

Canadian Social Work Review Revue canadienne de service social



Ontario's Family Health Teams Politics Within the Model

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Volume 32, Number 1-2, 2015

URI: <https://id.erudit.org/iderudit/1034146ar>

DOI: <https://doi.org/10.7202/1034146ar>

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Publisher(s)

Canadian Association for Social Work Education / Association canadienne pour la formation en travail social (CASWE-ACFTS)

ISSN

2369-5757 (digital)

[Explore this journal](#)

Cite this article

Ashcroft, R. (2015). Ontario's Family Health Teams: Politics Within the Model. *Canadian Social Work Review / Revue canadienne de service social*, 32(1-2), 117–132. <https://doi.org/10.7202/1034146ar>

Article abstract

This article provides an overview of political decisions that led up to the implementation of the Ontario Family Health Team (FHT) model. FHTs have broadened primary health care in Ontario by bringing together family physicians with various interdisciplinary professionals. Political decisions have long influenced the shape and need for the FHT model. Knowledge of historically imbedded elements in the FHT model helps to strengthen current and future policy and decision-making. This article is informed by qualitative data collected from interviews with seven policy informants and 29 FHT leaders.

ONTARIO'S FAMILY HEALTH TEAMS

Politics Within the Model

Rachelle Ashcroft

Abstract: This article provides an overview of political decisions that led up to the implementation of the Ontario Family Health Team (FHT) model. FHTs have broadened primary health care in Ontario by bringing together family physicians with various interdisciplinary professionals. Political decisions have long influenced the shape and need for the FHT model. Knowledge of historically imbedded elements in the FHT model helps to strengthen current and future policy and decision-making. This article is informed by qualitative data collected from interviews with seven policy informants and 29 FHT leaders.

Keywords: Primary care, politics, Family Health Teams

Abrégé : Le présent article fait un survol des décisions politiques qui ont mené à la mise en œuvre du modèle ontarien d'équipes de santé familiale (ÉSF). Ces équipes ont élargi la prestation de soins de santé primaires en Ontario en rassemblant des médecins de famille et divers autres professionnels. Les décisions politiques ont longtemps façonné le modèle d'ÉSF et influé sur la nécessité de celles-ci. Le fait de connaître les éléments de l'histoire rattachés au modèle d'ÉSF permet de renforcer la prise de décisions politiques actuelle et future. Cet article se fonde sur des données qualitatives recueillies à partir d'entrevues auprès de sept informateurs sur les politiques et de 29 chefs d'ÉSF.

Mots clés : Soins primaires, politiques, équipes de santé familiale

ONTARIO'S FAMILY HEALTH TEAMS (FHTs) are one model of primary health care (PHC) that emerged from a period of health-care system reform. Strengthening PHC systems has been a Canadian federal, provincial, and territorial priority (Strumpf et al., 2012). However, what appears lacking in the discussion is the role of political decisions in the creation of circumstances leading to the need for PHC reform, or the role of politics in relation to FHTs. By examining politics shaping FHTs, this

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Canadian Social Work Review, Volume 32, Number 2 (2015) / Revue canadienne de service social, volume 32, numéro 2 (2015)

Printed in Canada / Imprimé au Canada

article aims to increase abilities to critically analyze hidden assumptions in reforms, expand capacity to evaluate the effectiveness of reforms, and better enable the critique of health-care policy as it relates to the FHT model of PHC.

Political Economy of PHC

Health and health care are deeply political. Political and economic structures influence health outcomes (Ashcroft, 2010; Bambra, Fox, & Scott-Samuel, 2005; Bodenheimer, 2005; Coburn, 2006) and influence the form of PHC models (Félix-Bortolotti, 2009). Bambra et al. (2005) provide three definitions of “politics” that help conceptualize these relationships. The first definition is “politics as government” (Bambra et al., 2005, p. 190) whereby politics is mainly associated with government and state activities. Second, “politics as conflict resolution” (p. 190) sees politics as “concerned with the expression and resolution of conflicts through compromise, conciliation, negotiation, and other strategies” (p. 190). Third, “politics as power” is “the process through which desired outcomes are achieved in the production, distribution and use of scarce resources in all areas of social existence” (p. 190). The first definition is a top-down approach that separates politics from the community; while the last definition offers a broader view that sees politics as encompassing everything and can be applied to describe all power-structured relationships (Bambra et al., 2005). “Politics as power” definition is consistent with Coburn’s (2006) materialist political economy perspective that views health care as being a product of neo-liberalist political, economic, and social policy. The three definitions provide a useful lens for an exploration of FHTs. However, this author is most aligned with the definition of “politics as power” and agrees with Carpenter (2012) who states “access to health services are moral, social, and political” (p. 291).

Health is a resource within a neo-liberal economic system that results with some social groups benefitting more from it than others (Bambra et al., 2005; Coburn, 2006). Political, administrative, and interest group factors have a profound impact on health care systems and health outcomes (Bambra et al., 2005; Bodenheimer, 2005; Carpenter, 2012). For example, political traditions and ideologies affect health policies and population health outcomes (Navarro, Muntaner, Borrell, Benach, Quiroga, Rodríguez-Sanz, Vergés, & Pasarín, 2006). “Health policy is part of a broader public policy agenda, whose practical aspects are inextricably linked with power and politics” (Bambra et al., 2005, p. 191). Thus, power is exercised over health as part of a broader economic, social, political system (Ashcroft, 2010; Bambra et al., 2005).

Politics shape PHC models that take on different forms and priorities and are “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” (Félix-Bortolotti, 2009, p. 862). This article helps, in part, respond to calls for greater examination of the relationship between politics and health-care (Bambra et al., 2005; Bodenheimer, 2005; Carpenter, 2012) and helps demonstrate that PHC is situated within shifting discourses largely shaped by prevailing political economies (Coburn, 2006).

Conceptualizing PHC

The health systems literature makes a distinction between primary care (PC) and PHC (Razavi, 2014). PC can be viewed as the medical response to illness (Mable & Marriott, 2002; Razavi, 2014) typically provided by family physicians or another medical provider such as a nurse practitioner (Aggarwal, 2009; 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). Frankish, Moulton, Rootman, Cole, and Gray (2006) describe how PHC includes medical services, “usually provided by family physicians, and a broader concept that encompasses a range of health/social services provided through multidisciplinary teams” (p. 173). Main features of PHC include: first-contact care, accessibility, coordination of care, and comprehensiveness (Aggarwal, 2009; Ashcroft, 2015; Starfield, Shi, & Macinko, 2005).

PHC is considered to be an important part of Canada’s overall social and economic development. It also situates care in proximity to where people live and work, involves teamwork and collaboration, and is intended to have services organized and adapted to the needs of a population (Aggarwal, 2009). PHC became a key interest of the international health community resulting from the Declaration of Alma-Ata in 1978 (Lawn et al., 2008; Razavi, 2014).

With the Alma-Ata, the World Health Organization (WHO) cemented the importance of PHC and broadened the focus of health services (Bhatia & Rifkin, 2010). The Declaration of Alma-Ata emphasized the importance of health for all, and underlined PHC as one way of achieving it (Razavi, 2014). “A key determinant of health in many high performing countries is a well-functioning PHC system” (Razavi, 2014, p. 1). Similar to elsewhere in Canada, health-care system reform led to the emergence of a variety of different PHC models in Ontario.

PHC Models in Ontario

Ontario has been a leader in Canada’s PHC reform, and a range of models now exist (Glazier, Kopp, Schultz, Kiran, & Henry, 2012; Strumpf et al.,

2012). Different models of PHC are intended to serve different patient populations, community health needs, and provider preferences (Cook & Kachala, 2004; Glazier, Zogorski, & Rayner, 2012). Professional models of care are one model designed “to deliver medical services to patients who seek these services” (Cook & Kachala, 2004, p. 18). Key characteristics of professional models include: physicians being 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).

Community PHC models aim 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). In Ontario, Community Health Centres (CHCs) are an interdisciplinary model that includes physicians, nurse practitioners, social workers, and other health professionals (University of Ottawa, 2011). Ontario’s CHCs are community-governed and globally funded organizations (Hutchison et al., 2011). The aim of CHCs is to improve health care access for socially disadvantaged and vulnerable populations (Hutchison et al., 2011). CHCs increased in numbers between 1987 and 1992, going from eleven to forty-nine during that time period. However, additional program growth slowed dramatically (Hutchison et al., 2011). In 2011, Hutchison et al. reported that there were 56 CHCs that employed 139 salaried physicians and 90 nurse practitioners (Hutchison et al., 2011). Currently, 75 CHCs exist across Ontario (Association of Ontario Health Centres, n.d.).

The scope of professional and community PHC models in Ontario 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). McPherson, Kothari, and Sibbald (2010) provide a distinction between Ontario’s models and state that PHC reform in Ontario began in the 1970s with the introduction of CHCs. They further 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.... 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. (McPherson et al., 2010, p. 7)

Glazier, Zagorski, and Rayner (2012) conducted a study comparing foundational attributes of Ontario's PHC models, which serves as a good resource for those wanting to further explore the differences between these models.

FHTs: Ontario's Investment in PHC

FHTs are a newly introduced model of primary health care in Ontario, bringing together family physicians with other interprofessional health-care providers - such as social workers, dietitians, pharmacists, and others - for team based PHC services. Since 2005, 200 FHTs have been established in Ontario to improve access, health outcomes, and costs (Gocan, Laplante, & Woodend, 2014). They currently provide care to three million Ontarians (Glazier, Kopp, Schultz, Kiran, & Henry, 2012; College of Family Physicians of Canada, 2011). FHTs are intended to improve Ontarians' access to health care services, implement interdisciplinary team-based care, expand the scope of comprehensive care services, provide patient-centred care, increase access to mental health services within the PHC setting, and link patients to other parts of the health care system such as community mental health (Aggarwal, 2009; Ontario Ministry of Health and Long-Term Care, 2004).

The introduction of FHTs is a significant policy event in Ontario, shaped by various political decisions, priorities, and conditions. "The Canadian political environment and global push for PHC reform created a policy window in which FHTs appeared" (Razavi, 2014, p. 5). Yet FHTs are in their infancy and little is known about the determinants that have and continue to shape organizational development, quality of team collaboration, or outcomes that FHTs have achieved (Gocan et al., 2014).

Study Background

This article emerged from a study that investigated health care practices and organizational structures encouraged by the goals of Ontario's FHT model, as set out in provincial policy (Ashcroft, 2014). "Structures" refers to aspects of health care services that may influence delivery like the number and types of health care providers, and how they are organized to do their work (Starfield, 2001). The data revealed that politics were influential to the development of the FHT model. This article describes key political decisions and how politics has informed the FHT model. Content of this article is shaped by data collected with key informants. This article presents literature and data together in the findings section in order to present a clearer understanding of the contextual issues identified by key informants.

Methodology

An exploratory qualitative design was used in this study, guided by discourse analysis. Discourse analysis provides an approach for both theoretical and methodological levels of analysis (Smith, 2007). Discourse analysis is the study of social life, and investigates meaning in culture and interactions (Shaw & Bailey, 2009). It is through speech, writing, actions, and various productions of the social world that discourses and meaning become evident (White, 2004). Discourse analysis distinguishes three areas that are valuable in the investigation of meaning: context, how meanings are communicated, and what meanings are communicated (Gee, 2011; Fairclough, 1985). Gee's (2011) approach to discourse analysis sees meaning emerge from a combination of saying (informing), doing (action), and being (identity) – all interconnected, influenced by context, and involved in the forming of discourses. Thus, context is important to further our understanding of the FHT model as is presented in this article. Ashcroft (2014) presents findings from the study that correlate with the saying (informing), doing (action), and being (identity) framework (Gee, 2011).

Data sources for this study include Ontario Ministry of Health and Long-Term Care (MOHLTC) documents and a series of semi-structured informant interviews. Interviews were conducted with seven key policy informants and 29 FHT leaders. For an overview of the sample, please refer to Ashcroft (2014). Policy informants were MOHLTC policy and decision-makers, or consultants who contributed to the development of FHT policy. FHT leaders were those in leadership positions: physicians, executive directors, and clinical managers. Policy informants were selected through purposive and snowball sampling. FHT leaders were selected mainly through stratified purposive sampling (Miles & Huberman, 1994) that aimed for representation around two characteristics: geography and years (or “waves”) when FHT applications were approved. Snowball sampling also informed the FHT leader sample in the sense that four FHT leaders initiated the suggestion of including additional participants. Interviews were conducted using a semi-structured interview guide and occurred in person or by telephone.

Analysis of the findings relied upon three key methods. The first phase used initial constant comparison to capture major themes (Creswell, 2003). A framework provided by discourse analysis (Gee, 2011) guided the second phase of analysis. Third, a conceptual framework provided by Haggerty et al., (2007) was used to determine key attributes. Although not presented in this paper, a final step in the analysis applied Wallace's (2008) model of equity in health to the data. Findings presented in this paper emerged during the first two phases of analysis. A code has been assigned to each participant and used in the presentation of data in the form of quotations. Policy informants have been assigned the code

“PI,” followed by a number. FHT leaders have been assigned as “L” followed by a number. Literature is used in conjunction with data in order to provide a coherent description. This article combines literature and data in the findings section in order to present a clear understanding of the contextual issues identified by key informants.

Findings

Findings of this study reveal that the FHT model emerged from incremental changes and political decisions beginning in the early 1990s. When asked to describe how the FHT model began, participants referred to challenges experienced by family medicine in the early 1990s; some of the challenges experienced by family medicine during that period are also highlighted in Forester et al. (1994). One FHT leader described this period with concern: “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...” (L15.1). In order for changes to be implemented, policy and decision-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)

1995-2003: Harris Conservative Government

In 1995, with Mike Harris as Premier, the conservative government was elected to govern Ontario’s provincial office. The conservative government, under leadership of Mike Harris, had an economic and social vision congruent with the previous Thatcher Conservatives in the U.K., and the Regan-Bush Republican right (Neysmith, Bezanson, & O’Connell, 2005). Examples of provincial policy changes made by the Harris government included: “employment equity legislation was revoked; labour legislation was weakened; social assistance payments were cut by almost one quarter; and education, public service and health care sectors underwent massive restructuring, with cuts to their labour forces” (Neysmith et al., 2005, p. 9). The result included a rise in poverty, insecure safety nets, a shortage of health-care providers, and the emergence of patients with problems related to the social determinants of health and fewer community resources to draw upon for support (Neysmith et al., 2005). Policy changes during this time had a broad reaching impact that included and extended beyond PHC.

In a detailed account of Ontario's primary care 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 primary care in Ontario. 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). Then in 1996, the Ontario Medical Association (OMA) released a report that recommended the inclusion of alternate health care providers, 24-hour triage system, and reform to the dominant physician payment model (Aggarwal, 2009).

Despite these initiatives, policy informants described how decisions of the Harris-led government contributed to the shortage of family physicians:

We had the Mike Harris times so we had cuts in medical school enrolment...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)

The Harris cuts presented significant challenges to family medicine in Ontario. These were 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...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). According to one key policy informant, the impact of these policy changes was a primary care 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).

Participants indicated that – at least in part - these decisions contributed to the crisis of not having enough primary care physicians to meet the demand of health care services. 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). Public pressure increased for a political response to help resolve the very problem that stemmed from the cuts to family medicine: “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 improve primary care 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 advocated for family physicians and the implementation of a blended funding model. 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 the FHN framework was a prerequisite for the future implementation of FHTs:

We had our eye on the interdisciplinary ball the whole time since the ‘90s 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)

However, there was initial hesitation amongst Ontario’s family physicians to support the FHN model: “[T]here was cynicism and skepticism that anything that government was in favour of could be any good and it was even worse if the OMA was also in favour of it” (PI1). According to this policy informant, the initial uptake of group practice models was slow yet “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 launched the Ontario Family Health Network (OFHN). The OFHN was an arm's-length agency with Ruth Wilson as Chair. Wilson was one of the 1994 white paper authors who had originally expressed concerns of the state of family medicine in Ontario (Aggarwal, 2009). The OFHN had a three year mandate to improve primary care services in Ontario (Aggarwal, 2009). The OFHN was to work with the ministry and the OMA on model negotiations, planning, and operational policy development (Aggarwal, 2009). Not only was the government responding to the access challenges of health care services that it helped to create, there was now an attempt to repair the damaged relationship with family medicine.

Family Health Groups (FHGs)

In 2003, the FHG model was born from negotiations between Ontario's MOHLTC and the OMA and at time of negotiations "the government was far from reaching its goal of having 80 % of physicians participating in reform models" (Aggarwal, 2009, p. 149). The FHG model was different in that it shifted back to the traditional fee-for-service model, included financial incentives for additional services such as palliative care and care for patients with complex mental illness, and required three or more physicians to be co-located or work together virtually.

2002 – 2003: Harris to McGuinty – Anticipating a Change

Policy and decision makers were working on the FHT model in preparation for the 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 and highlighted the importance of accessing primary care physicians as a plank in the Liberal platform. The challenges created for primary care physicians by the previous governments became an asset to the platform of the McGuinty Liberals. The plank in the Liberal platform emphasized a goal to attach every Ontarian to a family doctor and was the catalyst for the FHT model as described by a key policy informant:

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)

McGuinty's Liberal platform in 2003 emphasized access as demonstrated by a policy informant: "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 policy informant illustrates the significance of the Liberal campaign platform to the development of 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 – 2012: McGuinty Liberal Government

McGuinty's Liberal government was elected in 2003, the same year that the First Ministers' Accord increased funding to provincial/territorial governments for PHC reform which meant the McGuinty's Liberals had access to economic resources soon after taking office (Aggarwal, 2009). This was evident according to one policy informant, who stated that shortly after the arrival of the McGuinty government "there was starting to be some loosening of the taps in terms of money" (PI1). The FHT model is inextricably linked with the McGuinty-led Liberal government. According to one policy informant, there was opportunity to assist the Liberal government in shaping the FHT model: "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). In December 2004, the Ontario government made an announcement on FHTs and put a call out for applications from interested health care providers. To date, there have been five calls for FHT applications: April 2005, December 2005, April 2006, December 2009, and May 2010.

FHTs: A Political Priority Project

With FHTs tied to the Liberal political platform, there was significant political support for the FHT model. One policy informant stated, "this is what the Premier wanted. The political support was fabulous" (PI6). Because the FHT model was initiated as part of a political platform, there was a desire to have rapid implementation 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). Thus, the main reason cited

as to why the FHT model required a rapid deployment was not to address a health issue but instead to meet the Liberal political needs. In order to respond to the Liberal's political needs, the FHT model was implemented even before it had been fully developed. According to one FHT leader, "I think they weren't quite ready. They didn't have their policies quite developed" (L2).

Key informants indicated there is an inherent political connection that continues to influence FHTs. 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). At the time of the interviews, the Ontario provincial election was scheduled for October 2011 and this caused some concern for FHT leaders. For example, one FHT leader was concerned that funding for FHTs would be discontinued Liberals were 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, 200 FHTs, off you go", because you're dealing with 1,600 physicians" (L8). In October 2011, McGuinty was once again elected to serve another another term. However, FHT leaders remind us of the role that political influence has: "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 also emphasized this sentiment:

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 healthcare system. And if you think it's anything different than that, then you're wrong. (L23)

The FHT model appeared to be insufficiently developed at time of implementation, partly because of the political desire to have rapid operationalization of FHTs. Development and implementation of the FHT model is inextricably linked to Ontario's political economy.

Discussion

Although this background is not the full history of PHC reform in Ontario, this study demonstrates three contextual factors have been most influential in shaping Ontario's FHT model: economic availability, political influence, and physician power.

Federal encouragement and support for PHC reform was communicated by making funds available by way of the Primary Health Care Transition Fund (PHCTF) (Aggarwal, 2009; Health Canada, 2012. 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 primary care was to shift towards greater inclusion of PHC (Strumpf et al., 2012; Hutchison, Levesque, Strumpf, & Coyle, 2011).

The history leading up to the implementation of the FHT model demonstrates the role political decisions played in shaping it in two key ways. First, the problems PHC reform aimed to rectify were a result of accumulated political decisions that impacted family medicine and the context of primary care. Second, with the two previous Conservative governments as adversaries to Ontario's primary care physicians, the McGuinty Liberals adopted a platform that aimed to please physicians. The FHT model emerged from McGuinty's political campaign platform and emphasized the importance of access to primary care physicians (Aggarwal, 2009). As a result, the FHT model was deployed before being sufficiently developed.

The FHT model is an example of a professional PHC model that has been negotiated and shaped according to the needs of physicians; the once tense relationship between primary care physicians and the government has become somewhat eased. What it also demonstrates is the enormous power held by physicians that is cemented in the Canada Health Act (Hutchison et al., 2011; Razavi, 2014). The FHT model, as a response to the advocacy and power of physicians, illustrates the role of politics as conflict resolution (Bambra et al., 2005). Furthermore, this power is reinforced in the fear that Ontarians' might return to the Harris Conservative years and not have access to a primary care physician. As I was leaving one of the interviews, a policy informant made a comment to me that suggested every politician knows not to break up the relationship between physician and patient, and asserted this is the reason physicians are so powerful. Although this statement was not part of our formal interview, these words left an impression on me.

Instead of identifying and reshaping macro structures that act as barriers in realizing rights to health (Coburn, 2006), the FHT model reifies power imbalances (Lupton, 2006). This is problematic because PHC models – including Ontario's FHTs – take on forms based on the political priorities that shape them (Félix-Bortolotti, 2009). Despite PHC intending to broaden the focus of health services by extending beyond the traditional medical model and physician services (Bhatia & Rifkin, 2010; Romanow 2002), the FHT model reinforces dominant assumptions about health and health care (Coburn, 2006).

It is recommended that characteristics and key components of the current FHT model be evaluated to ensure they are aligned with the health care needs of Ontario's population and not political or provider interests. Understanding historically embedded elements will help strengthen current day policy and decision-making and provide insight into the determinants that shape health outcomes (Bell, 2010; Bambra et

al., 2005). A greater understanding of how politics have influenced the development of the FHT model may help those who are struggling with current challenges.

REFERENCES

- Aggarwal, M. (2009). *Primary care reform: a case study of Ontario*. (PhD dissertation). University of Toronto, Toronto, ON.
- Ashcroft, R. (2014). Inadequate performance measures affecting practices, organizations, and outcomes of Ontario's Family Health Teams. *Healthcare Policy*, 10(1), 86-96
- Ashcroft, R. (2015). Health promotion and primary health care: Examining the discourse, *Social Work in Public Health*, 29(6), 606-615. .
- Ashcroft, R. (2010). Health inequities: Evaluation of two paradigms. *Health & Social Work*, 35(4), 249-256.
- Association of Ontario Health Centres. (n.d.). *CHC fact sheet. Membership: Community Health Centres*. Retrieved from: <http://aohc.org/chc-fact-sheet>.
- Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a politics of health. *Health Promotion International*, 20(2), 187-193.
- Bell, E. (2010). *Research for health policy*. New York, NY: Oxford University Press.
- Bhatia, M., & Rifkin, S. (2010). A renewed focus on primary health care: Revitalize or reframe? *Globalization and Health*, 6, 13.
- Bodenheimer, T. (2005). The political divide in health care: A Liberal perspective. *Health Affairs*, 24(6), 1426-1435.
- Canadian Institute for Health Information (CIHI). (2003). *Health care in Canada*. Ottawa, ON: CIHI.
- Carpenter, D. (2012). Is health politics different? *Annual Review of Political Science*, 15, 287-311.
- Coburn, D. (2006). Health and healthcare: A political economy perspective. In T. Bryant, D. Raphael, and M. Rioux, *Staying alive. Critical perspectives on health, illness, and health care* (pp. 59-84). Toronto, ON: Canadian Scholar's Press.
- College of Family Physicians of Canada (CFPC). (2011). *A vision for Canada. Family practice: The patient's medical home*. Discussion Paper. Mississauga, ON: CFPC.
- Cook, R. & Kachala, E. (2004). *Overview of selected primary health care models. A background document to the final report – Building a primary health care infrastructure in Halton-Peel: Planning for the future*. Halton-Peel, ON: Halton-Peel District Health Council.
- Creswell, J. (2007). *Qualitative inquiry & research design. Choosing among five approaches*. Thousand Oaks: Sage.
- Fairclough, N. (1985). Critical and descriptive goals in discourse analysis. *Journal of Pragmatics*, 9, 739-763.
- Félix-Bortolotti, M. (2009). Part 1 – unraveling primary health care conceptual predicaments through the lenses of complexity and political economy: a position paper for progressive transformation. *Journal of Evaluation in Clinical Practice*, 15(5), 861-867.

- Forester, J., Rosser, W., Hennen, B., Mcauley, R., Wilson, R., & Grogan, M. (1994). New approach to primary medical care: Nine-point plan for a family practice service. *Canadian Family Physician*, 40, 1523-1530.
- Frankish, J., Moulton, G., Rootman, I., Cole, C., & Gray, D. (2006). Setting a foundation: Underlying values and structures of health promotion in primary health care settings. *Primary Health Care Research and Development*, 7(2), 172-182.
- Gee, J. (2011). *An introduction to discourse analysis: Theory and method*. New York, NY: Routledge.
- Glazier, R., Kopp, A., Schultz, S., Kiran, T., & Henry, D. (2012). All the right intentions but few of the desired results: Lessons on access to primary care from Ontario's patient enrolment models. *Healthcare Quarterly*, 15(3), 17-21.
- Glazier, R., Zagorski, B., & Rayner, J. (2012). *Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008/09 to 2009/10. ICES investigative report*. Toronto, ON: Institute of Clinical and Evaluative Sciences.
- Gocan, S., Laplante, M. A., & Woodend, A. K. (2014). Interprofessional collaboration in Ontario's Family Health Teams: A review of the literature. *Journal of Research in Interprofessional Practice and Education*, 3(3), 1-19.
- Haggerty, J., Burge, F., Lévesque, J. F., Gass, D., Pineault, R., Beaulieu, M. D., & Santor, D. (2007). Operational definitions of attributes of primary health care: Consensus among Canadian experts. *Annals of Family Medicine*, 5(4), 336-342.
- Health Canada (2012). *Health care system. About primary health care*. Retrieved from: <http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos-eng.php#a4>.
- Hutchison, B., Levesque, J. F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: Systems in motion. *The Milbank Quarterly*, 89(2), 256-288.
- Lawn, J. E., Rohde, J., Rifkin, S., Were, M., Paul, V. K., & Chopra, M. (2008). Alma-Ata 30 years on: Revolutionary, relevant, and time to revitalise. *Lancet*, 372(9642), 917-27.
- Lupton, D. (2006). *Medicine as culture*. Thousand Oaks, California: Sage.
- Mable, A. L. & Marriott, J. (2002). *Sharing the Learning. The Health Transition Fund. Synthesis Series: Primary Health Care*. Ottawa, ON: Health Canada.
- Marriot, J., & Mable, A. (2000). *Opportunities and potential – A review of international literature on primary health care reform and models*. Prepared for the Health Human Resource Strategies Division, Health Policy and Communications Branch Health Canada. Minister of Public Works and Government Services Canada.
- McPherson, C., Kothari, A., & Sibbald, S. (2010). *Quality improvement in primary health care in Ontario: an environmental scan and capacity map*. Report prepared for the Quality Improvement in Primary Healthcare Project Planning Group. Retrieved from: http://www.qiip.ca/user_files/environmentalscan.pdf
- Miles, M., & Huberman, M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook (2nd Edition)*. Thousand Oaks: Sage.
- Navarro, V., Muntaner, C., Borrell, C., Benach, J., Quiroga, A., Rodríguez-Sanz, M., Vergés, N., & Pasarín, M. I. (2006). Politics and health outcomes. *Lancet*, 368(9540), 1033-7.

- Neysmith, S., Bezanson, K., & O'Connell, A. (2005). *Telling tales. Living with the effects of public policy*. Winnipeg, MB: Fernwood.
- Ontario Ministry of Health and Long-Term Care. (2004). *Family health teams – Advancing primary care. Bulletin No. 1*. Retrieved March 21, 2011 from http://www.health.gov.on.ca/transformation/fht/fht_bul/fht_bul_1_120604.pdf.
- Razavi, S. D. (2014). *Interprofessional primary health care (IPC) collaboration, Family Health Teams (FHTs) in Ontario* (Master's Thesis). McMaster University, Hamilton, ON.
- Romanow, R. (2002). *Shape the future of health care. Commission on the future of health care in Canada. Interim report*. Ottawa, ON.
- Rosser, W., & Kasperski, J. (2010). Establishing family medicine as the cornerstone of the transformation agenda: A ten-year retrospective. Ontario College of Family Physicians. Retrieved from: <http://ocfp.on.ca/docs/publications/board-retreat-appendix-a-establishing-fam-med-as-the-cornerstone-of-the-transformational-agenda.pdf?sfvrsn=3>.
- Shaw, S., & Bailey, J. (2009). Discourse analysis: what is it and why is it relevant to family practice? *Family Practice*, 26, 413-419.
- Smith, J. (2007). Critical discourse analysis for nursing research. *Nursing Inquiry*, 14(1), 60-70.
- Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly*, 83(3), 457-502.
- Starfield, B. (2001). Basic concepts in population health and health care. *Journal of Epidemiology & Community Health*, 55, 452-454.
- Strumpf, E., Levesque, J.F., Coyle, N., Hutchison, B., Barnes, M., & Wedel, R. (2012). Innovative and diverse strategies toward primary health care reform: Lessons learned from the Canadian experience. *JABFM*, 25(suppl.), S27-S33.
- University of Ottawa. (2011, September). *Primary care: definitions and historical developments*. Retrieved from: http://www.med.uottawa.ca/sim/data/Primary_Care.htm.
- Wallace, B. (2008). Introduction: The forces driving and embodied within a new field of equity in health. In B. Wallace (Ed.), *Toward equity in health: A new global approach to health disparities*. New York, NY: Springer.
- White, R. (2004). Discourse analysis and social constructionism. *Nurse Researcher*, 12(2), 7-16.