for review following the interview giving them the opportunity to modify or remove anything that was said in the interview. To enable participants to remain anonymous and unidentifiable, identifying information will be replaced with codes or pseudonyms in publications and other release of study findings. Participants’ names and names of specific FHTs will not be included in the research reporting in order to allow them to remain anonymous.

Limitations and Contributions

One limitation of this research is that it focuses on the FHT model that currently exists only within the province of Ontario. This limits the transferability of findings from being applied to other models of PHC. Further, this study is limited to the sources of data: MOHLTC guide documents, and in depth qualitative interviews with policy informants and FHT leaders. The inclusion of alternate document sources – such as any

additional manuals provided by the MOHLTC aimed at shaping FHTs – would have added an additional perspective. Using only the guide documents is limited.

Furthermore, documents are limited because there are additional ways that program policy information is communicated to FHTs – for example, communication may occur orally by way of a direct ministry representative. Therefore, documents are only one source of communicating meaning about FHTs. Also, as Family Health Teams are inclusive of various interdisciplinary professionals, conducting interviews with additional selected informants may have provided a different perspective and rich sources of data. Given that there is diversity between FHTs in terms of variations of interdisciplinary professionals, numbers of health professionals, and size of FHTs, FHTs themselves are not homogenous. Thus, future research on FHTs that is inclusive of a greater variety of perspectives will assist to broaden knowledge.

However, there are also numerous benefits associated with this research. FHTs are an interdisciplinary approach to PHC that emerged in Ontario in 2005. As this is a new model for delivery of PHC in Ontario, little research has been done. This research has potential benefits for the participants as it will provide them with information that can be used to reflect upon how to best to address health needs. Knowledge gained from this research will be of assistance to policy makers and provide information that will assist policy makers to reflect on how best to strengthen the FHT model. Furthermore, this study will add to a growing body of research on PHC. Although this research is specific to Ontario's FHTs, the added contribution to the PHC literature may facilitate future studies examining underlying health discourses in other locales. Importantly, this

research has benefits for the society at large as it will generate knowledge that may be used to enhance future health care delivery.

Conclusion

This chapter began by identifying the purpose of this study which was: a) to deepen our understanding of health discourses promoted by Ontario's FHT model; b) to explore how Ontario's FHT model compares to Haggerty et al.'s (2007) conceptual model of PHC; and c) to promote critical reflection in order to help inform decisions on how to improve quality of care and enhance health equity in FHTs. This chapter then provided an overview of the qualitative exploratory design guiding this study and how this study is largely descriptive, yet is also informed by a critical lens that is drawn from critical social work practice.

The overarching research question that is used to achieve the study's purpose which was identified as follows: What health care practices and organizational structures are encouraged by the FHT model? This chapter also identified four sub-questions that were used to focus the overarching research question. This chapter also provided an overview of how discourse analysis is used to guide this study.

An overview of discourse analysis inspired by Gee (2011a, 2011b) shapes examination of meanings that emerge from a combination of saying (informing), doing (action), and being (identity). Discourse analysis also guides this study by facilitating a review of the context shaping Ontario's FHTs. This chapter also described data collection methods starting with identification of the two data sources that comprise this study's sample: a) MOHLTC documents and b) in-depth qualitative interviews with policy informants and FHT leaders. A brief description was provided on the three

sampling strategies used in this study: a) purposive, b) stratified purposive, and c) snowball sampling strategies (Miles & Huberman, 1994).

This chapter then provided an overview of the following five phases of data analysis: a) open coding; b) application of discourse analysis framework of saying, doing, and being; c) theorizing of health discourses using Haggerty et al.'s (2007) model; d) application of Haggerty et al.'s (2007) model to the data; and e) application of Wallace's (2007) principles of equity in health to the data. This chapter then reviewed the associated ethical considerations. Lastly, the limitations and contributions of this study were discussed.

Chapter 4 – Context of Ontario’s FHTs

Discourse analysis emphasizes the importance of context (Gee, 2001a; Fairclough, 1989) in shaping meaning. Hence, this chapter provides a review of key contextual factors – historical, economic, and political – that have shaped FHTs. This chapter draws on a combination of data obtained from interviews with key policy informants and FHT leaders as well as literature – including literature provided to the principal investigator by some interview participants. The intent of this chapter is not to provide an in-depth overview of Ontario’s entire health care history but instead to highlight that which appears to be most significant in shaping Ontario’s FHTs. Content of this chapter is determined by what the key policy informants and FHT leaders identified as contextually relevant during the interviews. The inclusion of literature is necessary to expand on key areas of context identified within the data in order to provide as comprehensive of an overview as possible.

Background

Health care in Canada is funded by the national health insurance program comprised of the ten provincial and three territorial health insurance plans. Federal and provincial/territorial governments share responsibility for the provision of health care services to Canadians (Health Canada, 2011a; Health Canada, 2011b; Health Canada, 2011c). Canada’s federal government administers the Canada Health Act and funding is provided by way of the Canada Health Transfer. Provinces/territories are responsible for the delivery of health care services and are expected to comply with the criteria and

conditions outlined by the Canada Health Act (Health Canada, 2011a; Health Canada, 2011b; Health Canada, 2011c).

There has been considerable attention given to some of the challenges within Canadian health care calling for a strengthening of PHC (Aggarwal, 2009; Barer & Stoddart, 1991; College of Family Physicians of Canada, 2000; Commonwealth Fund, 2011; Kirby, 2002; Lalonde, 1974; Premier's Council on Health Strategy, 1991; Romanow, 2002; Schoen, Osborn, Huynh, Doty, Davis, Zapert, & Peugh, 2004; Sinclair, 2001). For example, some of Ontario's difficulties in PC cited by the Health Services Restructuring Commission report (1999) included:

a shortage of PC services in rural and northern regions; a diminished quality of life for providers...causing low morale; an untapped potential of health care providers; a shortage of nurse practitioners; a lack of coordination between PC and other levels of care; a lack of access...and inappropriate utilization of emergency departments. (Aggarwal, 2009, p. 21)

Even prior to the Health Services Restructuring Commission's report (1999) the chairs of Ontario's five university departments of family medicine were becoming increasingly concerned about these and other challenges that impacted Ontario's PC physicians (Rosser, Colwill, Rosser, Kasperski, & Wilson, 2010). Their central concern was that the dominant physician payment system was rewarding practices with high-volume instead of patient-centered care (Rosser et al., 2010) which resulted with some of the difficulties

highlighted by the Health Services Restructuring Commission (1999). The chairs of Ontario's university of family medicine departments outlined their concerns in an influential white paper and made recommendations advocating for comprehensive PHC in Ontario (Forster, Rosser, Hennen, Mcauley, Wilson, & Grogan, 1994).

One of the concerns raised by Forster et al. (1994) was that the fee-for-service funding system – based on a small business approach to providing care – did not encourage nor did it enable physicians to address the health issues of the community and populations that they served. “Incentives for tackling the broader determinants of health, such as poverty, homelessness, and domestic violence, or for creating prevention or early diagnosis programs [did] not exist for most practitioners” (p. 1524). An additional critique was that the fee-for-service payment model did not encourage comprehensive or continuous care. Forster et al. (1994) advocated for a PHC model inclusive of comprehensive service, approaches targeting individual as well as population based health issues, intersectoral collaboration, community development, and quality control.

Furthermore, Forster et al. (1994) proposed an interdisciplinary approach to PHC comprised of “generalist family physicians working collaboratively with other professionals” (p. 1524). However, changes needed to be made to the existing funding models to facilitate inclusion of these recommendations. Forester et al. (1994) also indicated that a new funding approach for PHC was needed and proposed the inclusion of a blended funding model such as one that had been devised by The College of Family Physicians of Canada. In the funding model proposed by the College of Family Physicians of Canada, “a practice organization would be entitled to funding from each budget component up to a ceiling determined by the number of people registered in the

practice, demographics, health status, and practice location” (p. 1527). Thus, the proposed blended funding model included reimbursement that facilitated individual as well as population based health care approaches. Along with recommending funding changes, Forster et al. (1994) advocated for the implementation of practice registration. Essentially, individuals seeking care would register with a PC physician who they would then be expected to rely on for all of their PC needs. Furthermore, the PC physician would assist in accessing secondary and tertiary health care services as required. Forester et al. (1994) suggested that the proposed changes would assist to alleviate some of the pressures that had been building in the secondary and tertiary care health sectors: “up to 85% of emergency-room care could be better provided by family physicians” (p. 1525).

At the same time that concerns were raised by Forester et al. (1994), family physicians were experiencing similar challenges as voiced by one FHT leader: “We started saying that there was something wrong with family medicine. Everyone is unhappy.... What is the problem?...We thought, what is it and can we fix it? We started talking amongst ourselves...” (L1.15). Similarly, a key policy informant indicated that the call for improvements to PC in Ontario was a result of the challenges experienced in practice: “This wasn’t a Tory project or a Liberal project, this was something that needed to happen” (PI1). However, for changes to be implemented policy makers needed to be engaged in the process:

To make these things happen we would need to find partners, and in particular we would need to work with government – Ministry of Health and with the Ontario Medical Association (OMA). So,

we were lucky that there were receptors in both of those organizations who were interested in some of the same ideas.
(PI1)

For example, two key individuals that became involved in the process of PC improvements included Marsha Barnes who was the Director of PC for Ontario's MOHLTC, and Wendy Graham at the OMA (Aggarwal, 2009).

1995-2003: Harris Conservative Government

In 1995, with Mike Harris as Premier, the conservative government was elected to govern Ontario's provincial office. In a detailed account of Ontario's history of PC reform, Aggarwal (2009) describes how in 1995 Jim Wilson - Ontario's conservative provincial Minister of Health - directed the Provincial Coordinating Committee on Community and Academic Health Sciences Centre Relations (PCCCAR) to provide advice on the future of PHC in Ontario (Aggarwal, 2009). Aggarwal (2009) goes on to describe how in 1995 the Federal/Provincial/Territorial Advisory Committee on Health Services "recommended the implementation of Primary Care Organizations (PCOs), capitated models (adjusted by age, gender and risk) with various health care providers involved in serving a population of patients" (p. 137). Furthermore, in 1996 the OMA released a report "which recommended the implementation of PC organizations with alternative health care providers that provide 24-hour access to services with a triage system in place. The payment model recommended was reformed [fee-for-service]" (p. 137).

Despite these initiatives, the Harris led government implemented policy decisions that created challenges for PC. According to one key policy informant decisions made by the Harris-led conservatives created challenges for PC due to cuts that targeted medical schools:

We had the Mike Harris times so we had cuts in medical school enrolment across the country; a 10% cut in medical school enrolment, a tightening of funding for, at least for family medicine.... the climate was not a happy one. There was a declining interest in family medicine and we really felt that something had to change. (PI1)

Further, the impact that the Harris cuts had on family medicine in Ontario is expanded on by another key policy informant:

There were a number of policy decisions made during that period of time that had a major impact on the health care system in general but very directly on family medicine. During that period of time, we cut med school enrolment by 10% but we also eliminated the rotating internship. And rotating internship led to general practice whereas our family medicine residency programs certified physicians in family medicine. With the reduction in the rotating internship, we went from graduating 53% of physicians

in this province into a general family practice to 38% and that was 38% of 10% less than what we had been producing before. So family medicine really took a hit in terms of the new doctors that we were graduating each year. (PI2)

According to Aggarwal (2009), the previous NDP government had placed a cap on global spending related to physician services. The Harris led conservative government continued this trend at the 1992-1993 level “and claw backs increased to 12%, 3% retrospectively for the year 1995-1996 and an additional 9% prospectively” (p. 135). The impact of these policy changes according to one key policy informant was that there was a PC physician “workforce that was diminishing in numbers, at the same time that the workload and complexity of the work that they were expected to do was rising dramatically” (PI2).

Coincidentally, some policy makers were displaying an ever increasing support for primary health care during this same time period (Aggarwal, 2009). For example, in 1997 the Canadian Conference of Provincial/Territorial Ministers of Health put out the report *A Renewed Vision for Canada's Health System* recommending the implementation of multidisciplinary approaches in PHC (Aggarwal, 2009; Canadian Provincial/Territorial Ministers, 1997). The report advocated that PHC adopt approaches that address both physical and mental health needs of the population (Aggarwal, 2009; Canadian Provincial/Territorial Ministers, 1997).

Also in 1997, the National Forum on Health released a report similarly advocating for the inclusion of multidisciplinary teams in PHC along with “remuneration that did not

promote volume but a continuum of prevention and treatment services” (Aggarwal, 2009, p. 139). In response to the National Forum on Health’s recommendation, 1997 saw the federal government establish a \$150 million Health Transfer Fund to support four main priority areas with one main priority area being PHC (Aggarwal, 2009). Shortly thereafter, Ontario’s Health Services Restructuring Commission (HSRC) released a report in 1999 recommending “the creation of primary health groups, not-for-profit entities that provide comprehensive PC services through multidisciplinary teams to a defined population on a 24/7 basis. This model would consist of capitation, rostering and risk sharing” (p. 139).

The Ontario public was becoming increasingly aware about some of the concerns surrounding PHC. According to one key policy informant: “When we went public with the fact that family medicine was in crisis, it was really the first time that the public realized that they weren’t alone...and they started banging on the doors of their MPs and MPPs’ offices saying, do something about it” (PI2). Another key policy informant also described the role of the public in fostering improvements to PHC: “MPPs were hearing from their constituents starting in around 2000 that they couldn’t get a family doctor. So, the Tories knew politically they had to do something” (PI1).

Family Health Networks (FHNs)

Additional pressures to make improvements in PC came in the form of labour negotiations between the OMA and the MOHLTC in 2000. According to Rosser and Kasperski (2010), the OMA labour negotiations “were anchored in strong support for family doctors and resulted in a commitment to develop a blended funding model for the family physicians of the province” (p. 2). One key policy informant indicated that “the

2000 labour negotiations set the framework for the idea that we would offer to family doctors in Ontario the ability to have a new form of practice and the practice was to be called Family Health Networks” (PI1). This key policy informant goes on to describe some of the components of the FHN model:

Elements of the networks were: they had to join together with other family doctors, they had to do 24/7 care, you had to provide extended evening hours, office hours, there would be a nurse led tele-triage line, comprehensive care would be incented financially. And we would pay family doctors more and differently. (PI1)

Furthermore, the policy informant indicated that the FHN framework was a prerequisite for the future implementation of interdisciplinary PHC:

We had our eye on the interdisciplinary ball the whole time since the mid-nineties but the only way of getting the offering out in the first place was through this mechanism of the labour negotiation of the OMA.... So the promise always was that we would eventually get to the interdisciplinary piece but first we needed to get family doctors in groups as opposed to solo and we needed to move to new payment methods and roster. (PI1)

The FHN model is physician governed, requires that a group of physicians work together virtually or are co-located (the original minimum number of five physicians was reduced to three in 2007), and consists of a blended model of capitation and fee-for-service incentives (Aggarwal, 2009). Additionally, the FHN model requires patients to roster with a physician. When the FHNs were revealed as an option, there was some initial hesitation amongst Ontario's family physicians. "[T]here was cynicism and skepticism that anything that government was in favor of could be any good and it was even worse if the OMA was also in favor of it" (PI1). According to this policy informant, the initial uptake of group practice models was slow. However, "the government of Ontario's goal was to have 80% of family physicians in FHNs by March 31, 2004" (Aggarwal, 2009, p. 146).

Ontario Family Health Network Agency

In 2001, Premier Mike Harris started up the Ontario Family Health Network (OFHN). The OFHN was an arm's-length agency with Ruth Wilson – one of the 1994 white paper authors- as the Chair. The OFHN had a three year mandate to "support the planning, implementation and management of [PHC] in Ontario" (Aggarwal, 2009). The OFHN was to work with the ministry and the OMA on model negotiations, planning, "and to develop operational policy based on ministerial direction" (p. 146).

Primary Health Care Transition Fund

On September 11, 2000, first ministers – who were advocating for interdisciplinary approaches to be included in PHC - vowed to improve PHC (Aggarwal, 2009). The federal government signalled a renewed interest in PHC with the implementation of the Primary Health Care Transition Fund (PHCTF). A key policy informant described how

PHC was becoming a priority: “Primary Care Transition Fund from the feds was coming along, and there was a renewed call and interest for primary care reform nationally” (PI1). The \$800 million PHCTF was intended to assist the provinces with the transitional costs of executing PHC initiatives (Aggarwal, 2009; Health Canada, 2008). One FHT leader talked about the importance of the PHCTF in expanding PHC:

[T]hey found about close to \$800 million, the feds did, and they sent that money off to the different provinces to look at transforming primary care. Ontario got \$213 million.... So a lot of individuals that had these grants...were thinking back to expanding the model of primary care to be more team-focused, more focus on the patient.... (L8)

Furthermore, a key policy informant described how the PHCTF was directly responsible for the expansion of new PHC projects in Ontario:

[T]he biggest piece was the Primary Health Care Transition Fund Project which was a joint Federal, Provincial, Territorial initiative. Ontario’s per share per capita of that contribution agreement was \$213,000,000. With that we created over 200 projects. We funded 200 projects in Ontario. (PI5)

According to another key policy informant, the PHCTF was integral for broadening PHC:

[I]t was important to see the impact of the interprofessional collaborations in a primary care practice with a goal to improving access for patients with a view to provide comprehensive integrated care for patients at the first point of contact which is primary care. So, the catalyst work for that was the work that we did under the Primary Care Transition Fund. (PI6)

Thus, the PHCTF funded projects provided a foundation for the implementation of the FHT model. One FHT leader stated that “the idea of these PHC-T projects was then to hopefully create the launching pad for Family Health Teams” (L8).

Family Health Groups (FHGs)

In 2003, the FHG model was born from negotiations between Ontario’s MOHLTC and the OMA (Aggarwal, 2009). At time of negotiations “the government was far from reaching its goal of having 80% of physicians participating in reform models; this new model was different from any other model introduced in that it was a shift back toward the traditional solo-practice, physician dominated model” (p. 149). The FHG model is a fee-for-service model that requires three or more physicians to be co-located or work together virtually. Along with fee-for-service payments, incentives are available “for a wide range of services including palliative care and care for seniors, patients with serious mental health illness and newborns” (p. 151).

2002 – 2003: Harris to McGuinty – Anticipating a Change

Even prior to the change in government, the Liberal government was influential in shaping FHT policy. Development of the FHT model began in anticipation of a change

in government. According to one policy informant, “behind the scenes...we had started the work to create Family Health Teams because we knew what was coming in terms of a change of government and in terms of a change in platform, that there would be a change in health policy if the government did change” (PI6). The policy informant further described the initial developments of FHT policy: “We started to model what Family Health Teams would look like; and so that work started around early 2003...so that if there was a change in government...we would have a policy package ready for Cabinet submission. So, that’s how it started” (PI6). The McGuinty Liberals ran a campaign that included FHTs at the forefront; access particularly to PHC physicians was highlighted as a platform priority. Further, the Liberal platform emphasized a goal to attach every Ontarian to a family doctor. A key policy informant describes the extent to which the FHTs were linked with the Liberal’s campaign:

Their campaign platform was Family Health Teams. And they promised 150 Family Health Teams. What they said was they wanted Family Health Teams to be bottom up... They wanted something that communities themselves could propose and they also proposed funding for interdisciplinary providers. That offering came along when the liberals came into power. (PI1)

Another policy informant emphasized that first-contact access was one intention of McGuinty’s Liberal platform in 2003: “It was on their platform – 150 Family Health Teams committed, one point of access, access for all, access to improve system

navigation. They wanted every single Ontarian to have a family doctor”. (PI6) Another key policy informant further illustrates the significance of the Liberal’s campaign platform to the development of the FHTs: “They came in with the mandate to create Family Health Teams which built upon previous primary care models such as the previous primary care centres and primary care networks that had been developed prior to the Liberal government coming into power”. (PI5)

2003 – 2011: McGuinty Liberal Government

McGuinty’s Liberal government was elected in 2003, the same year that that the First Ministers’ Accord increased funding to provincial/territorial governments for the purpose of PHC reform (Aggarwal, 2009). Thus, soon after taking office McGuinty’s Liberals had access to economic resources dedicated to PHC. This was evident according to one policy informant, who stated that it was shortly after the arrival of the McGuinty government that “there was starting to be some loosening of the taps in terms of money” (PI1). In 2004, federal commitment for health care funds emerged in the form of a ten year federal-provincial-territorial Health Accord (Aggarwal, 2009).

Emergence of FHTs

The emergence of the FHTs is closely linked with the McGuinty-led Liberal government. According to one policy informant, there was even opportunity to assist the Liberal government in shaping FHT policy. “We were working really closely with the liberals and helped them to develop their policy and as you can see, their policy is heavily into the Family Health Team model” (PI2). This policy informant further describes some of the recommendations that were made to the Liberal government as the FHT model was being developed:

So we said to the government, make it easy, just have a process in which physicians who were in a group practice who were really keen and eager to work with nurses, nurse practitioners, dietitians, and...social workers...within their practices.... So they developed what was referred to as the letter of interest. (PI2)

FHTs were announced in December 2004; the Ontario government put a call out for applications whereby interested health care providers submitted a business plan for review by the ministry. “The OMA did not have a role in the application process, but the method of payment was determined through negotiations with the OMA” (Aggarwal, 2009, p. 158). Up to current date, calls for FHT applications have emerged in five waves: April 2005, December 2005, April 2006, December 2009, and May 2010. As of August 2010, the total number of approved FHTs in Ontario has reached 200; however, not all of these FHTs have yet become operationalized.

FHTs: A Political Priority Project

Given that the FHTs were tied to the Liberal political platform, there was significant support and political will driving the model. According to one key policy informant, “This is what the Premier wanted. The political support was fabulous” (PI6). Because the FHTs were initiated as part of a political platform, there was a desire to have rapid implementation of the model as described by a FHT leader: “Family Health Teams were a political platform, yeah. And then they had to be rolled out very quickly. So, I mean the Ministry wasn’t ahead of the curve. We were all learning together” (L12). The rapid deployment of the model was challenging for both the FHT leaders as well as the

policy makers according to a FHT leader: “I think they were ready but I think they weren’t quite ready. They didn’t have their policies quite developed” (L2).

FHT Funding

Bringing FHTs into being was initiated with a new funding source according to this policy informant: “And went forward and asked for the funding and secured the funding. And most of it I think was new money because we didn’t take funds from elsewhere because most of the programs and FHTs themselves were brand new. The only element that was probably not new money was the element related to physician funding because that was enshrined in the OHIP – in the physician envelopes that we already had” (PI6).

In terms of funding mechanisms, “payment is made to the FHT and distributed according to physicians based on the agreement made at the governance level” (Aggarwal, 2009, p. 157). There are three different payment options that are made available to physicians including: blended capitation (FHN/FHO), complement-based funding targeting specialized models, and blended salaried compensation which offer salary plus financial benefits (Aggarwal, 2009). The FHT approach of primary health care builds upon elements of “existing primary health care models” (MOHLTC, 2007a, p. 2) such as the physician group practice funding models. In order to implement the FHT model, a prerequisite is that there be a physician group based practice funding model in place which coincides with one of the recommendations set forth by Forster et al. (1994). Implementation of the FHT model has been cited as a means to achieving better individual and population based health outcomes (Health Council of Canada, 2005; Institute of Medicine, 2001; Soklaridis, Oandasan, & Kimpton 2007).

Thus, the FHTs are shaped with a comingling of funding sources. Although the FHT in practice refers to the comingling of physicians and IHPs, the two main funding sources distinctively separate how this is approached. One policy informant provides an example of these distinctions shaping FHTs: “We do not fund as I was saying, equipment or IT or whatever for physicians because through their CAP rates, they’re responsible for their own overhead. We don’t cover the admin costs related to a physician’s office either because again, their CAP rate covers it” (PI3).

Changing Leadership within the MOHLTC (Approx. 2007-2010)

In 2006, Deputy Health Minister Ron Sapsford announced that the MOHLTC would be implementing a transition to a new organizational structure (Lurie, 2006). Changes to the MOHLTC organizational structure included members of the senior management group as well as other levels to into different positions and job roles (Lurie, 2006). The impact that these organizational structural changes undertaken within the MOHLTC has had on PHC is noted by one key policy informant: “One of the biggest things that happened to the primary care team in the Ministry is that, like we went through a huge restructuring, stewardship and restructuring exercise and some people got scattered everywhere” (PI6). According to Cadotte (2008), “the pace and scope of change within MOHLTC has been dramatic” (p. 10). As described by a key policy informant, the internal structural changes has been challenging for the ministry: “There’s been a lot of loss. I mean, in the last two or three years the turnover has really lead to a loss, a real gap in knowledge.... People literally were moved to different places and different jobs so literally plunk. This person is moving, that person is moving, all that expertise and knowledge” (PI6). The ministry restructuring has presented challenges for

ministry policy makers and decision makers responsible for PHC. According to a key policy informant:

We lost a lot of momentum there in a way because you have people with the knowledge leaving.... The functional structure at the Ministry...means that you have to go to different places to get that expertise now. So, if chronic care management education, and health promotion education sits with a different Ministry now, it's really important to engage them. But, you have to engage them at various levels and various functional areas. So, primary care needs to engage them. Strategies need to engage them. We need to engage them but it's a lot of functional linkages but yet you're not getting an umbrella picture because nobody is pulling it all together into one. (PI6)

Federal Funding: Health Accord (2004-2014)

The Health Accord is a ten year federal funding agreement signed by Paul Martin's liberals in 2004. Under the Health Accord, the federal government committed to providing an increase of funding to the provinces and territories of \$17.3 billion in the first three years, with the intention that the number was to rise to \$34.8 billion after five years (Health Canada, 2011d). "The Accord addressed several key issues in health care, namely prescription drug coverage, home care, diagnostic services, timeliness of care and [PHC] reform" (Motiwala, Flood, Coyte, & Laporte, 2005).

Although the Health Accord has made federal funds available to Ontario early on in McGuinty's term, according to one policy informant there is concern as Canada moves closer to the expiration of the agreement. "We've got the Health Accord expiring in 2014, people are already nervous about health transfers from the feds to the provinces plus the retrenchment that we're seeing across the world and certainly across OECD countries. So, if we expect that there won't be an additional large number of resources for primary care, it's going to be a question of choosing what's cost effective" (PI1). Without a renewed agreement in place, the pending Health Accord expiration adds to tension around the availability of funding for the FHTs.

Changing Economic Times

Adding to financial concern, the landscape of global economics significantly deteriorated in 2008. Ontario's 2009 provincial budget noted the effects of the economic spiral in indicating that "Ontario is not immune to the global downturn" (Duncan, 2009, p. 4). The fall of the global economy had an impact on the availability of funding for the FHTs. According to one FHT leader: "With the economy falling too, I think that was totally unanticipated. Here you were being thrown money left, right, and centre, and then all of a sudden the money dries up..." (L8).

A key policy informant also corroborates the impact that the global economic downturn had particularly on the later FHTs: "The whole world changed very abruptly two and a half years ago. But the early adopters, I mean, there was much more money. There was much more leniency in terms of whatever" (PI3). This key policy informant goes on to describe how there has been a change in the availability of economic resources for the FHTs. "It's a bigger challenge now because the funding availability isn't once

what it was...” (PI3). Currently the broader economic climate is “turning the corner” (Duncan, 2011, p. xv) and “jobs are coming back” (p. xv). Ontario’s Minister of Finance tells us that “the economy is improving” (p. xv) thus there is some uncertainty about the future availability of economic resources.

Political Influence

There continues to be a recognition of the political connection associated with the FHTs. “Are we politically tied, absolutely we’re politically tied. They have no money but they’ve added fifty new teams” (L2). With the upcoming Ontario provincial election scheduled for October 2011 are varying opinions amongst the key informants in terms of the future sustenance of the model. One FHT leader indicated that there are concerns that funding for FHTs may not continue if the Liberals are not re-elected into office. “I think too that we’re all very fearful that if our government changes in the next election, are they going to pull funding for Family Health Teams. Because what we’re doing you can’t measure in three or four years” (L9). On the contrary, another FHT leader expressed little concern. “I don’t think that I’m too concerned. I think that it would be very difficult for government to come and say, “okay, two hundred FHTs, off you go”, because you’re dealing with 1600 physicians” (L8).

Although the FHT model has been implemented, FHT leaders described how politics will continue to shape the model long term. For example, one FHT leader stated: “Are we politically tied, absolutely we’re politically tied. They have no money but they’ve added fifty new teams” (L2). Data collection occurred prior to the October 2011 Ontario provincial election which had evoked some concerns from FHT leaders about the sustainability of funding based on that election outcome: “I think too that we’re all very

fearful that if our government changes in the next election, are they going to pull funding for Family Health Teams. Because what we're doing you can't measure in three or four years" (L9). On the contrary, another FHT leader expressed little concern. "I don't think that I'm too concerned. I think that it would be very difficult for government to come and say, "okay, two hundred FHTs, off you go", because you're dealing with 1600 physicians" (L8). In October 2011, McGuinty was once again elected into another term in office. However, these FHT leaders remind us that FHTs are politically influenced: "It truly is a manifestation of a political will at a provincial level which will determine what the future of the model holds" (L10). Another FHT leader emphasized the political influence that will continue to shape the FHT model:

When you talk about relationship and communication, you can only be effective if you actually know who's driving the bus, and what is being driven by the bureaucrats in Toronto so that so-and-so can get re-elected by our health care system. And if you think it's anything different than that then you're wrong. (L23)

Conclusion

Although this background is not the full history of PHC reform in Ontario, key historical, economic, and political influences contributing to the implementation of FHTs have been highlighted. The overview provided in this chapter is guided by findings within the data. However, literature has been included in order to provide a comprehensive overview of themes that emerged from the data.

Chapter 5 – Findings

Organization of Findings

Discourse Analysis

This chapter presents findings of a discourse analysis of Ontario's FHTs. In discourse analysis, meaning emerges from a combination of saying (informing), doing (action), and being (identity) (Gee, 2011b). Inspired by Gee (2011a, 2011b) (see Chapter 3), discourse analysis is guiding the analysis and presentation of findings as follows: saying (informing) refers to talking about attributes of PHC, doing (action) refers to health care practices, and being (identity) refers to FHT organizational structures.

PHC Framework

Haggerty et al. (2007) provide a comprehensive framework of attributes that underpin PHC (Appendix I) and assists in understanding discourse meanings. The inclusion of this framework provides a means to interpret and guide presentation of findings. One of the attributes informing structural dimensions of PHC is multidisciplinary team; although the terms multidisciplinary and interdisciplinary are at times used interchangeably within the literature, interdisciplinary "implies a greater degree of co-operation in clinical work" (Bélanger & Rodriguez, 2008, p. 588). In the presentation of findings, I will use the term interdisciplinary in order to be consistent with the intention of FHTs (MOHLTC, 2005a). Further, when referencing Haggerty et al.'s (2007) framework, I will substitute the attribute of "multidisciplinary team" with "interdisciplinary team" in order to promote consistency in the analysis and presentation of findings. However, in order to promote validity, terms will be presented as they appear when quoting data. Dimensions of Haggerty et al.'s (2007) lexicon will be

included and addressed as they emerge from the data. A list of definitions of PHC attributes discussed in this chapter is provided (Appendix I) and can be used as a reference while reviewing this chapter.

Using Haggerty et al.'s (2007) framework as a guide, a summary of all PHC attributes that have emerged in the data is provided as Table 5.1. Table 5.1 identifies all PHC attributes that have emerged across all three data sources and at the level of discourse. The use of bold font indicates that congruency with a particular PHC attribute is encouraged and/or achieved at the level of indicated discourse. Furthermore, the use of underlining indicates areas of tension or difficulties that have been identified in relation to a particular PHC attribute at the level of indicated discourse. Table 5.1 illustrates a few key findings worthy of note.

First, this table illustrates that MOHLTC documents reveal values congruent with a broad scope of PHC attributes. However, despite saying that a broad scope of PHC attributes is desirable, documents only provide direction on achieving congruency across all three levels of discourse for four key attributes, namely first-contact accessibility, accommodation accessibility, comprehensiveness of services, and interdisciplinary team. Table 5.1 also illustrates that the interviews with policy informants demonstrate that they perceive that the FHT model should be congruent with a broad scope of PHC attributes. However, interview with FHT leaders suggested they consider an even broader scope of PHC attributes valuable and important. FHT leaders talked about the importance of PHC attributes that span clinical, structural, person-oriented, and community-oriented dimensions of PHC as valuable. Furthermore, FHT leaders described health care practices that are congruent with or strive to be congruent with a broad range of PHC

attributes. Also, the interviews with FHT leaders indicated ways that the FHT structure has been shaped in order to achieve or attempt to achieve congruency with PHC attributes spanning clinical, structural, person-oriented, and community-oriented dimensions of PHC.

Table 5.1 also illustrates some of the challenges that are emerging in FHTs. For example, FHT leaders identified minimal challenges with health care practices informed by clinical practice attributes of PHC; however, they indicated there are significant challenges with the implementation of health care practices informed by the structural dimensions of PHC (note the many underlined symbols under FHT leaders with respect to the structural dimensions indicating that there is tension in the “doing” aspects of the structural attributes of FHTs). Furthermore, Table 5.1 demonstrates that FHT leaders have identified an array of challenges in the development of the FHT organizational structure, as demonstrated by the many underlined symbols under FHT leaders with respect to “being” aspects of the structural dimensions.

Table 5.1 demonstrates two additional phenomena are worthy of note. It is evident that FHT leaders described striving for or achieving congruency with a much broader range of PHC attributes than was promoted in documents and by policy informants. A second interesting observation is the absence of person-oriented dimensions of PHC found in the data provided by documents or policy informants especially in terms of Doing and Being. Thus, Table 5.1 illustrates that there are significant findings that emerged from the data analysis in relation to the degree to which discourses about the FHT model are congruent with PHC attributes.

Table 5.1: PHC Attributes Emerging in Data According to Level of Discourse and Across Data Sources

PHC Attributes	Documents	Policy Informants	FHT Leaders
Level of Discourse	Saying (S), Doing (D), Being (B)		
Clinical Practice Attributes			
First-contact accessibility	S D B	S D	S <u>D</u> B
Accommodation accessibility	S D B	S D	S <u>D</u> B
Comprehensiveness of services	S D B	S <u>D</u> B	S <u>D</u> B
Informational continuity	S B	S	S D
Management continuity	S		S D B
Technical quality of clinical care	S		S D
Structural Dimensions			
Clinical information management	S B	S <u>D</u> B	S <u>D</u> B
Interdisciplinary team	S D B	S <u>D</u> B	S <u>D</u> B
Quality improvement process	S B	S <u>D</u> B	S <u>D</u> B
System integration	S B	S <u>D</u> B	S <u>D</u>
Person-Oriented Dimensions			
Advocacy			S D
Continuity-relational	S	S	S <u>D</u> B
Cultural sensitivity	S		S D
Family-centered care	S	S	D
Interpersonal communication	S		S D B
Respectfulness			
Whole-person care	S	S	S D
Community-Oriented Dimensions			
Client/community participation	S B		S D B
Equity	S B		S B
Intersectoral team	S B	S D	S <u>D</u> B
Population orientation	S B	S B	S <u>D</u> B
System Performance			
Accountability	S D B	S <u>D</u> B	S <u>D</u> B
Availability	S	B	S
Efficiency/productivity	S	S <u>D</u> B	S <u>D</u>

Bold = Congruency with attribute encouraged and/or achieved
Underline = Tension or difficulties identified

Deciding on the Salient Findings

Although large amounts of data were analyzed with respect to its congruency with all of the PHC attributes identified by Haggerty et al. (2007), not all of the findings will be reported on in this chapter. Rather, this chapter will present the most salient of findings with respect to the research questions outlined in chapter 3. This chapter is organized around two salient findings: foundational PHC attributes of the FHT model and inadequate indicators.

Foundational PHC attributes of the FHT model is the first salient finding and has emerged from an exploration of all PHC attributes that emerged in the comparison of the data with Haggerty et al.'s (2007) lexicon. Foundational attributes of the FHT model were identified using the following key criteria: congruency promoted by policy across the categories of saying, doing, and being. Inclusion criteria extended beyond mere encouragement with congruency and included only those attributes whereby documented health policy provided direction or criteria on how FHTs should achieve congruency with PHC attributes. Thus, foundational attributes are those attributes that meet congruency in the following three ways: congruency with a PHC attribute is vocalized as desirable by FHT policy, health care practices that facilitate congruency with PHC attribute are identified by FHT policy, and direction is provided regarding how to shape the FHT organizational structure in order to promote congruency with the PHC attribute. Criteria used to identify the foundational PHC attributes of the FHT model requires inclusion of both processes and structures that shape PHC. According to Donabedian's (1966) influential work, PHC is informed by both processes and structures. Thus, criteria used to determine the first salient finding also helps to present findings of those PHC attributes

that inform both processes and structures of FHTs. Documents and policy informants have been the most influential of data sources used in the identification of foundational PHC attributes. However, data from FHT leaders has also been used to inform and provide greater detail regarding the implementation of these foundational PHC attributes.

Inadequate indicators is the second salient finding that is presented in this chapter; it presents findings related to the performance evaluation of FHTs. Criteria used to determine inclusion in the second finding is inspired by Félix-Bortolotti (2009) and Sandy et al. (2009) who demonstrate the influence that performance measures have on shaping health system priorities and health outcomes. Furthermore, Haggerty et al.'s (2007) framework has also inspired identification of the second salient finding. For example, one PHC attribute informing system performance is accountability, which indicates the importance of implementing a mechanism of performance monitoring for evaluation purposes. Thus, the inadequate indicators present results from the data analysis that focus on the evaluation of the system performance of FHTs.

Foundational PHC Attributes of FHT Model

Despite document and policy informants' suggestion that the inclusion of a broad scope of PHC attributes is valued in FHTs (Table 5.1), the data provides evidence that only four key PHC attributes are promoted by the FHT model. All data sources have been used to explore the categories of saying, doing, and being for all PHC attributes that have emerged in the data. Congruency across the categories of saying, doing, and being has assisted in the identification of foundational PHC attributes of the FHT model.

The four key PHC attributes shaping FHTs are: first-contact accessibility, accommodation accessibility, comprehensiveness of services, and interdisciplinary team

(Table 5.2). Based on all three data sources, FHT policy encourages congruency with these four PHC attributes, provides direction on how these attributes may inform health care practice, and gives direction on how to shape the FHT organization in a way that is inclusive of these attributes. Although there is diversity between FHTs in terms of size, composition of interdisciplinary team, and health care strategies, based on all data sources, these four PHC attributes are foundational properties across FHTs. These four PHC attributes shaping FHTs will be explored in a way that facilitates an understanding of how these PHC attributes have shaped FHTs; further, these attributes will be explored in a way that helps identify influential health discourses that inform FHTs.

Table 5.2: Foundational PHC Attributes of FHT Model

Clinical Practice Attributes	Structural Dimensions
First contact accessibility	Interdisciplinary team
Accommodation accessibility	
Comprehensiveness of services	

First-Contact Accessibility

Saying: Valuing congruency

All three data sources provide strong evidence that first-contact accessibility is a key PHC attribute shaping FHTs. One FHT leader provides evidence that first-contact accessibility is an underlying goal of the FHTs: “The goal of the Ministry’s program was to make sure that these FHTs took orphan patients out of the system. And they did. They took out 500,000 in the first...four years” (L16). Another FHT leader demonstrates the importance of first-contact accessibility in shaping FHTs: “When we opened our doors that was our mandate that we would...take orphan patients.” (L13). “Orphan patients” is a term used to refer to individuals who do not have access to a PC physician. Another

FHT leader stated, “We have 1600 patients who were previously unattached that we took on” (L18). Thus, the MOHLTC encourages FHTs to achieve congruency with first-contact access that is demonstrated by the inclusion of one key practice: patient enrolment.

Doing: Patient enrolment

Although first-contact accessibility has been a significant PHC attribute from the onset of model implementation, first-contact accessibility has increasingly become the foundational PHC attribute influencing FHTs. This is illustrated by the following policy informant: “Access wasn’t as much an issue in the early days as it is now. It was much more about improvement but then access became almost the number one issue and the commitment for attaching patients to doctors” (PI4). The main practice that is intended to demonstrate congruency with first-contact accessibility is patient enrolment – also referred to as rostering. One policy informant demonstrated the extent of the expectation of patient enrolment: “Patient enrolment is an underlying component of Family Health Teams and besides, like it’s in the Cabinet” (PI3). A key practice of FHTs is “that there had to be patient enrolment” (PI5) with the Ontario Liberal Government Cabinet reinforcing the expectation. Thus, health care practices promoted by first-contact access appear to be intended to facilitate contact between an individual and a physician; in contrast, practices observed in other health care services and interventions are not informed by this PHC attribute. First-contact access does not guide practices beyond encouraging the initial contact with a provider. Access to care is considered important from the perspective of all health discourses; however, it is only one small property influencing health. Furthermore, first-contact access does not inform nor provide

direction on the shape that health care beyond the first-contact will take. For example, first-contact access does not indicate whether or not health care services will be informed by the biomedical, biopsychosocial, health promotion, SDOH, or holism discourses. First-contact access does not provide information or guidance on whether health care services in FHTs are to be informed by clinical-oriented, structural, person-oriented, or community-oriented dimensions of PHC. This PHC attribute alone is inadequate to guide health care practices in FHTs.

An emphasis on first-contact accessibility is evident in the development and implementation of funding models intended to promote congruency. This is expressed by one policy informant who illustrated the importance of first-contact accessibility: “The payment models have all went to increase access” (PI4). It is important to note that patient enrolment is a practice that was implemented in solo-physician and physician group PC practices. Consequently, this attribute and the expected practices shaping FHTs are no different than PC. With physician payment models being interdependent with the demonstration of success, the MOHLTC communicates the need for physicians to achieve congruency with first-contact access.

Being: Emphasizing physicians

The data provides strong evidence for the belief that the inclusion of interdisciplinary health professionals in FHTs facilitates congruency with first-contact accessibility. According to MOHLTC documents, interdisciplinary health professionals influence access: “Family Health Teams will improve access to primary health care through the introduction of interdisciplinary health teams” (MOHLTC, 2007a, p. 2). However, with patient enrolment as the means to demonstrate access, the document’s

statement suggests a stronger intention to increase enrolment numbers than to support interdisciplinary teams.

Although the FHT model has facilitated access to a variety of health services that previously were not available in PC, this is not reflected in financial incentives shaping first-person access. According to one FHT leader, “I think FHTs are an excellent way to provide care from the standpoint that patients in the community who may not have access to certain services, like a dietician or a social worker or a psychiatrist, that we can provide access to them relatively quickly” (L21). Throughout my social work health practice, accessing social work and mental health services for the individuals and families I worked with was always a struggle; particularly funded services. A significant benefit of the FHTs is that the services of interdisciplinary health professionals are now made available to individuals and communities. Data also provides evidence that FHTs have been important for facilitating access to health services for rural and Northern communities. According to one FHT leader: “Family Health Teams are becoming...in the northwest anyways, a very important and pivotal piece within those communities” (L2). Another FHT leader described the importance of attending to first-contact accessibility because of the challenges in smaller communities: “Especially for smaller communities...we’ve had to travel so often for so many things that this gives us really good access to several different...aspects of health care” (L11).

However, the direction provided to FHTs is to “expand access to services for patients including those who previously may have encountered difficulty finding a regular family physician and a Family Health Team will expand the scope of services available to all patients (MOHLTC, 2005a, p.3). This, suggests that FHTs are to be

viewed as an extended version of PC. One of the differences between PC and PHC is that services have the potential to be more informed by assumptions and interventions linked to the biopsychosocial, health promotion, SDOH, and holism discourses.

However, the MOHLTC statement above suggests that the intention is for FHTs to provide greater access to services without altering or making space for the inclusion of additional health discourse perspectives: the goal seems to be greater access to the same health care practices that one would find in a solo-physician PC practice.

Based on payment models, congruency with first-contact access is dependent on the inclusion of physicians willing to enroll patients in FHTs. For example, the Guide for Patient Enrolment (MOHLTC, 2005b) states, “Family physicians are...encouraged to take new patients into their practices. A premium is available to physicians when they enroll new patients” (p. 2). All three data sources indicate that payment models are intended to promote congruency with first-contact accessibility exclusively aimed at physicians. Thus, policy guiding the FHT model has constructed first-contact accessibility in a way that is dependent on the inclusion of physicians. According to one policy informant, “FHTs are...they’re not a patient enrolment model but in order for physicians to be involved in a Family Health Team, then they have to be in an approved funding model all of which include physician enrolment” (PI3). Although this policy informant indicates that the FHT model is not intended to be a patient enrolment model, practices that are promoted and organizational expectations suggest otherwise. Furthermore, the greater the number of physicians included within the composition of a FHT the greater the patient enrolment, thus congruency with first-contact accessibility

can be achieved. What is communicated is an underlying belief that health can only be achieved by facilitating contact between a patient and a physician.

Accommodation Accessibility

Saying: Valuing congruency

Accommodation accessibility is a second foundational PHC attribute shaping FHTs. Based on all three data sources, accommodation accessibility is valued and FHTs are encouraged to adopt practices and shape the FHT identity in a way that promotes congruency with accommodation accessibility. According to the following, documents value accommodation accessibility: “Enrolling with a FHT ensures that patients have access to primary health care treatment or advice, 24 hours a day, seven days a week, through a combination of regular and extended office hours, and a nurse-staffed Telephone Health Advisory Service” (MOHLTC, 2005b, p. 1). Like the previous foundational PHC attribute, accommodation accessibility facilitates contact between individuals and a health care provider. Furthermore, the previous document includes other health care providers in achieving congruency with accommodation accessibility; in this case nurses are included. Documents describe a variety of organizational characteristics – relating to areas such as telephone service, and hours of operation – to facilitate congruency with accommodation accessibility. Further, advanced access is one key practice that is intended to foster congruency with accommodation accessibility.

Doing: Advanced access

Although there are a variety of organizational characteristics that are attended to, the data analysis provides evidence that advanced access is one of the main practices that is being promoted to facilitate congruency with accommodation accessibility. One policy

informant provides a description of advanced access: “Its advanced access, open access, same day appointment type model in terms of access to a physician or a primary health care provider” (PI3). This policy informant continues to describe how advanced access has become increasingly emphasized over time: “Advanced access...it’s becoming more and more important and the Ministry priority, particularly for FHT physicians and FHTs themselves” (PI3). Thus, in order to achieve congruency with accommodation accessibility, for FHTs – and mainly for FHT physicians – one key practice that is encouraged is same day appointment scheduling. According to policy informants, advanced access has been successful in facilitating contact with a physician: “Access to practice has worked really well in changing people’s ability to get in and be seen – and I think that it’s been probably the most successful piece” (PI2).

There is strong evidence in the data that accommodation accessibility is influencing practices in FHTs. FHTs strive to achieve congruency with accommodation accessibility in several ways. For example, one FHT leader who was a physician indicated that “the first major change that I made was sort of commit to the office...We did do the formal measurement of supply and demand and realized that...I wouldn’t be able to meet the demand if I wasn’t there more often” (L20). Not surprising, a key way to promote access is just to be present at the FHT. However, determining patterns in the request for services shapes how open access is implemented.

The main way that FHTs are displaying congruency with accessibility-accommodation is with the implementation of flexible appointment systems such as open access. This is illustrated by one FHT leader: “We’ve been able to make the open access generally work. Once you realize the patterns in your office, you realize where you can

start booking people or where you can put your booked patients” (L20). According to one FHT leader, the implementation of open access has been promoted by the MOHLTC and in training by QIIP; however, this FHT leader states that what works best in practice is a variation of open access:

There’s this whole discussion around open access, and as much as I hear about open access, I hear just as much about how many people have actually implemented a hybrid of open access, not true open access. So QIIP will come out and say open access, open access, the Ministry will say open access, open access.

What FHTs are actually doing is a hybrid of the methodology.

(L4)

Another FHT leader also described a hybrid approach to advanced access and described how congruency with accommodation accessibility includes a combination of both open access as well as booked appointments: “Know your practice and the patients need to have appropriate access to the doctor....When people say advanced access, many of the doctors are on a hybrid model. And most of our patients get in within a day” (L12.1). Although it is important to facilitate timely contact with a care provider, measures of accommodation accessibility only provide information on practices and organizational characteristics that facilitate this contact with a PHC provider. One FHT leader put it this way: “Advanced access is just a matter of accessibility so it’s a pretty thin measure of service provision” (L10.1). Similar to first-contact access, attempts to achieve

accommodation accessibility have focused on contact between an individual and a physician. Furthermore, accommodation accessibility does not provide information on the configuration, assumptions, or approaches that health care practices will assume.

Being: Emphasizing physicians

Similar to the previous PHC attribute, the MOHLTC promotes congruency with accommodation accessibility by privileging physicians with financial incentives. One FHT leader explains:

There's an access bonus given if your patients don't use other services. So don't go to walk-in clinics or use other family doctors....Every time your patient, if any of the patients in the clinic uses services elsewhere that you could provide—so if they go to the emergency room it's fine, if they go to specialists it's fine—it's when they go to walk-in clinics or other type of family medicine that we might get dinged for....It gets deducted from that maximum amount of outside usage bonus down to zero.

(L21)

Providing an access bonus to physicians communicates to FHTs that achieving congruency with accommodation accessibility is dependent on physicians: “The Access Bonus is a payment to blended capitation groups for exclusively providing core services to their enrolled patients” (MOHLTC, 2009a, p. 5). Despite documents describing the involvement of various health professionals in order to achieve accommodation

accessibility – such as the nurse-staffed Telephone Health Advisory Service – financial incentives are not offered to non-physician health professionals. Similar to first-contact accessibility, policy directives provide a message that physicians are essential for achieving congruency with the attribute accommodation accessibility. Policy again reinforces a belief that health is only achievable by making contact with a physician. Although important, having access to a physician is only one facet that facilitates health. This attribute only guides contact; accommodation accessibility provides minimal direction regarding the implementation of health care services that extend beyond the facilitation of contact.

Comprehensiveness of Services

Saying: Valuing congruency

Based on all data sources, comprehensiveness of services is a third PHC attribute shaping FHTs. Comprehensiveness of services is also an attribute that would have informed PC physician solo-practices even prior to the implementation of the FHT model. However, all data sources strongly indicate that the intention of the FHT model is to shape comprehensiveness of services in a way that is inclusive of but not limited to PC health care services. According to documents, congruency with comprehensiveness of services is facilitated when PHC includes a broad scope of activities including: health assessments, diagnosis and treatment, primary reproductive care, primary mental health care, primary palliative care, rehabilitation, support for discharge planning, out-patient follow-up, home-care services, and health systems linkages (MOHLTC, 2009a; MOHLTC, 2009c). It appears that congruency with comprehensiveness of services is likely intended to include but not be limited to physician care. According to one policy

informant, the intention of the FHTs is “not just medical treatment. Not just come and see your doctor and get more pills” (PI6).

Evidence from all data sources strongly indicates that prevention strategies are intended to be included in the measure of comprehensiveness of services. Prevention is viewed from a physiological perspective with emphasis on chronic disease; FHTs are to intervene in “chronic diseases early...to prevent disease progression and reduce potential health complications” (MOHLTC, 2005c, p. 4). According to one policy informant, “chronic diseases that we are seeing now, most of them are preventable. ...One of the mandates around Family Health Teams is disease prevention” (PI6). Thus, the FHT model promotes inclusion of practices that are aimed at prevention and management of chronic diseases such as diabetes. One policy informant states, “Since 2005, the government’s emphasis on the diabetes strategy has been tremendously increased... Family Health Teams, it becomes sort of the place where that happens from” (PI4). Comprehensiveness of services is most informed by the biomedical health discourse and somewhat by the biopsychosocial and health promotion discourses.

Doing: Encouraging prevention

Evidence from all data sources indicate that funding models and financial incentives have been implemented in order to influence practices supporting comprehensiveness of services. One policy informant indicated that physicians’ underlying capitation payment model has been implemented in order to encourage preventative care practices: “You develop non-fee-for-service funding models, mainly the capitation funding models, to try to encourage different types of behavior that focuses on preventative care” (PI5). An additional way that the FHT model has attempted to

achieve comprehensiveness of services is with the inclusion of financial incentives targeting specific care practices. For example, one policy informant stated, “We have preventative bonuses for mammograms, pap smears, flu shots, influenza care, vaccinations for children and the like” (PI2).

Data collected from FHT leaders provides evidence that the inclusion of financial incentives has been successful in shaping practices in FHTs. For example, one FHT leader stated: “They have done some of the stuff that’s ministry mandated. So, for the things we get bonuses on like pap smears and mammograms and childhood immunizations and such” (L17). Another FHT leader stated: “People still need to know how they’re doing with their haemoglobin AC1s, and how they’re doing with their weights and mammograms and initially it was really easy to persuade every one of the importance for doing half a dozen ones...there are bonus payments for them” (L12). It is evident to see that the health care practices that are being promoted by the MOHLTC above are those most informed from the biomedical health discourse. Despite financial incentives being directed towards physicians, they are influencing the practice of other health professionals within the FHT. According to one FHT leader:

One of our goals was to attain a 90% completion rate of the FHN preventative care targets. So, FHN has preventative care targets to meet and then the docs get incentive bonuses. It’s not all about the money, it’s about achieving these preventative targets. So they have incentive bonuses for the flu shot, mammograms, paps,

FOBTs. So we said, as a Family Health Team we will strive to get 90% completion rate. (L3)

Thus, the suggestion is that various health professionals within the FHT are committed to meeting prevention targets. However, prevention areas outlined by the MOHLTC are narrow in scope. According to one FHT leader, the defined parameters that are provided by the MOHLTC are limiting:

They decide that diabetes is important so they're going to provide some extra dollars to the docs that do a good job with diabetes...same thing goes for pap smears. They don't do anything for bone density or they don't do anything for PSAs or having blood pressures on a chart, or any of those things. I'd rather them take that back and just give us more resources.

(L12.2)

According to one policy informant, the intention of FHTs is “to meet, not just episodic care but better preventative medicine as well...with social workers...to deal with the problems that the family is facing that's not just an infection” (PI4). However, the only PHC attribute that communicates to FHTs how health care practices are to be shaped is not inclusive of these practices. Comprehensiveness of services is the attribute informing PC health care services; health care practices promoted in FHTs are similar to those that would emerge in a solo-physician PC setting.

Being: Emphasizing physicians

Once again, achieving goals related to comprehensiveness of services in FHTs emphasizes the inclusion of physicians in FHTs. Financial incentives intended to increase preventative practices are aimed at physicians. Financial payments and incentives aimed at physicians cover a broad scope including areas such as: smoking cessation counseling, pap smears, mammograms, influenza vaccines for seniors, immunizations, colorectal screening, palliative care, prenatal care, home visits, diabetic care, and care for individuals with congestive heart failure (MOHLTC, 2009a). Although allied health care staff are considered important in prevention activities (MOHLTC, 2006b), the financial incentives rewarding these practices go to physicians and not to allied health professionals. With comprehensiveness of care historically being the locus of individual PC medical services, it is not surprising that the MOHLTC is promoting health care practices that center around physicians. However, the concern is that this is the only foundational attribute that provides FHTs with direction on how to shape health care services. Thus, the message to FHTs and to physicians who have moved from solo-practice into the FHT model is to continue health care practices as per usual. Again, the concern is not that there is an inclusion of individual medical care; instead the concern is that there is a limitation of other health discourses informing health care practices. As of this point, three of the four foundational PHC attributes informing the FHT model communicate the expectation of continuing on PC instead of the inclusion of PHC. The foundational attributes of the FHT model are not promoting a shift from PC to PHC; thus, we should not anticipate change in assumptions or discourses shaping health care

services. It is evident that tensions will arise with the introduction of interdisciplinary teams.

Interdisciplinary Team

Saying: Valuing congruency

Evidence from all three data sources strongly indicates that the inclusion of interdisciplinary teams is an expectation of FHTs. So far, the interdisciplinary team is the first attribute to distinguish the FHT model as a PHC and not a PC model. There is strong evidence from the documents, policy informants, and FHT leaders that they all consider the inclusion of interdisciplinary teams valuable in meeting health care needs. For example, one document states, “Ontario’s population health needs are complex and diverse, and it is increasingly recognized that these needs are best met by teams of health providers working in collaboration with each other, and with patients” (MOHLTC, 2005a, p. 3). As well, one policy informant stated: “It became clear that meeting the needs of the growing population and an aging population with more chronic illnesses where the literature is pretty strong in demonstrating that interprofessional teams is very good with managing the more complex patients” (PI5).

All policy informants included in the study indicated that inclusion of interdisciplinary teams is a core attribute of FHTs. One policy informant stated, “The whole model of care is for interdisciplinary collaborative model” (PI3). FHT leaders also agree that interdisciplinary teams are a central tenet of FHTs. One FHT leader stated, “This model is about, definitely being part of a team and not working individually” (L21). Interestingly, the previous three attributes shaping FHT practices and identity present some contradictions to this statement. Based on evidence in all three data

sources, the PHC attribute of interdisciplinary team is considered valued. However, the implementation of interdisciplinary teams in FHTs requires new health care practices that many were both unprepared for and not anticipating. Given that three foundational attributes shaping the FHT model are promoting practices and structures that are comparable to traditional PC, it is no wonder that physicians entering FHTs were not anticipating changes that emerge from the comingling of health discourses.

Doing: Teamwork being new

There is strong evidence from policy informants and FHT leaders that the inclusion of interdisciplinary teams in PHC involves new health care practices for many. One FHT leader stated, “Teamwork wasn’t always how it’s been” (L2). According to the data, the inclusion of interdisciplinary teams has been particularly difficult for PC physicians that have required the inclusion of new health care and organizational practices different than PC. I also heard from participants that group practice models – where physicians were practicing amongst other physicians – did not require collaborate care practices.

According to one FHT leader, “You don’t get into medical school by being a team player...it’s very different. You’re asking people to do something that they may have never done before and they might not even have an inherent understanding of what that means” (L9). The inclusion of interdisciplinary teams has introduced some of the FHT physicians to new ways of approaching health care – understandable given that different health professionals may be informed by different health discourses than solo-PC physicians may have previously encountered. In my own social work practice, I had numerous encounters with physicians and other health professionals who had informed me that I was the first social worker they had worked with. This meant that in those

circumstances, being introduced to my assumptions about health that links social structures to health outcomes was a new perspective for them. I suspect this to be similar in FHTs. Up to the inclusion of interdisciplinary teams, the discourse analysis involving foundational PHC attributes did not support the inclusion of different assumptions on how health care practices should be shaped. The inclusion of interdisciplinary teams requires the involvement of health discourses that inform team based health care practices quite different from solo PC.

Evidence in the data analysis indicates that physicians have had difficulty with the inclusion of interdisciplinary teams. According to one policy informant, “It’s a new way of practice for some” (PI3). As well, the following FHT leader described the challenge of moving from solo PC practice to an interdisciplinary team environment: “Traditionally as docs you’re your own boss and you have to commit yourself of everything...unfortunately [you can’t] take that same approach into working with each other and working in groups” (L17). Thus, this FHT leader indicates that PC ways of health care practice are not effective within an interdisciplinary setting. One policy informant also indicates that one of the challenges to developing FHTs was that there was a lack of knowledge and preparation required to foster success in interdisciplinary teams: “It wasn’t enough to get teams funded and together. They needed the skill set to work together and maximize the investments” (PI5). However, the FHT model itself is promoting health care practices and structures that are not encouraging these new approaches. In fact, not everyone who joined the FHT did so with the interest in collaborative care. One FHT leader stated, “It was mostly a financial reason for joining, not a ‘I want to work in a group. I want to be multidisciplinary’. So it’s tough. A lot of

people weren't very willing to change or work differently...so there's been a lot of frustration" (L17).

Furthermore, exploration of the previous three PHC attributes has demonstrated how physicians and physician services are privileged in the FHT model. With the privileged member of the interdisciplinary FHT team struggling to understand and incorporate team-based health care practices, we can expect problems to take place in these FHTs. Moreover, evidence from policy informants and FHT leaders demonstrates that financial incentives aimed at individual physicians are creating difficulties for interdisciplinary collaboration.

The discourse analysis also provides evidence that MOHLTC financial incentives aimed at physicians are creating tension in interdisciplinary teams. Despite the interdisciplinary team being the one salient attribute that distinguishes the FHTs as a PHC model instead a PC model, policy has not developed financial incentives that are reflective of this. One policy informant describes the tensions that have emerged:

Some of the funding models stuff we found out became an irritant... We had provided physicians with bonuses with a sort of pay for performances.... Well, in a team environment that didn't work very well because – and still doesn't I guess – because a lot of the team are contributing to things. (PI5)

Financial incentives exclude all health care providers who are not physicians. Based on the contextual factors leading to FHT implementation, the FHT model has built upon

existing PC models. It appears that the MOHLTC has implemented similar approaches for funding in the FHT model as in the previous PC models.

Being: “The right fit for the FHT”

Developing FHTs in a way that promotes congruency with the PHC attribute interdisciplinary team has been challenging. According to the data, FHT leaders are provided with guidelines regarding types and numbers of health professionals that are eligible for funding. However, there is strong indication in the data analysis that the development of an organization that promotes a culture of interdisciplinary teamwork requires more than hiring a particular professional. According to the data, developing an organization that promotes an interdisciplinary culture requires finding people who are suited to collaboration. According to one leader, “It’s about finding the right fit, the right people – the right fit for the FHT” (L21). “The right fit for the FHT” is a phrase that emerged many times in the data signifying that not everyone is suited to work in a collaborative model. Another FHT leader expanded on this idea: “People come with skills. They all have good academic preparation and any other skills they need, we can teach. But you know what we can’t teach is attitude” (L22). Attitude and a willingness to work in an interdisciplinary team environment were often cited as important in the development of the FHT organization. I have found myself wondering if attitude and the “right fit for the FHT” refers to people who may be more adaptable to the comingling of health discourses. Another FHT leader stated, “There’s some physicians and there’s some staff that are not the right fit for this type of model” (L22). It appears to me that there are different motivators that led to physicians becoming involved in the FHT in the first place. First, some physicians entered the FHT model because they saw it as a way to

enhance PHC services. These are likely the right fit for the FHT and likely entered with the intention of working with others. Second, the FHT model seems to have been advertised to physicians as a way of lessening the burdens of their PC workload. Thirdly, the FHT model seems to have been presented as a way for PC physicians to generate more income. It is the last two categories of physicians that likely entered the FHT model with little preparation to provide health care services collaboratively.

Additionally, there is strong evidence in the data indicating that FHT leaders have experienced challenges in determining “the right fit for the FHT”. According to the data FHT leaders – who have been primarily physicians – have not had adequate preparation nor have they had previous exposure to different types of health professionals. Thus, hiring and determining what composition the interdisciplinary team should take has been difficult as illustrated by the following FHT leader:

Most of things fail early on because it certainly is lack of experience and knowledge on our part...how do you even just sort of interview people and select the right people...a lot of the mistakes made early on were not having clear expectations of the people that we hired...We're unfamiliar with that as physicians... It would have been nice to have some education or expectation, or something about that beforehand rather than just kind of learning the hard way. (L17)

However, it is my own opinion that this process requires more than interviewing skills, it requires exposure and a willingness to engage in an understanding of other's views on how to approach health. Additionally, promoting congruency with interdisciplinary team requires more than just the inclusion of a range of health professionals. Although documents – such as the *Guide to Interdisciplinary Roles and Responsibilities* (MOHLTC, 2005a) – provide a brief overview of some health care practices that might be assumed by various interprofessional health professionals, FHTs have not been prepared for collaborative practice nor for the development of a collaborative organization. For example, the *Guide to Collaborate Team Practice* (MOHLTC, 2005f) is meant to provide guidance in developing an organization that encourages interdisciplinary collaboration; however, a thirteen page document is clearly not sufficient for those new to collaborative team approaches to care.

Additionally, the FHT model sends mixed messages. On one hand, the model privileges physicians and suggests that health care practices can continue in FHTs as they previously did in PC. On the other hand, there is an expectation of collaboration with interdisciplinary teams. One FHT leader described, “There’s trouble with interacting with the staff and expectations and what you can ask of them, what you can’t, and more working along with them than having them work under you as opposed to you having your own staff” (L17). Despite interdisciplinary teams being a foundational property of the FHT model, data from policy informants and FHT leaders provide evidence that little consideration was made regarding collaboration prior to model implementation. This is illustrated by one policy informant who when asked to identify any unexpected outcomes of the FHT model responded:

The interprofessional relationships and the depth of knowledge that our teams had to have...it was new.... The interprofessional relationships and the communication was the toughest.... While we at the Ministry were...trying to gear them up and give them guidance...[it was] a lot of things to deal with all at the same time while also dealing with the relationships issue. I think in hindsight...that was the thing that we paid attention to the least.

(PI6)

Although the entire model has been developed to promote congruency with interdisciplinary team, there is no indication that the model promotes the inclusion of interdisciplinary health care practices.

Being: Visionaries making it work

Despite the challenges, a few visionaries have been able to make it work and emphasize the importance of fostering a culture that promotes interdisciplinary team collaboration. This is illustrated in the dialogue between two FHT leaders whereby the first FHT leader in this interaction makes an analogy of developing a FHT with building a house: “The important thing is to get that foundation good and solid before you start building anything. Make sure you know what you’re doing” (L12.2). The second FHT leader involved in this dialogue replied by saying: “Establishing a culture” (L12.1). Followed by: “A lot of the other teams build a really nice house but there was nothing supporting it” (L12.2). Thus, the implication is that the foundation required for collaborative care approaches is an identity that has a foundation – or culture – congruent

with collaboration. However, physicians who entered into the FHT model with a desire to enhance PHC are probably more likely to strive for a collaborative culture than those who entered the FHT model as a way to decrease workload burdens or generate income.

The visionaries describe how achieving a culture of interdisciplinary collaboration develops over time through the intentional implementation of team oriented activities related to clinical practice, education, and research:

There's an understanding that the different professions have different cultures and by working through clinical, education, and research models together, I think there's been an understanding of what each profession can contribute and what their strengths are and how we can really work with each other better...it took a lot of meetings, it took a lot of discussion, communication to define those roles, goals, responsibilities of each person within the team.

(L5)

Developing a culture that promotes congruency with interdisciplinary team requires influence from health discourses that value relationships – such as the biopsychosocial or health promotion discourses. This is illustrated by one FHT leader who indicated that: “this work depends on the building of relationships and so you have to allow the time for that” (L4). However, implementing health care practices and structures that foster the cultural change described by the above FHT leaders is not being directed by the FHT

model itself. As well, it appears that these visionaries have looked beyond what is being promoted by the foundational PHC attributes reifying PC.

Summary

The FHT model primarily promotes congruency with four PHC attributes: first-contact access, accommodation access, comprehensiveness of services, and interdisciplinary team. These four PHC attributes are intended to shape health care practices and organizational structures of FHTs. Foundational PHC attributes of the FHT model are reifying PC practices and structures, thus, not preparing or promoting the inclusion of broader health discourses that can inform PHC. With two of the four attributes of the model emphasizing access to care, the MOHLTC is over emphasizing access and underemphasize other important PHC attributes. To demonstrate congruency with first-contact access, physicians are rewarded for engaging in the practice of enrolling patients. Additionally, the MOHLTC again privileges physicians with the provision of a financial bonus for demonstrating congruency with accommodation accessibility. However, what becomes evident is that patient enrolment is similar to a wedding – it is a ceremony signifying commitment yet does not provide any information about the marriage to come.

An emphasis on access means that there is an immediate limitation on alternative ways of viewing or approaching health care in FHTs. The FHT model does not promote considering on how to shape health care practices in a way that is inclusive of assumptions and approaches informed by the biopsychosocial, health promotion, SDOH, and holism discourses – a host of PHC attributes are immediately excluded because they have not previously informed PC. This is not to imply that access is not important,

because it is. However, access only promotes initial contact with health care providers. Access does not promote critical thought on the underpinnings of assumptions shaping health and health care. As well, with three foundational attributes shaping FHTs appearing to reify PC, the FHT model does not provide any indication of the desire to broaden health care practices beyond the scope of clinical-practice attributes. There is no indication that the FHT model intends to facilitate inclusion of health care practices and structures shaped by person-oriented and community-oriented dimensions of PHC.

It is no wonder that the inclusion of interdisciplinary teams has been challenging given that the FHT model gives little indication – other than adding interdisciplinary health care professionals – that health care practices will be shaped any differently than it was in PC. The MOHLTC promotes a model of care that suggests little difference between PC and PHC. With new health care practices not being anticipated and individual PC practices encouraged and reinforced with the inclusion of typified physician financial incentives, the FHT model does not promote nor prepare FHTs for the comingling of health discourses that inform PHC. Many FHTs are experiencing challenges associated with the introduction of interdisciplinary teams; however, I suspect that the reason for these challenges stem from the clash of cultures that goes beyond professional issues. I suspect that these challenges are resulting because of the lack of consideration and preparation for the multiple views that we from our diverse discourses in health care bring.

However, as I gathered data for this study I had the opportunity to visit a variety of FHTs. Despite being informed by the same MOHLTC model, FHTs are diverse. I visited FHTs that looked similar to a small doctor's office, and I visited others that were

larger in size and appeared more inclusive of their surrounding community. Some FHTs diverged beyond the four foundational PHC attributes and appeared inclusive of a broader scope of PHC attributes than what is being promoted by the FHT model. During the course of the data gathering phase, there were some FHTs that I began to refer to as the visionaries. These are the FHTs that appeared to be inclusive of additional PHC attributes than what is promoted by the FHT model. These were FHT leaders who expressed a desire to implement health care strategies that centered around person-oriented and community-oriented properties of PHC. I found myself inspired by these visionaries, inspired by some of their creative approaches to health care, and inspired in how they were organizing themselves in order to meet the health needs of their communities. As a social worker, it is the FHTs of the visionaries that I would love to work in. I suspect that these visionaries – perhaps from knowledge gained through their own practice experiences – have intended to shape FHT practices and structures in a way that promotes inclusion of the various health discourses. Thus, this intention goes beyond just the mere inclusion of additional health professionals. I also had the impression that social workers' perspectives and practices would be considered more valuable in these FHTs than those that are taking their direction more so from the four foundational attributes. Although FHT leaders of the visionary FHTs spoke about comprehensiveness of services and medical care, they also spoke about ways that they wanted to meet the needs of their community in diverse ways. However, an examination of the FHT model demonstrates that attaining a visionary FHT extends far beyond the model that is promoted by the MOHLTC. Based on the four foundational PHC attributes being promoted by the FHT model, the MOHLTC appears to be encouraging a model that

is an extension of PC with limited inclusion of attributes beyond the scope of clinical-practice.

Inadequate Performance Indicators

The second salient finding that strongly emerged in the data is inadequate performance indicators. This term refers to the performance measures being used to evaluate the success of FHTs. Inadequate performance indicators will be illustrated by describing the four sub-themes that emerged in the data. First, valuing quantity will demonstrate the emphasis that the MOHLTC has placed on quantity of patients and patient contacts as a measure of FHT “success”. Second, health care practices in FHTs emerging in response to the demands of patient volume will be explored. Third, it will be demonstrated how performance indicators are producing inaccurate results, which are being used to shape the FHT organizational structure. Fourth, findings will demonstrate how inadequate performance indicators are negatively impacting health outcomes.

Saying: Valuing Quantity

The discourse analysis provides strong evidence that the MOHLTC employs quantity of patients enrolled and patient contact numbers as a measure of FHT success. According to the data, the primary indicator used by the MOHLTC to determine the success of FHTs is the number of individual patients enrolled with FHT physicians. This is illustrated by the following policy informant’s statement: “The increased emphasis on access and unattached patients as we call them, has meant that we’ve become more and more disciplined and expect more discipline from the Family Health Teams in terms of meeting enrolment targets” (PI4). The value that the MOHLTC places on using quantity of patients enrolled as a measure of FHT success is also evident in the following FHT

leader's statement, "There are formal outcomes that the Ministry's looking for. Those are really around visit numbers and roster numbers" (L4). Based on this evidence from this FHT leader, the MOHLTC values the quantity of individual patient numbers and the quantity of individual patient contacts. Another FHT leader states, "What we're told is we're measuring Family Health Team success by...how many people we've rostered" (L23). What also emerges in this study's data is that the MOHLTC's emphasis on quantity is challenging for many FHTs.

That this emphasis is creating tensions for FHTs is demonstrated by the following FHT leader: "One of the biggest challenges is...where we all want to go and what the Ministry's currently right now asking us to submit -- and that's just volume-driven-type quantity. We want quality, they want quantity" (L8). Based on the data, the MOHLTC's use of quantity as a measure of success is problematic. For example, one FHT leader stated, "There's got to be a better way that we can measure our success" (L23.1). The data indicates that the emphasis on quantity is neglecting other important attributes of PHC that ideally would shape FHTs. For example, one FHT leader stated, "All of the other things which make up the value proposition of primary care to its population that it serves are absent, all we have is this microscope on the wrong numbers" (L10.1). Another FHT leader voices concern with the indicators being used to determine FHT success: "The way that they measure success is not necessarily how I would measure success. They measure success by how many rostered patients have you enrolled....For us, we would rather look more at patient outcomes...We're more interested in things that actually make a difference in the practice" (L8). This FHT leader went on to state, "I think that's where we'll have a bit of a disconnect between what is success. I really truly

don't believe what they're measuring is success at all" (L8). Based on evidence provided by these FHT leaders, the MOHLTC's emphasis on quantity is inadequate because measures of broader attributes of PHC and health outcomes are not measured. The following FHT leader demonstrates the ultimate example of how there is incongruity between measures being used to determine FHT success and the actual quality of health care services:

On paper, they can show that lots more people can say that they have a health care provider today than they did before the Family Health Team. But, I think a lot of people would say and still say that they have difficulty accessing their primary care provider...that goal has not been met and part of the reason is the reason that I talked about before which was one of the drawbacks to the rostering system is it does, if you have any sort of business sense you soon realize that I don't have to be in my office...but still have this income stream coming in and so on and so forth. So, I don't know if physicians are spending as much time in the office as they were beforehand when they were fee-for-service. I would say that there is incentives to sign people up and roster them. (L20)

In the example provided by the FHT leader above, indicators being used provide no information about quality service.

The MOHLTC's emphasis on quantity as a measure of FHT success may deter the inclusion of PHC attributes that may in some cases limit the numbers of patients enrolled. Quantification of results can provide useful information such as the numbers of individuals who use a particular program; however, the emphasis that the MOHLTC has on quantity as the measure of FHTs' success deters inclusion of activities that do not produce numerical outcomes. In the promotion of health and wellbeing, quantifying outcomes only provides part of the picture. Using patient enrolment numbers as indicators of success provides challenges to social work in FHTs. Current patient enrolment numbers refer to those patients enrolled by a physician but tells nothing of the service being provided by the social worker, or any other health professional within the health care team.

Social work is familiar with some of the challenges that emerge when quantification is the valued indicator of effectiveness. As a social worker in a tertiary care hospital, I too frequently found myself challenged to demonstrate my effectiveness due to indicators of success not being inclusive of the scope of my contributions. For example, evaluating my success based on hospital discharge numbers did not demonstrate the depth or extent of my effectiveness as a social worker. Furthermore, the evaluation of my effectiveness based on the numbers of patients I saw each day provided limited information on my work or on the outcomes that emerged. For example, my contributions that spanned over a two year time period leading to the development of an inner-city housing project for people with brain injuries would not be included. As well, hospital discharge numbers and the numbers of patients seen over a time period were also inadequate in demonstrating my effectiveness in assisting a family and my

interdisciplinary team through the process of end-of-life decision-making. Although quantification provided some useful information regarding my impact, it only provided some of the details of my work. Information about the types of health care services and scope of activities may have been a useful addition. The MOHLTC's emphasis on quantity as an evaluation tool poses challenges for social workers and other allied health professionals in FHTs to demonstrate their effectiveness and the extent of their contributions. The emphasis on quantity also appears to be having an impact on health care practices implemented in FHTs.

Doing: Volume Influencing Practice

Based on the data analysis, inadequate indicators are influencing health care practices within FHTs in two ways. First, specific health care practices are being implemented in response to the demands of patient volume. Second, health care practices are encouraged to include programs that promote greater numbers of encounters. Although patients are enrolled to individual physicians, the emphasis on patient volume impacts the practices of other health care providers within the FHT. For example, one policy informant described how patient volume has influenced the practice of dietitians within FHTs: "Dietitians have traditionally provided one-on-one counseling and they are finding that the volume of patients needing their care has been so overwhelming that they're starting to do group work" (PI2). Although the benefit of group work is known to social work, in this case the rationale for implementing group work is not because of clinical benefits but instead as a way to keep up with the demands emerging from volume. This is one example of how indicators may be inadequate because health care practices are being driven by a need to increase numbers of patients rather than measures

of the effectiveness of interventions. What should be occurring is that health care practices be implemented because they are effective and promote healthy outcomes, not as a means to keep up to demands resulting from an inadequate evaluation measure. This further heightens a concern for social work. The inclusion of social work in PHC settings is positive because social work services then become more widely available to individuals and families. However, what is concerning is that health care services provided by social work might be influenced and shaped in response to the demand of volume. Furthermore, social work health care services are implemented in response to physician enrolment numbers. It would be interesting to explore whether or not a patient would be able to access a FHT social worker without having to see or make contact with the physician. If not, the message from the MOHLTC is that physicians are the gatekeepers for social work and the other interdisciplinary health care services.

Furthermore, with quantity of encounters that FHTs have with people in relation to a particular disease, FHTs are encouraged to implement health care practices formulated in a way to promote transactions. The following FHT leader provides an example of this:

When you're told to report your number of transactions by chronic disease, by allied health professional, essentially what that is saying is take these allied health professionals and have them do programs. And if you want to spend a lot of money, that's how you do it because then every diabetic becomes a client of the program....You can go endlessly to all the sort of programmatic transaction based things that programs can do. But

what you end up doing is hardly impacting at all on the actual patient oriented outcomes that are important to the population.

(L10.1)

This example illustrates that reporting numbers based on disease transactions shapes health care practices by encouraging inclusion of programs that can foster larger numbers of patients with a specific disease being seen. In this case, the message that is sent is to develop disease-focused programs and encourage all the patients with that diagnosis to attend. For example, to illustrate success from this perspective, every diabetic that belongs to a FHT would be asked to attend a diabetic insulin monitoring program whether they require it or not. Although a person may have diabetes, they may not have difficulties with insulin management and not need this program. An alternative way of determining program success is based on population outcomes – this approach would determine success based on outcomes of the total patient roster and encourage interventions aimed at those who most require it. The FHT leader continued on by stating that program indicators of success are not reflective of the experiences of FHT physicians and makes reference to an uproar on the physicians' list serve:

There was a firestorm and it was a backlash reaction to what they were using as indicators. There was a sense that they didn't really reflect what practitioners understood and sensed was the reason why they were practicing primary care...I rarely ever see a diabetic where it's an access or clinical challenge in my practice.

Those that don't achieve outcomes usually don't for particular reasons...I have an alcoholic schizophrenic who also happens to be diabetic. (L10.1)

What this FHT leader suggests is that indicators that determine success by disease-based encounters would want the above patient to attend an insulin management program. However, using an outcome-oriented or even a person-centered perspective may facilitate inclusion of health care services that assist with addictions or the mental health concerns. Furthermore, if indicators judged success even more broadly, then additional social factors that might be influencing the alcoholism or mental health symptoms – such as trauma – may then be considered appropriate areas to direct health services. Thus, success determined by the number of disease-based encounters, does not equate to better service to patients' needs. This is not to indicate that focus on specific diseases is not important in programming; however, it is a concern when programs are being implemented in response to top-down indicators and not in response to the population or person's needs. Currently, without disease-focused transactions, achieving success as defined by the MOHLTC becomes difficult.

Furthermore, FHT leaders describe how inadequate performance indicators detract from person-centered care. For example, one FHT leader stated: "Patients just don't present as one problem....Patients aren't a disease" (L12.1). Another FHT leader agrees and described this as challenging: "How do we manage patients as patients, not as disease-specific?" (L21). A third FHT leader stated: "Patients aren't a disease" (L12.2). Current performance indicators are inadequate for supporting person-centered care,

which is a foundation of PC and PHC. Further, one FHT leader indicated that even multiple diseases pose a challenge for these indicators: “How do we care for patients with multiple co-morbidities as opposed to just focusing on one disease, specific disease?” (L21). Even a policy informant recognized that current indicators of success are presenting challenges for person-centered care: “Person-centered care diminished with the accountability framework” (PI2). Another policy informant agrees:

Working right now...is voluminous and it's about just ploughing through the numbers, which makes it hard to look up and out. There's a tendency to be looking down...it's about two things – managing within...budgets and having good accountability...I would argue that client care gets talked about secondly, thirdly. (PI7)

This policy informant continues to describe how inadequate performance indicators detract from person-centered care:

I think docs who really get health care beyond the transaction and the medical piece, understand that there are invariably issues, systemic issues, related to money, housing, or family dynamics that are either contributing or causal to whatever the issue is. And docs don't have time within whatever their funding model is in whatever province they're in *and* with the kind of patient loads

that they have to address those. (PI7)

Evidence from this policy informant further illustrates the impact that indicators of success have on shaping health care practices, in this case, person-centered care. Given that one of the strengths of PHC is that it is person-centered, the message that person-oriented dimensions of PHC are not rewarded in FHTs is concerning. As well, an additional concern that requires exploration is the influence that inadequate indicators may have on shaping the structure of the FHT organization.

Being: Inaccurate Measurement Shaping FHTs

The third area demonstrating the inadequacy of performance indicators was found in the analysis of the impact on the FHT identity. One concern is in the allotment of funding for interdisciplinary health providers. According to one FHT leader, the MOHLTC's method of assessing success does not adequately reflect the amount of care actually being provided in FHTs, which then puts funding at risk. In this case, the FHT leader is describing how the signing of a patient roster form is not an accurate assessment because there are some individuals who choose not to sign:

It has an implication for policy, because those people will still use our services, we don't prevent them from doing so, but their numbers are not included in the count that the Ministry uses to judge our success. So, if those people generate visits for our dietician and yet the Ministry would say, "Oh well, you don't

have a very big roster. Your roster's not large enough to support a full-time dietician. We're going to cut your funding. (L4)

Thus, the quantified measure that the MOHLTC is using to determine success is not accurately representing the real demands of health care in some FHTs and in the example provided by the FHT leader above, may result in decreased funding for interdisciplinary health providers. This is concerning because the data analysis indicates that the patient rostering method is not an accurate representation of health care services, particularly in Northern communities. According to FHT leaders, patient rostering is not working for First Nation's people. One FHT leader stated, "Aboriginal people don't want to roster, as a generalization, not all" (L2). Another FHT leader agreed and stated, "The First Nations' component is difficult...they don't like to roster" (L3). When asked the reason why patient enrolment is not working for First Nations' people, one FHT leader stated, "It's a trust issue, that's part of it. I think it's a trust issue. I think it's a cultural piece" (L2). Another FHT leader was unsure of the reasons why First Nations' people were more adverse to patient enrolment, "Many of them are not rostered and they will not roster and I'm not sure why. So, they just sort of come when they need to come and I think they are a little hesitant about rostering" (L11). One FHT leader further expands:

The First Nations component is difficult. First of all, they don't like to roster. Secondly, they go for care sort of traditionally all over...part of the problem with that is that if you are rostered patients and you seek care elsewhere, your physician is

financially penalized...So, physicians have been reluctant to roster First Nations' people (L3).

There is strong evidence in the data that some FHTs continue to provide health care services even to patients who choose not to sign a formal patient enrolment form. If the determination of interdisciplinary health care provider funding is based on an inaccurate measure, then the funding of some FHTs – particularly Northern FHTs – will not be congruent with the health care demands. Hence, Northern FHTs may be at risk of receiving less funding for interdisciplinary health providers. This further presents health care access challenges to Northern communities.

Although there is no evidence in the data, the emphasis on inadequate indicators involving number of rostered patients and number of patient encounters makes it worthwhile to hypothesize one additional impact to the FHT identity: encouraging inclusion of interdisciplinary health professionals whose practice result in increased numbers. Such allied health professionals may be considered more valuable when determining which health care professionals to hire, particularly for FHT leaders who may not have extensive knowledge about the roles of the various health professionals. Given how challenging the implementation of interdisciplinary teams has been for FHTs – including the determination of which interdisciplinary health professionals – one property that may guide FHT leaders in their hiring decision may be related to expected impact on current indicators of success. If this is the case, then the interdisciplinary health professionals that would be most desirable additions to the FHT team are those

that would increase number of patients and number of patient interactions. An alternative view might be to include health professionals based on ability to impact health outcomes.

Health Outcomes: Volume Emphasis Encouraging Acuity

Based on evidence in the data, an additional concern that exists due to the inadequate performance indicators of success is that practices become more about meeting the expectations of numbers and less about health outcomes. For example, using patient enrolment numbers as a key measure of success only provides an assessment of effort regarding quantity of individuals who are enrolled; evaluation of patient experiences, adequacy of health care practices, and health outcomes are excluded. This concern is identified by the following FHT leader: “In many cases, I think that there are practices providing poor services and getting paid a lot of money because they rostered the world and don’t service them” (L10.1). Based on this FHT leader’s statement, a FHT may be viewed as successful because the quantity of patient enrolment is high; yet, the rostered individuals may not even be receiving health care services.

Furthermore, inadequate indicators may even result with individuals who require care being excluded from FHTs. According to the following FHT leader, increasing patient volumes means being selective about which individuals are accepted as patients: “If we wanted to manipulate the system, if it’s all about roster, then we would cherry pick which patients we got because then we’d want single males...healthy...with no issues, because then our physicians could take on 2000 patients each” (L21). According to this FHT leader, single healthy males require the least amount of health care services. This FHT leader is also suggesting that healthy individuals requiring fewer health care services are desirable for patient enrolment; less demands for services means that more

individuals can be enrolled thus increasing patient volume without associated increased labour. Individuals with simple health issues do not require extensive time or services because their care needs are minimal. Whereas individuals with more complex health issues – including women, the elderly, vulnerable populations, and potentially anyone with health or mental health concerns – will require more time and services to respond to their care needs. Thus, measuring success by the number of individuals enrolled to a FHT encourages the exclusion of those most requiring health care services; evaluation indicators driving the exclusion of those most needing health services are ultimately ineffective in facilitating access. Furthermore, what may have been easily prevented or addressed becomes at a later stage, an acute health crisis. This is described by the following FHT leader:

What that means in medicine...is oftentimes you get people in the worst case of the course of whatever illness or issue that they have, because they've waited until the last minute in that they don't have actual access for preventative or earlier intervention or use of services that would have actually mitigated the issue in the first place. So we end up becoming quite responsive on the acute end. (L23.2)

Thus, current indicators of success are also ineffective in the promotion of healthy outcomes. As a social worker who practiced in Winnipeg's inner city hospital, I witnessed this phenomenon frequently when observing the concerns that would lead

people to seek care from the emergency room. Physical and mental health concerns that may once have been easily addressed in PHC settings became a crisis requiring specialized tertiary health care. Thus, inadequate performance indicators that focus solely on patient volumes can impact health care practices in a way that detracts from timely attention to health care needs, and reinforces responses informed solely from a biomedical discourse.

Summary

The data analysis strongly suggests that inadequate indicators are being used to evaluate the success of FHTs. Indicators of success are based on quantity, not quality. The emphasis on quantity in the form of patient enrolment numbers and numbers of disease-oriented contacts provides challenges to FHTs who strive to implement health care practices informed by person-oriented and community-oriented dimensions of PHC. Furthermore, health care practices are being implemented in response to volume that is emerging as a result of the indicators rather than best practices. Not only is the emphasis on quantity not encouraging congruency of FHTs with PHC attributes, the measure of quantity of patients rostered does not always result in accurate numbers.

Lastly, a significant concern arising from the use of inadequate indicators is the resulting encouragement of acuity in health outcomes. Current indicators are inadequate because they are promoting the exclusion of individuals from health care practices that will have negative and expensive health outcomes in the long run. Thus, current indicators of success are providing significant challenges for FHTs. Those FHTs that are successful in the implementation of health care practices spanning the broad scope of PHC attributes and implementing health care practices in response to their community needs are doing so

in spite of policy directives. The one thing that current indicators appear to be successful in is generating income.

Conclusion

This chapter provided findings on the four foundational PHC attributes shaping FHTs: first-person contact, accommodation accessibility, comprehensiveness of services, and interdisciplinary team. The FHT model promotes an extension of PC and does not promote the inclusion of health discourses beyond what existed in PC. Thus, the FHT model did not prepare FHTs for the inclusion of different assumptions about health or different opinions on how health services should be shaped. The inclusion of interdisciplinary teams may have introduced new ways of understanding and approaching health care services that previously were not included in PC – a meeting of the “health cultures”. However, even for those FHT leaders who entered the FHTs with the intention of developing collaborative PHC services and structures, it appears that they were not provided with the knowledge or skills to do so.

Further, inadequate performance indicators are basing the success of FHTs on the volume of patients enrolled. Patient enrolment is an indicator that was used in PC practice and is now being used to determine FHT success. This signifies an expectation of continuing PC health care practices with the inclusion of interdisciplinary teams as physician-helpers. Furthermore, judgement about the success of the entire FHT is dependent on an indicator that requires patients to be enrolled yet does not give any indication that a health care provider was even seen. For physicians who have signed onto the FHT to generate income, this is the perfect model: your income increases from signing on patients and even though you may not be showing up for work, indicators

point to your success. However, for physicians and others who have joined the FHTs and who are motivated to improve PHC and the health of their communities, this model has problems. The FHT model does not promote any change in the underlying assumptions and health practices from PC to PHC. Further, performance indicators are detracting from person-centered care by promoting a view of person-as-disease.

At a time that social work is being introduced to a new sector of the health care system, performance indicators are posing challenges to the inclusion of person-centered care. What effect this might have on shaping the health care practices of social work is currently unknown. With practices being influenced by performance indicators, the promotion of person-as-disease, and the dominance of physicians in shaping all aspects of the model, the FHT model is promoting the biomedical discourse and detracting from the core attributes of PHC which is person-centered care. However, despite the biomedical influence in the FHT model, there appears to be some visionaries who are attempting to shape FHTs in a way that is inclusive of a broader scope of PHC despite what is being promoted by the MOHLTC.

Chapter 6 – Discussion and Recommendations

Embarking on this dissertation journey, one of my intentions was to illustrate that various assumptions – or health discourses – inform PHC. I believe that by illustrating the assumptions currently guiding health care practices, promoters of PHC will be more informed and will then be able to make better decisions on how to improve health care practices and structures. With person-centered care (not disease-focused care) at the heart of PHC (Starfield, 1998), I believe that PHC is an important locus for social work. This is because person-centred care takes into consideration a person's experiences, family life, social supports, culture, community context, the importance of relationships in health care, and recognizes the connections between the physical, emotional, and social aspects that shape health (Haggerty et al., 2007; Stewart, Brown, Weston, McWhinney, McWilliam, & Freeman, 2003) – these are all areas of importance for social work practice. I am excited at the potential of PHC because these foundations underpinning the PHC system are congruent with the knowledge base and values guiding social work discourses.

I have often wondered what a health care system that is developed from a person-centered perspective would look like. Person-centred care requires the inclusion of assumptions about health that span various health discourses; however, with the biomedical discourse being most prominent in shaping research and health care practices (Longino & Murphy, 1995, Raphael, 2006), assumptions guiding person-centered care are likely to be underrepresented in the shaping of health care systems. Person-centered

care is one of the properties that differentiate PHC from the rest of the health care system. I suspected that this would be one of the reasons that PHC reform might encounter difficulties when put into practice; it intends to shape health care practices and structures in a way that draws on knowledge from health discourses that are underrepresented in the dominant health care system. This means that the people within the health care system may have to think about health in a way that they may not have done before. For example, a health care system that is based on assumptions and beliefs grounded in the biomedical health discourse will likely look much different than a health care system grounded in assumptions related to the holism and SDOH discourses. This is not to imply that person-centred care does not take place elsewhere, it does – I have witnessed it, and I have participated in it. However, in my experience, person-centred care is taking place within a health care system that has not been developed from a person-centred discourse – and this creates tensions and challenges. As I embarked on this study, I wondered about the ways that person-centered care may be informing the model. Given that there is no one model of PHC, would FHTs be similar to the CHCs that I once worked with? I also wondered about the challenges that would emerge for policy makers and FHT leaders in an attempt to shape a PHC model that is inherently person-centered. Although there are excellent examples of person-centered health systems in Ontario with the CHCs, CHCs provide health care services to only 2% of Ontario's population (Hutchison et al., 2001). What this suggested to me is that developing health care systems in a way that is inclusive of diverse health discourses – like those that emerge in person-centred care PHC – is new for Ontario's policy and decision makers and for many health care professionals. I suspected that the emergence of FHTs may be challenging for

policy makers and for FHT leaders for this reason. In fact, one policy informant indicated to me that SDOH was important, and easy to understand in theory, but hard to implement in policy. Furthermore, I suspected that there may be challenges with the FHT model and within FHTs because FHTs as a PHC model evolved from existing PC models.

The FHT model has been part of the shift for many, going from PC to PHC. What this means is that an area of the health care system moved from solo-physician care to an interdisciplinary setting. Bell (2010) tells us that the majority of policy difficulties emerge as a result of historically imbedded elements. One challenge that I thought might be emerging is related to the concept of health discourses. Although PC and PHC are both rooted in person-centered care, in my opinion, person-centered care is not always understood or approached the same way. For example, the property that might distinguish person-centered care in a solo-physician PC setting is the fact that there is a long-term continual relationship between the physician and patient. The long-term continual relationship enables the physician to gain in-depth knowledge about a person's life that can be used in decision-making. In contrast, as a social worker, person-centered means that I am actively intervening in ways that take into consideration unique family issues, housing, economics, and community environments. Although the PC physician and I are rooted in a similar foundation, we approach it differently. In my opinion, that is the benefit of having interdisciplinary teams – we complement one another because we draw on knowledge from the various health discourses. However, what this means for FHTs is that even though the various interdisciplinary team members may all be grounded in a person-centered foundation, physicians from solo-practice may not have

previously considered person-centered care in a way other than from their own perspective. It is for this reason that I suspected that some tensions may be emerging in FHTs.

Based on my practice experience, effective interdisciplinary collaboration requires grappling with different perspectives, finding ways to resolve differences, and learning to better appreciate the alternative perspectives of other disciplines. The different perspectives are both inevitable and desirable. I have chosen to use an analysis of health discourses in this study because for me, it is one way to illustrate that the different perspectives shaping health care practices and structures are being informed by different assumptions and worldviews about health and health care. I anticipated that within FHTs, there might be a collision of “health cultures” taking place; not only because of the various professional perspectives being brought together, but also because of the foundational assumptions informing views about health and health care. It is my opinion based on my practice experiences, that sometimes disagreements between different health professions are presented as a professional issue when, in reality, they may be related more to our different disciplines’ fundamental assumptions about health and health care.

Health Discourses

My reason for including an examination of health discourses in this study was to demonstrate that there are different ways of thinking about health. These different ways of thinking about health – or health discourses as described in this study – are shaped by assumptions and beliefs that guide which health care strategies are considered most legitimate according to that discourse. Thus, health care strategies that are promoted by one health discourse may dramatically differ from those promoted from another.

Although health discourses are presented as separate from one another, it is my belief that in health care settings they come together like a composite of “health cultures”. It is also my opinion that the quality of health care is improved by a diversity of health discourses to shape policy, health care practices, and health care structures. Thus, the use of health discourses as a conceptual tool aids in determining how best to shape policy, health care practices, and structures by fostering a deeper reflection and understanding of what is being promoted given underlying assumptions.

Despite their usefulness as a conceptual tool, health discourses are limited in that they do not provide information on influential contextual issues such as economic, social, or even competing professional issues that also inform health care systems. However, applying knowledge of different discourses is an approach that can foster an analysis of key assumptions; an analysis and discussion that has been absent from PHC reform and as a result impeding initiatives like the FHTs (Hutchison et al., 2001). Thus, as a conceptual tool, health discourses provide us with a lens that can assist in deepening our understanding of the assumptions guiding health care practices and structures.

Health Discourses and PHC

Haggerty et al.’s (2007) lexicon demonstrates that various health discourses inform health care practices and health care structures in PHC (Table 2.3). There are existing examples of the comingling of health discourses in PHC such as with CHC’s. However, with CHCs providing health care services to only 2% of Ontario’s population (Hutchison et al., 2001), it suggests that the majority of health professionals working in Ontario’s PC and PHC sectors have not yet worked in a setting where a diversity of health discourses is evident. Furthermore, prior to the implementation of the FHTs, only 3% of Ontario’s

population were receiving care in a PHC model inclusive of interdisciplinary teams (including CHCs) (McPherson et al., 2010). This suggests that the “cultural shift” where values, assumptions, and beliefs meet is still in its infancy in PHC. Further, as the solo-physician PC sector shifts to PHC, we see an area of the health care system – policy and practice settings included – that previously hadn’t encountered or drawn upon assumptions and strategies from the full range of health discourses. Hutchison et al. (2001) indicate that one of the hindrances to PC reform is that these discussions of underlying values and assumptions have not occurred. For a health care system dominantly informed from a biomedical health discourse (Raphael, 2006), shaping health care in a way that is person-centered, and makes the link between social and environmental influences is difficult. I designed this study in a way that would provide me and maybe other researchers with a foundation of knowledge that could be built upon, starting with an examination of these underlying assumptions.

Health Discourses and FHTs

Health discourses are a conceptual tool that assists to deepen our knowledge of the assumptions guiding health care practices and structures of Ontario’s FHT model. For example, Haggerty et al.’s (2007) model of PHC appear to be informed by a mix of biomedical, health promotion, biopsychosocial, SDOH, and holism discourses. Furthermore, the person-oriented dimensions of Haggerty et al.’s (2007) lexicon appear to draw upon knowledge from these various discourses. With PHC referring to both processes and structures (Donabedian, 1966), underlying assumptions of foundational PHC attributes influence the shape of both health care processes and organizational structures that emerge in PHC models.

The four foundational PHC attributes informing the FHT model provide insights into the underlying assumptions and health discourses that are being promoted. The FHT model promotes congruency with the following four PHC attributes: first-contact accessibility, accommodation accessibility, comprehensiveness of services, and interdisciplinary team. Thus, the MOHLTC is promoting a model of PHC that does not significantly deviate from the PC models that FHTs are built upon. Based on the four foundational PHC attributes informing FHTs, Ontario's FHT model is comparable to PHC as described by Frankish et al. (2006). Similar to what is being promoted by the MOHLTC, Frankish et al. (2006) described a model of PHC centralized around a primarily medical model provided by family physicians with a range of health and social services provided by an interdisciplinary team. According to Frankish et al. (2006), what distinguishes PC from PHC in this case is the addition of interdisciplinary teams.

Like PC, the foundational PHC attributes of the FHT model are informed primarily by the biomedical and somewhat by the biopsychosocial and health promotion discourses. However, the inclusion of interdisciplinary teams broadens the possibility of health discourses depending on the view of the interdisciplinary health professionals. For example, a FHT with a social worker would likely be having more discussions as a team that draw upon knowledge from the SDOH discourse – perhaps in discussion about the influence that housing and income have on health – than a FHT with no social work professional. Thus, through the inclusion of interdisciplinary teams, consideration of the broader influences of health may be occurring. However, by suggesting that the FHT model is the same as PC – except with the inclusion of interdisciplinary teams – the FHT model itself has not promoted nor prepared for the inclusion of broader health discourses.

FHTs that appear to be more successful in achieving collaboration in the provision of care seem to be pursuing an understanding of different “health discourse cultures” which develops over time and through activities related to clinical practice, education, and research. However, there is no indication in the FHT model that foundational health care practices in FHTs would be different than they were in PC. During the course of my research, I had the opportunity to witness that there are indeed some FHTs that have adopted health care practices that extend beyond what is promoted by the four foundational PHC attributes informing the model. However, it is not the FHT model that is encouraging it. For example, in the case of the visionary FHTs, I suspect that the FHT leaders developing the FHTs have drawn knowledge from the FHT model as well as other sources, such as their own and the interdisciplinary team’s previous practice experience. I also suspect that the visionary FHTs have – from the onset of the operationalization of their FHT – had an intention to develop health care practices and FHT structures in a way that extend beyond the FHT model. What is interesting is that this study revealed that the FHT model does not include any foundational attributes related to the person-oriented dimensions of PHC despite person-centered being central to PHC.

Person-centered care is a foundational principle in PHC that appears to span all PHC models (Starfield, 1998; Stewart et al., 2003) and draws upon knowledge that spans various health discourses like the biomedical, health promotion, biopsychosocial, SDOH, and holism. Not only does the FHT model not promote person-centred care given the absence of person-oriented dimensions of PHC from its foundation, but the gaps revealed by the “inadequate performance indicators” finding are deterring person-centered care by

promoting a disease-centered view that differs from the person-centered intentions of PHC (Starfield, 1998). Thus, the disease-centered view appears to be informed by assumptions stemming more from the biomedical discourse perspective than biopsychosocial, for example. This is posing a challenge to health care practices and FHTs structures which from a person-centred perspective do not view people as diseases. Although person-centered care is a foundational principle in all PHC models, the indicators being used to assess success are not measuring attributes of person-centered care. Might the continued use of inadequate indicators of success that deter person-centered practices and structures have a long-term impact by influencing underlying assumptions in a way that person-centered care becomes decreasingly valuable in PHC? I found examples of FHTs that strive for person-centered care and some that displayed congruency with community-oriented dimensions of PHC. However, to do so they are encountering the concern described by Romanow (2002) as “going against the grain” because as Romanow (2002) suggested, the philosophy and health care practices in PHC differ from other areas of the health care system. Furthermore, the FHT model provides a disincentive to physicians who try to implement change. In fact, physicians in FHTs are financially rewarded for maintaining the status quo promoted by the MOHLTC. One reason that the FHTs that I have termed “the visionaries” are experiencing challenges is because the FHT model is implemented in a way that aims to maintain the status quo of PC in the assumptions and health care practices that are promoted.

Summary

The FHT model has not promoted nor prepared FHTs for the comingling of health discourses that emerges in PHC. Three of the four foundational attributes identified by

this study are those that inform PC; this suggests that change in the foundational assumptions guiding health care practices and structures was not adequately recognized as important and therefore not promoted adequately. The one foundational PHC attribute that fosters greater inclusion of health discourses is interdisciplinary team. One challenge that is arising in FHTs is that the MOHLTC indicators of success are having the effect of deterring person-centered care and instead promoting a disease-oriented view of health care services and structures. An examination of FHTs in relation to Wallace's (2008) model of equity in health assists in providing a deeper reflection on the underpinnings of the FHT model.

Equity in Health

As a social worker in health, I have had a longstanding interest in the pursuit of social justice and equity in my practice. Despite my commitment, there are times when I struggled to understand the ways that an abstract concept like equity could guide me in my work. I understood the concept but I wanted to learn more about how it could help me shape my health care practice. More broadly, I wondered what a health care system that was guided by equity – and more informed by this value that is central to the social work profession – would look like. I became interested in pursuing research in PHC because of the common philosophical underpinning of equity guiding both social work and PHC. Wallace (2008) provides a model that helps to illustrate three key components: how the FHT model promotes congruency with equity in health, how the FHT model is promoting inequity in health, and identification of areas in which the FHT model can be enhanced in order to strengthen congruency with equity in health

Congruency with Equity in Health

The FHT model displays some congruency with Wallace's (2008) model of equity in health in three main ways. First, the FHT model's emphasis on the inclusion of prevention strategies in health care practices demonstrates some congruency with equity in health. The FHT model emphasizes prevention approaches which are central to PHC (Ramsden et al., 2011) and shape comprehensiveness of services in PHC (Haggerty et al., 2007). Second, the inclusion of interdisciplinary teams also fosters some congruency with equity by making possible the inclusion of diverse perspectives and health discourses. Team members' diverse backgrounds, experiences, and education can be expected to enhance problem-solving and enrich the collective knowledge of FHTs. Third, the FHT model promotes congruency with Wallace's (2008) model of equity in health by striving to promote access to health resources. Two attributes informing PHC – first-contact accessibility and accommodation accessibility – strongly inform FHTs. One of the aims of the FHT model is to promote greater opportunity of access to physicians and various interdisciplinary health care providers. Thus, some degree of congruency with equity in health is promoted here. However, Wallace's (2008) model of equity in health assists to uncover two areas of concern whereby the FHT model does not promote congruency with equity in health.

Incongruency with Equity in Health

Wallace's (2008) model of equity in health assists to demonstrate two areas in which the FHT model is promoting incongruency with equity in health. First, comparison of the equity in health model with the FHT model reveals that the FHT model promotes hierarchies and limits inclusion of equitable non-hierarchical relationships

which is incongruent with equity in health. Ontario's FHT model contradicts Wallace's (2008) first principle of paradigm shift which calls for non-hierarchical relationships by privileging physicians; reinforcing a hierarchy that is reified by policy in Canada's Health Act (Huchinson, 2001). Clearly, Ontario's FHT model privileges physicians in all aspects of the FHT development process: in the initiation of the FHT, in the provision of and payment for health care services, and in encouraging structures that are parallel to physician PC models. Furthermore, Gee (2011a) tells us that practices have a significant influence in determining who is considered acceptable. The FHT model reifies physician dominance by financially rewarding health care practices and structures that are physician-informed, despite the interdisciplinary foundation of the model. Furthermore, physician dominance is reinforced in the FHT model whereby the primary indicator of FHT success is measuring a practice – patient enrolment – that can only be accomplished by a physician. Gee (2011a) also tells us that along with money, practices endorse status, power, and acceptance. In this case, rewarding only one type of professional within the interdisciplinary team reinforces the status and power of physicians.

The second way that the FHT model promotes incongruency with Wallace's (2008) model of equity in health is in relation to cultural competence and cultural appropriateness. This is one of the most concerning findings of the study. According to Betancourt, Green, Carrillo, and Park (2005), cultural competence is "a strategy to improve quality and eliminate racial/ethnic disparities in health" (as cited in Wallace, 2008, p. 20). Current indicators of success do not take into consideration the experiences and needs of First Nations people seeking health care services at FHTs. Thus, FHTs providing health care services to First Nations people can be at a disadvantage for

funding for interdisciplinary health care providers. Furthermore, inadequate indicators are potentially promoting the exclusion of First Nations people from receiving care because some physicians are reluctant to enroll them in FHTs.

Despite patient enrolment not being a practice and measurement that works for First Nations' people, it seems to me that those FHTs with strong leadership – physicians and executive directors committed to strengthen PHC – are those that continue to provide health care services to First Nations people even without the patient enrolment. These FHTs then have a higher demand for health care services than what is being measured by performance indicators. However, based on my experiences from the study it seems to me that FHTs with physicians who entered with the main intention of generating income are those that likely will follow the direction of the MOHLTC indicators and not provide health care services to patients who choose not to sign a patient enrolment form. This phenomenon is not exclusive to but largely impacts First Nations people. Thus, MOHLTC's indicators promote incongruency with cultural competency and cultural appropriateness. The aim of equity in health is to eliminate racial disparities in health (Betancourt et al., 2005), yet the impact that current indicators have may be contributing to racial disparities. Although the extent of the impact that inadequate performance indicators have on First Nations people is currently not known, there is evidence in this study that the concern that some First Nations people may have about patient enrolment is related to trust. Continued use of indicators of performance that do not include the experiences of First Nations people may perpetuate further health inequities and further display incongruency with equity in health.

Strengthening Congruency with Equity in Health

There are four ways that the Ontario FHT model can be enhanced in order to strengthen and promote greater congruency with a model of equity in health. The first way is by encouraging and supporting the inclusion of person-centered and community-centred care. Also, formulating measurement indicators and incentives so that person-centered and community-centred care is rewarded will further promote congruency with Wallace's (2008) model of equity in health. Person-centered care can also assist to promote congruency with the third principle of Wallace's (2008) model of equity in health – new theories, perspectives, and identities – by facilitating health care services to be inclusive of: biology, behaviour, social, environment, and structural aspects of health (Diderichsen, Evans, & Whitehead, 2001; Wallace, 2008).

A second way that the Ontario FHT model can promote greater congruency with Wallace's (2008) model is by helping FHTs to better prepare for interdisciplinary collaboration. Although it seems that some FHTs are successfully collaborating with one another, it is my impression that these are anomalies and that a significant number of FHTs are struggling with interdisciplinary collaboration. FHTs in which team members collaborate well together will likely be better equipped to engage in problem-solving that benefits patients than FHT teams that do not collaborate well together. Thus, by better preparing FHTs for collaborative care the MOHLTC can assist to promote greater congruency with equity in health, in particular when patients have complex needs that include knowledge of the SDOH.

The third area that needs to be addressed in order to promote congruency with equity in health is to promote equitable staff relationships. Although not required by the

FHT model, interviews with FHT leaders revealed some creative ways that some FHTs are striving to address this. For example, some FHTs have adopted organizational practices of FHTs that include all staff members in FHT decisions. For example, at one FHT, the receptionist had equal input to other team members as to which physician was going to be hired. The belief at that particular FHT was that because everyone had to work together and everyone affected each other, everyone should have the opportunity to give input and shape decisions if they chose. However, I believe these types of organizational practices are not common in FHTs, and definitely not promoted by the FHT model. Fourth, to strengthen equity in health, the development and implementation of indicators that reward culturally competent responses to the needs of First Nations people and communities need to become a priority.

Summary

Ontario's FHT model appears to be guided by some of the principles identified in Wallace's (2008) model of equity. These include the promotion of prevention strategies, the emphasis on access to health care, and the requirement of interdisciplinary teams. The two concerns about the FHT model with respect to equity were identified: the first involves the promotion of hierarchical staff and relationships and power imbalances among and between staff within FHTs. A second concern is that current performance indicators may be promoting inequitable access and health care services for marginalized people, especially First Nations people. Wallace's (2008) model of equity in health assists to identify the four key ways that the FHT model can be strengthened to increase equity in health. These include: addition of PHC attributes and indicators that promote person-centered and community-centered health care services and structures, better

preparation of FHTs for interdisciplinary collaboration, promoting equitable relationships among the various disciplines within the team, and lastly, development and implementation of indicators that are meaningful to assess responsiveness to the health care needs of First Nations people and communities. Although examination of health discourses and Wallace's (2008) model of equity in health have provided useful information that has helped to deepen our understanding of the strengths and limitations of the FHT model, additional information is needed to fully understanding how contextual factors have influenced the FHT model to be shaped in this manner.

Contextual Factors

An examination of contextual factors helps to illustrate how these factors have influenced the shape of the FHT model and the foundational PHC attributes that are being promoted. Three contextual factors have been most influential in shaping Ontario's FHT model: physician power, political influence, and federal encouragement. First, the FHT model demonstrates the power of physicians in shaping the FHT model.

Ontario's PC physicians have long voiced dissatisfaction in terms of workload and working conditions within the PC model (Forster et al., 1994). Physicians in practice, the OMA, and the Ontario schools of medicine advocated for a move to PHC (Aggarwal, 2009). The FHT model has been one response and it has been clearly shaped according to the needs voiced by physicians. As noted above, the FHT model is shaped in relation to three foundational attributes that have also shaped solo and group physician practices for some time: first-contact accessibility, accommodation accessibility, and comprehensiveness of services. Furthermore, the FHT model itself does not require that physicians adopt any new health care practices, though they may choose to do so on their

own accord. By not promoting new health care practices, the FHT model gives the impression that interdisciplinary health professionals have been provided as physician helpers. Furthermore, with current performance indicators, physicians can easily attain success and praise by the MOHLTC by enrolling large volumes of patients. As well, the MOHLTC is directing a number of financial incentives towards physicians, but not to other members of the team. The FHT model has been shaped in response to the needs of physicians. As I was leaving one of the interviews, the policy informant made a statement to me indicating that every politician knows not to break up the relationship between a physician and their patient, and asserted that is why physicians are so powerful. Although this statement was not part of our formal interview, these words left an impression on me.

Political influence is the second contextual factor that has shaped the FHT model. With the two previous Conservative governments having angered PC physicians, the McGuinty Liberals adopted a platform that aimed to please them. The FHT model emerged from McGuinty's political campaign platform and emphasized the importance of access to PC physicians (Aggarwal, 2009). The FHT model has done just that by promoting a model whereby two of the four PHC attributes are access focused. Furthermore, indicators being used to evaluate FHTs have been used as a tool to demonstrate the success of McGuinty's Liberals; patient enrolment numbers can demonstrate that McGuinty is following through on his promise to enhance access. Not only was the FHT model developed in response to the needs of physicians, in a way it has assisted to lessen concerns by the public regarding future physician shortages.

Furthermore, McGuinty's political influence was enhanced by federal encouragement to pursue PHC.

The third influential contextual factor is federal encouragement. Federal encouragement and support for PHC reform was communicated by the initiation of PHCTF (Aggarwal, 2009; Health Canada, 2011). The PHCTF provided the economic means for PHC pilot projects that eventually led to the FHTs. More importantly, PHCTF was a signal to Ontario and the rest of Canada that PC was encouraged to shift towards greater inclusion of the attributes of PHC.

Gaining a deeper understanding of the FHT model requires looking at the three key contextual factors that have most influenced the FHT model. Parallel to what Félix-Bortolotti (2009) described, foundational attributes that inform the FHT model have been influenced by three key contextual factors: physician power, political influence, and federal encouragement.

Recommendations

Policy and Decision Makers

The findings of this study lead to four recommendations for policy and decision makers. First, it is recommended that policy and decision makers in Ontario review the health care practices and structures that are promoted by the current FHT model with a view to modifying the model so that it promotes greater equity and person-centered PHC. Policy makers are encouraged to include foundational PHC attributes in the FHT model that promote and encourage person-centered and community-centered care. A framework of PHC like the one developed by Haggerty et al. (2007) could assist policy makers to reflect on key attributes that are missing and that should be included in the FHT model.

Second, it is recommended that policy makers re-examine current indicators that are being used to evaluate FHT success. Particular emphasis should be placed on indicators that measure and encourage health care practices and structures congruent with person-centred care.

Third, it is recommended that policy makers include First Nations health representatives and communities in the examination of health practices and structures that assess the needs of First Nations people in a meaningful way. Particular attention should be paid to the lack of trust that some First Nations people feel towards the government, and its implication for ensuring that they have access to PHC.

Fourth, policy makers are advised to examine what is known about how best to encourage interdisciplinary team collaboration in FHTs. A consideration that requires particular attention is a system of financial reimbursement and other incentives that include the entire FHT team.

FHT Leaders

Two recommendations are directed towards FHT leaders. First, FHT leaders are advised to employ a PHC framework – such as the one provided by Haggerty et al. (2008) – to reflect on the attributes that are being promoted in the way that they deliver health care services, and what might need to change if they are to provide care in a way that is more consistent with the tenets of PHC. FHT leaders are encouraged to introduce policies and procedures that promote the inclusion of person-centred care.

Second, it is recommended that FHT leaders and health practitioners make team collaboration a priority. FHT leaders and health practitioners are advised to implement

ongoing activities such as team case discussions and decision-making practices in order to facilitate interdisciplinary collaboration.

Educators

Two recommendations are aimed at educators. First, educators of health practitioners should critically assess their curriculum and pedagogical approaches to ascertain whether they prepare students to critically assess health concerns, and to think critically about how best to respond to health needs of the most vulnerable. Curriculum that incorporates diverse health discourses will prepare future health practitioners to think about health and health needs from a variety of perspectives and will assist graduates to understand the diversity of health cultures they will encounter in practice.

Second, educators of health practitioners – particularly of physicians – are recommended to review existing pedagogical approaches and explore how best to prepare students for interdisciplinary collaboration in their roles as future health care leaders and health care practitioners. Educators of health practitioners are recommended to develop knowledge and skills that prepare leaders and practitioners for interdisciplinary health care practice in PHC models such as FHTs. Educators are recommended to critically assess curriculum and pedagogical approaches in order to determine how best to foster a knowledge base and skills for collaborative health practice while retaining the assets of the disciplinary lens which is sought in the first place.

Researchers

This study demonstrates the need for research in several key areas of PHC, namely: to determine what PHC attributes best respond to the health needs of Ontarian's receiving care in FHTs, to identify what performance indicators are most relevant to evaluate and

support success of PHC in FHTs; to identify what performance indicators can best demonstrate and evaluate the success of interdisciplinary team work in FHTs; to determine in partnership with First Nation's people how FHTs can best respond to the needs of First Nation's communities; and to determine what health care practices and organizational structures will promote greater equity for Ontarian's receiving care in FHTs.

Relevance to Social Work

This study is relevant to social work in several ways. One of the early factors that lead me to pursue a doctorate in social work was my interest in exploring how health care systems might be shaped from a person-centered perspective. PHC as a health care system displays congruency with social work's value of equity and desire to meet the needs of individual patients and communities as defined by the individual and particular community. Social work is recommended to be active in PCH reforms because it can play a useful role in PHC reform initiatives by helping to develop policy and health care practices that are person-centered. Also, social work can assist by contributing to the team's efforts to understand how to transform a commitment to equity into practice.

Further, the emergence of the FHT model – and the emphasis on PHC reform across all provinces – signals that there is recognition of the need of greater inclusion of the values and skills possessed by social work in PHC. This study assists to fill a gap for social work health professionals by providing insight into the foundational underpinnings of one model of PHC. The study demonstrates to social work that as educators we need to consider how best to prepare social work for practice in PHC settings, particularly around interdisciplinary collaborative practice. Lastly, this study aims to encourage

social workers to be increasingly active in PHC research. Social work has a lens that will enhance PHC because social work has knowledge and skills that attend to the person-oriented and community-oriented dimensions of PHC. For example, social work can assist PHC in understanding how a person's family and environmental context is related to their health needs – an important component of person-centered care. Furthermore, social work discourses are inclusive of knowledge and strategies related to community development and community participation – important components of community-centered care. Also, based on my practice experience social workers have experience in facilitating intersectoral relationships within and beyond the immediate work setting; also an attribute of community-oriented dimensions of PHC. Thus, social work will help to broaden the inclusion of additional PHC attributes that were not present in the solo-physician PC models. This study aims to demonstrate to social work how our active involvement in PHC research can add an alternative perspective to understanding health concerns and thus contribute to improvement in how we respond to them.

Conclusion

An examination of Ontario's FHT model demonstrated that four foundational PHC attributes are being promoted. Three of the four foundational PHC attributes are those that have also informed solo-physician PC practices for some time. An examination of health discourses illustrates that the FHT model has not promoted nor prepared FHTs for the inclusion of additional health discourses beyond those that inform PC; the FHT model promotes health care practices that are similar to PC. However, there are challenges associated with interdisciplinary collaboration, the one attribute that distinguishes the FHT model as a PHC model. While this new model of health care delivery presents

challenges for social work, it also provides us an opportunity to gain allies in our advocacy for greater equity and social justice.

The FHT model has demonstrated some degree of congruency with Wallace's (2008) model of equity in health by encouraging inclusion of prevention strategies, emphasis on access, and inclusion of interdisciplinary teams. However, the FHT model demonstrates inequity in health by promoting hierarchical relationships and power imbalances within FHTs. Also, performance indicators appear to be promoting inequitable access and health care services especially for First Nations people. An examination of three key contextual factors assists to explain the current shape of the FHT model. Priorities of the FHT model and current performance indicators being used have been influenced by three key contextual factors: physician power, political influence, and economic support. This chapter included recommendations directed at policy and decision makers, FHT Leaders, and educators. It concluded with a brief discussion of the relevancy of this study for social work.

Appendices
Appendix A – MOHLTC Documents Included in Study

Document Name	Number of Pages
Roadmap to FHT Implementation	13
Roadmap to FHT Implementation Flowchart	2
Visual Identity Guidelines Introduction Letter	1
Visual Identity Guidelines	19
Guide to Health Promotion and Disease Prevention	16
Guide to Governance and Accountability	10
Guide to Communications	8
Guide to Community Funding Partnerships and Program/Service Integration	20
Designing Channels for Health – A Reference Guide for Planning Public and Private Spaces	119
FHT Development Grant Agreement	16
FHT Implementation Check List	11
Guide to Interdisciplinary Provider Compensation	7
Guide to Chronic Disease Management and Prevention	12
Guide to Development Grant Application	6
Guide to Physician Compensation	27
Guide to Strategic and Program Planning	11
Guide to Interdisciplinary Team Roles and Responsibilities	29
Guide to Transitional Funding	52
Guide to Patient Enrolment	4
Guide to Telephone Health Advisory Service (THAS)	4
Guide to Independent Health Facilities Licensing	8
Guide to Collaborative Team Practice	16
Operational Plan Template	(excel template)
Guide to Business Plan and Operational Plan Development	16
Guide to Information Technology	4
Guide to Integrating French Language Health Services in Family Health Teams	5
Total Pages:	436*

*actual text pages less than total pages

Appendix B – Study Sample

Interview	Date of Interview	Participant Background	FHT Wave	Geographic Region	Governance Model	Interview: In-person or Telephone
Policy Interview 1	Nov 4, 2010	MOHLTC, and other than MOHLTC				In-person
Policy Interview 2	Nov 15, 2010	Other than MOHLTC				In-person
Policy Interview 3	Nov15, 2010	MOHLTC				In-person
Policy Interview 4	Dec 3, 2010	MOHLTC				In-person
Policy Interview 5	Dec 6, 2010	MOHLTC				Telephone
Policy Interview 6	Dec 14, 2010	MOHLTC				In-person
Policy Interview 7	Dec 16, 2010	Other than MOHLTC				In-person
Leader Interview 1	Nov 5, 2010	Clinical Manager	3	SW	Provider Led	In-person
Leader Interview 2	Nov17, 2010	Executive Director	1	NW	Mixed	In-person
Leader Interview 3	Nov18, 2010	Executive Director	3	NW	Provider Led	In-person
Leader Interview 4	Nov 23, 2010	Executive Director	1	Central	Provider Led	In-person
Leader Interview 5	Dec 1, 2010	Physician	1	SW	Provider Led	In-person
Leader Interview 6	Dec 3, 2010	Physician	2	Central*	Provider Led	In-person
Leader Interview 7	Dec 18, 2010	Physician	3	SE	Provider Led	Telephone
Leader Interview 8	Jan 5, 2011	Executive Director	2	Central*	Provider Led	In-person
Leader Interview 9	Jan 6, 2011	Clinical Manager	3	SW	Mixed	In-person
Leader Interview 10	Jan 11, 2011	Physician and Executive Director	1	Central	Provider Led	In-person
Leader Interview 11	Jan 17, 2011	Executive Director	3	NE	Provider Led	In-person
Leader Interview 12	Jan 18, 2011	Physician and Executive Director	1	SE	Provider Led	In-person
Leader Interview 13	Jan 19, 2011	Executive Director	1	SW	Community Led	In-person
Leader Interview 14	Jan 20, 2011	Physician	2	SE	Provider Led	In-person

Leader Interview 15	Jan 25, 2011	Physician and Executive Director and Clinical Manager	1	SE	Provider Led	In-person
Leader Interview 16	Jan 26, 2011	Executive Director	2	SW*	Provider Led	In-person
Leader Interview 17	Jan 26, 2011	Physician	2	SW*	Provider Led	In-person
Leader Interview 18	Jan 31, 2011	Executive Director	2	SE	Community Led	Telephone
Leader Interview 19	Feb 1, 2011	Physician	1	NW	Provider Led	Telephone
Leader Interview 20	Feb 4, 2011	Physician	3	NE	Provider Led	Telephone
Leader Interview 21	Mar 10, 2011	Executive Director	3	Central	Mixed	In-person
Leader Interview 22	Mar 15, 2011	Executive Director	4	NW	Mixed	Telephone
Leader Interview 23	Mar 23, 2011	Executive Director and Clinical Manager	2	NE	Provider Led	Telephone
Leader Interview 24	April 11, 2011	Executive Director	1	NE	Provider Led	Telephone
Totals:	Interviews: (N=31) Policy informant interviews (n=7) FHT leader interviews (n=24)	Sample: Policy informants (n=7) Physicians (n=10) Executive Directors (n=15) Clinical Leaders (n=4) Total Sample: (N=36) Policy (n=7) Leaders (n=29)	wave 1(n=9) wave 2(n=7) wave 3 (n=7) wave 4 (n=1)	SW (n=6) SE (n=5) NW(n=4) NE (n= 4) Central (n=5)		

*Same FHT

Appendix C – Letter of Invitation to Policy Informants

My name is Rachelle Ashcroft and I am a doctoral student at Wilfrid Laurier University in the Faculty of Social Work. For my PhD dissertation, I am conducting research entitled “Primary Health Care: The Discourses of Ontario’s Family Health Teams”. The initial part of the research study includes an analysis of influential policy guiding Ontario’s Family Health Teams. The latter portion of the study will explore the ways that influential policy has shaped direct practice in the Family Health Teams.

I am interested in interviewing Ontario Family Health Team policy informants. This includes people who have been influential in shaping policy – formally or informally – as well as those who may be well informed about Family Health Team policy. Given that you are someone who fits into this category – because you have been recommended to me as a policy informant or your name has appeared on Family Health Team documents – I am interested in having your participation in this study.

Interviews will be approximately 1-1½ hours in length, at a location convenient for you. If you choose to participate in this study, there are no foreseeable risks or costs that would be incurred by you. If you choose to participate, your identity and any identifying information will be kept confidential. Participation in this study is voluntary. Any refusal to participate or discontinuation of participation will involve no penalty. If you were to choose to withdraw from this study, any data related to your interview will be destroyed. If you do choose to participate in this study, you have the right to refuse to answer any question posed by the researcher.

If you agree to be interviewed, your participation in this research study will be invaluable. Your participation will contribute to the development of knowledge surrounding the Ontario Family Health Teams.

I would appreciate the opportunity to interview you about your experiences and insights in shaping policy for the Ontario Family Health Teams. If you are interested please contact me, Rachelle Ashcroft, via email at rashcroft@wlu.ca or telephone at (647) 347-3774. If you have any concerns regarding this research study, please feel free to contact me. You are also welcome to contact my advisor Dr. Anne Westhues via email at awesthue@wlu.ca or telephone at (519) 884-1970 extension 5222.

The Research Ethics Board at Wilfrid Laurier University has reviewed and approved this project. If you feel you have not been treated according to the descriptions in this informed consent statement/information letter, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-1970, extension 5225, or rbasso@wlu.ca.

Respectfully,
Rachelle Ashcroft

Appendix D – Letter of Invitation to FHT Leaders

My name is Rachelle Ashcroft and I am a doctoral student at Wilfrid Laurier University in the Faculty of Social Work. For my PhD dissertation, I am conducting research entitled “Primary Health Care: The Discourses of Ontario’s Family Health Teams”. The initial part of the research study includes an analysis of influential policy guiding Ontario’s Family Health Teams. The latter portion of the study will explore the ways that influential policy has shaped direct practice in the Family Health Teams and will explore the various approaches to health that Family Health Teams take.

I am interested in interviewing leaders of Ontario Family Health Teams. Interviews will be approximately 1-1½ hours in length, at a location convenient for you. If you choose to participate in this study, there are no foreseeable risks or costs that would be incurred by you. If you choose to participate, your identity and any identifying information will be kept confidential. Participation in this study is voluntary. Any refusal to participate or discontinuation of participation will involve no penalty. If you were to choose to withdraw from this study, any data related to your interview will be destroyed. If you do choose to participate in this study, you have the right to refuse to answer any question posed by the researcher.

If you agree to be interviewed, your participation in this research study will be invaluable. Your participation will contribute to the development of knowledge surrounding the Ontario Family Health Teams.

I would appreciate the opportunity to interview you about your experiences and insights in shaping policy for the Ontario Family Health Teams. If you are interested please contact me, Rachelle Ashcroft, via email at rashcroft@wlu.ca or telephone at (647) 347-3774. If you have any concerns regarding this research study, please feel free to contact me. You are also welcome to contact my advisor Dr. Anne Westhues via email at awesthue@wlu.ca or telephone at (519) 884-1970 extension 5222.

The Research Ethics Board at Wilfrid Laurier University has reviewed and approved this project. If you feel you have not been treated according to the descriptions in this informed consent statement/information letter, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-1970, extension 5225, or rbasso@wlu.ca.

Respectfully,
Rachelle Ashcroft

Appendix E – Interview Guide for Policy Informants

- Tell me about your role in shaping Ontario Family Health Team policy
 - Formal analyst? Formal/informal contributor?
 - During what part of the process did you become involved?
 - Period of involvement?
 - Did you prepare any policy documents?
 - Consultations?

- What do you consider the key policies guiding the Ontario Family Health Teams?
 - When were they implemented?
 - Formal documents? No documents?
 - Who are they geared towards?

- What helped to guide you in the development of Ontario Family Health Team policy?
 - Any guiding values?
 - Any guiding principles?
 - Models?
 - Who has been involved in the process/decisions?
 - Past documents, policies used as aids in the development of policy?

- What were/are the goals of Ontario Family Health policy?
 - Aspirations of policy?
 - Family Health Team guidance?
 - Shaping Interdisciplinary practice?

- How is health understood in Ontario Family Health policy?
 - Any competing ideas?
 - Flexibility for regions?
 - Reasons for interdisciplinary approach?
 - Inclusion/recognition of social, environmental, structural, community, population aspects of health?

- What would you say are the greatest strengths of Ontario's Family Health policy?

- What would you say are the limitations of Ontario's Family Health policy?

Appendix F – Interview Guide for FHT Leaders

- Tell me about the background of this Family Health Team.
 - When did it start?
 - Process of establishing the FHT?
 - Who comprises the Family Health Team?
 - Professionals involved? Community involvement?
 - FHT structures?
 - Governance?
 - Goals of FHT?

- In what ways has provincial policy assisted your Family Health Team's view/approach to health?
 - Any other guidance?
 - Support?

- In what ways has provincial policy been challenging to your Family Health Team's view/approach to health?

- What does this Family Health Team see as its job?
 - Strengths and challenges in achieving that?
 - How are you getting there?
 - How do you determine success?
 - Health care practices?
 - Areas of priority?

- What does this Family Health Team hope to accomplish?
 - How do you get there?

- How do you think about health?
 - Prevention? Treatment? Community development?
 - Social issues?
 - Structural issues?
 - What role does your Family Health Team have with the surrounding community?

- How does this Family Health Team work together?
 - What does 'team' mean?
 - How are decisions made?
 - How does communication occur?

Appendix G – Consent Form for In-Person Interviews

I agree to participate in the study conducted by Rachelle Ashcroft, doctoral student, Faculty of Social Work, Wilfrid Laurier University, entitled “Primary Health Care: The Discourses of Ontario’s Family Health Teams”. I understand that the purpose of this study is to explore influential policies guiding Ontario’s Family Health Teams, and the ways that influential policy has shaped direct practice in the Family Health Teams. Further I understand that this study will explore the various approaches to health that Family Health Teams take. I agree to meet one-on-one with a researcher for an interview to discuss my views on the Ontario Family Health Teams. I understand that the interview will be approximately 1 to 1½ hours in length.

I understand that the interview will be audio-recorded and transcribed but for confidentiality my name and other identifying information will be removed so that my identity will not be known. All data collected will be stored in a password protected computer and destroyed once the study is completed and the possibility of publishing new articles from the data is exhausted.

I understand that my participation in this study is voluntary and I may decline to participate without penalty. If I withdraw from the study before data collection is completed, my data will be destroyed. I also understand that I have the right to omit any question(s) I choose. I understand that my confidentiality will be respected unless required by law or where research documents are ordered to be produced by a court of law and where researchers are obliged to report to the appropriate authorities.

If I have any questions about the study or experience any adverse effects as a result of participating in the study, I may contact Rachelle Ashcroft at 647-347-3774 or Dr. Anne Westhues, Professor, Wilfrid Laurier University, at 519-884-1970, extension 5222. I understand that this project has been reviewed and approved by the University Research Ethics Board. If I have questions about research subjects’ rights and research-related injury, I may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, 519-884-0710, extension 5225.

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Name of Participant

Signature

Investigator’s Signature

Date

Appendix H – Consent Form for Telephone Interviews

I agree to participate in the study conducted by Rachelle Ashcroft, doctoral student, Faculty of Social Work, Wilfrid Laurier University, entitled “Primary Health Care: The Discourses of Ontario’s Family Health Teams”. I understand that the purpose of this study is to explore influential policies guiding Ontario’s Family Health Teams, and the ways that influential policy has shaped direct practice in the Family Health Teams. Further I understand that this study will explore the various approaches to health that Family Health Teams take. I agree to meet one-on-one with a researcher for an interview to discuss my views on the Ontario Family Health Teams. I understand that the interview will be approximately 1 to 1½ hours in length.

I understand that the interview will be audio-recorded and transcribed but for confidentiality my name and other identifying information will be removed so that my identity will not be known. All data collected will be stored in a password protected computer and destroyed once the study is completed and the possibility of publishing new articles from the data is exhausted. Because this project employs e-based or telephone based data collection and transmission techniques, the confidentiality and privacy of data cannot be guaranteed.

I understand that my participation in this study is voluntary and I may decline to participate without penalty. If I withdraw from the study before data collection is completed, my data will be destroyed. I also understand that I have the right to omit any question(s) I choose. I understand that my confidentiality will be respected unless required by law or where research documents are ordered to be produced by a court of law and where researchers are obliged to report to the appropriate authorities.

If I have any questions about the study or experience any adverse effects as a result of participating in the study, I may contact Rachelle Ashcroft at 647-347-3774 or Dr. Anne Westhues, Professor, Wilfrid Laurier University, at 519-884-1970, extension 5222. I understand that this project has been reviewed and approved by the University Research Ethics Board. If I have questions about research subjects’ rights and research-related injury, I may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, 519-884-0710, extension 5225.

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Name of Participant

Signature

Investigator’s Signature

Date

Appendix I – Definitions of PHC Attributes (Haggerty et al., 2007, p. 340)

PHC Attributes
Clinical Practice Attributes
<p>First-contact accessibility: The ease with which a person can obtain needed care (including advice and support) from the practitioner of choice within a time frame appropriate to the urgency of the problem.</p> <p>Accommodation accessibility: The way primary health care resources are organized to accommodate a wide range of patients' abilities to contact health care clinicians and reach health care services. (The organization of characteristics such as telephone services, flexible appointment systems, hours of operation, and walk-in periods)</p> <p>Comprehensiveness of services :The provision, either directly or indirectly, of a full range of services to meet patients' health care needs. This includes health promotion, prevention, diagnosis and treatment of common conditions, referral to other clinicians, management of chronic conditions, rehabilitation, palliative care and, in some models, social services.</p> <p>Informational continuity: The extent to which information about past care is used to make current care appropriate to the patient.</p> <p>Management continuity: The delivery of services by different clinicians in a timely and complementary manner such that care is connected and coherent.</p> <p>Technical quality of clinical care: The degree to which clinical procedures reflect current research evidence and/or meet commonly accepted standards for technical content or skill.</p>
Structural Dimensions
<p>Clinical information management: The adequacy of methods and systems to capture, update, retrieve, and monitor patient data in a timely, pertinent, and confidential manner.</p> <p>Multidisciplinary team: Practitioners from various health disciplines collaborate in providing ongoing health care.</p> <p>Quality improvement process: The institutionalization of policies and procedures that provide feedback about structures and practices and lead to improvements in clinical quality of care and provide assurance of safety.</p> <p>System integration: The extent to which the health care unit organization has established and maintains linkages with other parts of the health care and social service system to facilitate transfer of care and coordinate concurrent care between different health care organizations.</p>
Person-Oriented Dimensions
<p>Advocacy: The extent to which clinicians represent the best interests of individual patients and patient groups in matters of health (including broad determinants) and health care.</p> <p>Continuity-relational: A therapeutic relationship between a patient and one or more clinicians that spans various health care events and results in accumulated knowledge of the patient and care consistent with the patient's needs.</p> <p>Cultural sensitivity: The extent to which a clinician integrates cultural considerations into communication, assessment, diagnosis, and treatment planning.</p> <p>Family-centered care: The extent to which the clinician considers the family (in all its expressions) and understands its influence on a person's health and engages it as a partner in ongoing health care.</p> <p>Interpersonal communication: The ability of the clinician to elicit and understand patient</p>

concerns, explain health care issues, and engage in shared decision making, if desired.

Respectfulness: The extent to which health professionals and support staff meet users' expectations about interpersonal treatment, demonstrate respect for the dignity of patients, and provide adequate privacy.

Whole-person care: The extent to which a clinician elicits and considers the physical, emotional, and social aspects of a patient's health and considers the community context in their care.

Community-Oriented Dimensions

Client/community participation: The involvement of clients and community members in decisions regarding the structure of the practice and services provided (ex. Advisory committees, community governance).

Equity: The extent to which access to health care and quality services are provided on the basis of health needs, without systematic differences on the basis of individual or social characteristics.

Intersectoral team: The extent to which the primary care clinician collaborates with practitioners from non-health sectors in providing services that influence health.

Population orientation: The extent to which the primary care clinicians assess and respond to the health needs of the population they serve. (In professional models, the population is the patient population served; in community models, it is defined by geography or social characteristics).

System Performance

Accountability: The extent to which the responsibilities of professionals and governance structures are defined, their performance is monitored, and appropriate information on results is made available to stakeholders.

Availability: The fit between the number and type of human and physical resources and the volume and types of care required by the catchment population served in a defined period of time.

Efficiency/productivity: Achieving the desired results with the most cost-effective use of resources*

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