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Advancing Team-Based Care in Private Practices: A Case Study of a Public-Private Hybrid Model

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Abstract

Background: Despite widespread enthusiasm for team-based care models, adoption remains a challenge across Canadian jurisdictions, especially in private practices. The transformation of primary care demands innovative approaches that reconcile physician autonomy with the systemic need for collaborative, team-based care. This article examines an innovative public-private hybrid model in which publicly funded non-physician team members are integrated into a private clinic. It offers insights into how such reconciliation might be achieved.

Methods: This study draws on a case study of a pilot project involving a primary care private practice transitioning to team-based care in Canada. Three qualitative data collection methods were employed: document analysis, semi-structured interviews ($n=27$), and non-participatory observations (six days). A manual thematic analysis of the data was conducted, results were triangulated, and the coding system was refined through research team discussions.

Results: Findings highlight both the benefits and challenges of hybrid models as a pathway for primary care reform. Benefits include enabling transition to team-based care by addressing resource constraints, preserving core aspects of family physicians' professional autonomy, and incorporating patient-centered thinking within organizations typically oriented toward efficiency and sustainability. Challenges include physician distrust of public authorities, incompatibility with the fee-for-service payment model, and structural and operational barriers.

Conclusions: This research offers insights into how incremental reforms can leverage existing private infrastructure while advancing collaborative care. These findings may inform strategies in jurisdictions where primary care remains heavily reliant on independent practitioners. Future research should examine the conditions under which such models can be sustained and scaled, and how they reshape professional roles, governance, and accountability in primary care.

Keywords: primary care, team-based care, hybrid care models, healthcare policy, healthcare system transformation

1. Introduction

The primary care system in Canada is facing a crisis, marked by poor patient access, provider burnout, and fewer graduates choosing family medicine (1-4). The prevailing physicians' "soloist" and "family physicians only" model is under increasing pressure (5) with escalating workloads and costs.

As a response, "team-based" care is now widely recognized as a central strategy to strengthen primary care systems. The World Health Organization defines "collaborative practice" or "team-based care" as a situation where multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care (6). By bringing together health professionals from different disciplines to deliver coordinated and comprehensive services, team-based care is expected to improve access, quality of care, and provider well-being. In Canada, this model has become a key component of primary care reform efforts over the past two decades.

In Saskatchewan, primary care is largely organized around physician-led private practices¹ and, until recently, investment to support the move

¹ "Private practice" refers to a model of healthcare delivery in which physicians (or groups of physicians) own and manage their clinical practice as independent businesses. In

towards team-based care remained limited. In recent years, however, an innovative public-private hybrid organizational model has emerged. With funding support from the provincial health authority, private practices are gradually integrating publicly funded non-physician team members (including nurses, behavioural health consultants, social workers and medical office assistants). The goal is to improve service capacity, and therefore patient access, by decreasing family physicians' workload.

The first of these initiatives demonstrated promising results, including reduced wait times, expanded service offerings, improved continuity of care, high levels of physician satisfaction, and the progressive expansion of nurses' scope of practice. Building on these encouraging outcomes, these earliest sites secured permanent funding, and this model is now increasingly shaping the direction of primary care delivery in Saskatchewan.

However, evidence tends to suggest that implementing team-based care within physician-led private practice settings can be challenging. The private practice model is closely tied to professional autonomy and entrepreneurship, values central to physicians' professional identity (7-9), and most private practices still operate under the fee-for-service² (FFS) payment model. These

the Canadian context, these practices generally operate under a fee-for-service payment model, whereby physicians bill the public health insurance system directly. Thus, while delivery is privately organized, services are predominantly publicly funded.

² In Canada, most private practice family physicians are remunerated (or at least partly) under a fee-for-service model, whereby they bill the provincial public health insurance plan for each clinical service provided. Family physicians typically operate as independent practitioners and are responsible for covering the overhead costs of running their practice (including staff salaries, clinic space, equipment, and administrative support) out of the payments they receive.

characteristics have been shown to be poorly aligned with team-based care (10,11).

In addition, experiences from other jurisdictions suggest that such hybrid arrangements can face significant challenges. For instance, the Family Medicine Group (FMG) model in Quebec, that similarly integrates publicly funded professionals within private practices to improve access and coordination of care (12), has struggled to fully realize its objectives. Introduced in the early 2000s, they have faced persistent challenges, including limited improvements in access, difficulties in care coordination, incompatibility with fee-for-service payment model, and the underutilization of non-physician team members (13,14).

Taken together, these elements highlight the complexity of implementing such public-private models. At the same time, the Saskatchewan experience may not lead to similar outcomes, given the distinct context and implementation approach. Whereas FMGs were introduced as part of a highly institutionalized, top-down reform process (a feature often identified as a central limitation of the model (13)), the Saskatchewan initiatives are emerging through a more incremental and experimental approach driven by pilot projects and locally initiated practices. Examining how this model unfolds in practice is therefore particularly valuable to better understand its dynamics, opportunities, and constraints, and to inform future policy in Saskatchewan and beyond.

This paper addresses this need through an in-depth case study of a primary care clinic in Saskatchewan. It examines how public-private hybrid models can facilitate the transition of private practices to team-based care, as well as the benefits and challenges associated with this approach. The article first provides background on the studied pilot initiative, followed by the study's methodology and results. These findings inform a discussion of the broader implications of hybrid models, including their potential to drive system-level change, their compatibility with physician-led private practice, and their implications for accountability. Although this study focuses on Saskatchewan, the challenges examined are common across Canada and other jurisdictions with FFS-based private practices.

2. Background

Under Canada's federal system, responsibility for the funding, governance, organization, and delivery of primary care rests with provincial and territorial governments. Although services are publicly funded, they are primarily delivered through physician-led, FFS, private practices. Saskatchewan's primary care system is highly reliant on this model, an issue that is compounded by a shortage of family physicians and ongoing recruitment and retention challenges (15) especially in rural areas.

Responding to these pressures, a primary care clinic in southern Saskatchewan implemented a pilot project in 2023 to transition from a traditional "family physicians only" private practice to a team-based model.

Located in a semi-rural, agricultural region, the clinic serves about 10,000 patients. While the clinic is owned by a single physician, governance is shared among the family physician group. Prior to the pilot project, the clinic operated as a traditional private practice, with eight part-time family physicians working on a coordinated schedule, each assigned fixed clinic days (approximately 2.5 days per week) and spending the remainder of their time in acute care, emergency departments and community-based care settings. Physicians covered for one another and routinely saw each other's patients. They were supported by privately hired receptionists and MOAs.

In 2022, the clinic began its transition toward team-based care. The first change was the co-location of a mental health counselor funded by the Saskatchewan Health Authority (SHA) and focused on addressing mental health and addiction needs of patients. Over time, that role evolved into a Behavioral Health Consultant (BHC) position with a broader clinical scope.

Building on the success of this initial step, the team-based care initiative expanded into a formal pilot project in October 2023. The pilot was funded by the SHA, with the goal of developing a Patient Medical Home (PMH) care model. The PMH is a physician-led, team-based model developed by the College of Family Physicians of Canada (16), in which patients are attached to family physicians who work collaboratively with an interprofessional team to deliver coordinated, and patient-centered care. As part of the pilot, the SHA funded the integration of additional team members, including nurses and medical office assistants, with the expectation that this would reduce

family physician workload, expand service offerings, and improve patient access.

At the time of data collection in early 2025, the clinic consisted of one clinic manager, eight family physicians, one licensed practical nurse, two registered nurses, one BHC, four MOAs, and three receptionists. In April 2025, the pilot formally transitioned into a permanent initiative, with sustained funding provided by the provincial Ministry of Health. Under this arrangement, the clinic operates as a public-private hybrid organizational model in which family physicians continue to be remunerated through FFS payments, while newly added team members are publicly funded.

While early indications suggested improvements in patient access and physician satisfaction, the hybrid arrangement also introduced organizational, operational, and governance challenges. As this model begins to inspire additional initiatives in the province and beyond, a systematic examination of its implementation, benefits, and limitations is needed. Accordingly, this study addresses the following research questions: (i) How do public-private hybrid organizational arrangements facilitate the implementation of team-based care in primary care private practices? (ii) What benefits and challenges emerge from this approach?

3. Methods

To address the research questions, we used a qualitative case study design focused on the clinic's public-private hybrid model of care. A case study

design was well suited to capturing the organizational, professional, and governance dynamics of this model within its real-world context. We adopted an abductive approach, with data collection and analysis being informed by literature on team-based care, primary care organization, and health system reform. No single formal framework was applied in order to maintain an exploratory perspective and remain open to themes emerging from participants' accounts.

3.1. Data collection

We used three complementary data collection methods: document analysis, semi-structured interviews, and non-participatory observations. First, document analysis allowed us to clearly understand the pilot's background and implementation context. Documents included materials formally describing the pilot, such as role descriptions, work standards, routine measures, and reports on initial outcomes. This analysis informed the development of interview guides and observation protocols.

Second, we conducted semi-structured interviews to capture stakeholder experiences. A total of 27 interviews were completed, with seven family physicians, three nurses, three family medicine residents, one clinic manager, one BHC, one MOA, 10 patients, and one SHA representative. Informed consent was obtained from all participants prior to data collection. Interviews were audio-recorded and transcribed verbatim.

Participants were selected based on their exposure to both pre- and post-pilot care models, enabling them to reflect on the transition. Clinic staff and physicians were recruited via email or letters where email was unavailable. Patient recruitment involved several strategies, including posters displayed in the clinic and an announcement posted on the clinic's Facebook page. To ensure diverse patient perspectives, patients were selected using a pre-screening questionnaire that captured age, length of registration with the clinic, and the approximate number of visits in the past 12 months.

Interview guides were developed specifically for this study and adapted to participant roles and research stage. One example can be found in supplementary files. Patients were primarily asked to describe their experience with the clinic since the pilot, including perceptions of access, satisfaction, additional services, and quality of care. Clinic staff and physicians were invited to reflect on changes in care delivery model, teamwork dynamics, role distribution, and work processes, as well as factors that supported or hindered implementation.

Finally, we conducted non-participatory observations of clinic workflows, completing two separate three-day observation periods. We observed daily clinic operations, morning huddles, informal interactions among team members, and a meeting involving clinic leaders and SHA representatives. We also shadowed each of the three nurses for extended periods during routine activities, including patient encounters, triage, and documentation. Observational data were recorded as detailed field notes.

Data collection continued until thematic saturation was reached, defined as the point at which no new codes, themes, or dimensions emerged during subsequent interviews and observations.

3.2. Data analysis

Data collection and analysis proceeded iteratively, with preliminary analysis conducted between data collection periods to refine interview guides and observational focus. We conducted multiple rounds of manual thematic analysis using an abductive approach. Initial themes were informed by the research objectives and literature, while additional themes emerged inductively during the data analysis. Regular discussions among the research team helped refine the coding system, clarify emerging categories, and improve the analysis.

Findings from the interview analysis were compared with those from observations and document analysis to identify convergence and discrepancies across data sources. This triangulation strengthened analytic credibility. Although interview excerpts are used to illustrate key findings in the Results section, interpretations are grounded in the full body of data.

Authors are aware that their positioning may have shaped how certain dynamics were understood. This was mitigated in three main ways. First, the diversity of researchers' backgrounds within the research team brought different perspectives and helped challenge assumptions throughout the research process. Second, the analysis was conducted collaboratively, with regular discussions to challenge interpretations and ensure that themes

remained grounded in the data. Finally, following analysis, results were shared with the clinic team to confirm that findings accurately reflected their experience and to validate interpretive accuracy.

4. Results

The pilot project was widely regarded as a success by interviewees, particularly with respect to care delivery, patient outcomes, and provider satisfaction. Nonetheless, the data also revealed differences in perspectives and concerns among providers and highlighted both the advantages and challenges of the public-private hybrid model. The findings are organized around the key benefits and challenges of the model as identified by interviewees.

4.1. Benefits of the hybrid model

According to participants, the primary benefits of the hybrid model were (i) the removal of resource constraints, (ii) the preservation of family physicians' autonomy, and (iii) the promotion of patient-centered care.

4.1.1. Removal of resource constraints

The clinic's physician group had long expressed interest in moving away from "family physicians only" practice towards a more collaborative care model, but as a private practice they faced substantial barriers in doing so. Chief among these was a lack of financial resources to hire additional non-physician team members, whose salaries and benefits would have to be

covered by physicians, without generating corresponding billable revenue. Recruiting experienced nurses was described as particularly costly, making such investments difficult to justify in the short term. By reallocating existing employees to the clinic and covering their compensation, the SHA removed this financial barrier.

Integrating new team members also required substantial changes to workflows, coordination mechanisms, and clinical routines, demanding time and effort from the family physicians. To facilitate the transition, the health authorities provided partial funding for one of the physicians to assume a leadership role in implementing the pilot. This support allowed for dedicated time to manage change processes, liaise with stakeholders, and ensure the new roles were integrated in ways that were aligned with the clinic's operational realities and care objectives. As one physician noted:

“One of the most important components that maybe isn't front and center and people don't always see, is that physician leadership. Our physician leader [...] has been very important, helped us stay on track, develop those work standards and keep our new staff on track with their learning and with integrating into the clinic. So, if this is going to be duplicated at other places, having that funding available for physician leadership, it's going to be very important. And someone who's like a champion at it, right?”
(Family Physician).

This funding for physician leadership also fostered sustained engagement across the family physician group, which proved pivotal to the successful rollout of the pilot. A SHA representative described this engagement:

“They take the bull by the horns, they create the workflows, and they integrate them [the new team members] into the team. Physicians are really engaged, they take turns being ‘doctor of the day,’ all of that stuff. That engagement level is there. [...] That physician leadership I think just creates buy-in in itself.” (SHA representative).

Under these conditions, the hybrid model mitigated resource constraints and enabled the clinic to pursue organizational change at a moment when physicians were motivated to innovate but lacked the capacity to do so independently.

4.1.2. Preservation of family physicians’ autonomy

Although clinic physicians expressed strong support for team-based care, many initially feared that greater involvement from the SHA could threaten their professional autonomy. One physician explained this concern in relation to the FFS model: “We as fee-for-service physicians prioritize our autonomy and freedom. That’s one of the reasons that we work in this model. So, kind of being reluctant to do something that would kind of tie our hands with that.” (Family Physician). The concern about losing professional autonomy was a recurring theme in physician interviews, with several of them mentioning that it could be a barrier to adopting the hybrid public-private organizational

model in other clinics. As the pilot progressed, however, most physicians reported that these fears proved largely unfounded. As one physician reflected, apprehensions about external interference were more perceived than real: “I think it’s a false barrier. I don't think it's real, but I think that that could be something that people see as a reluctance to allow SHA into their practice.” (Family Physician).

Overall, family physicians retained complete autonomy over clinical (e.g., how they deliver care and manage their patient panels) and organizational (e.g., how the clinic operates in terms of scheduling, workflows, and internal policies) aspects. In terms of governance, they also retained substantial autonomy: while the hybrid model required certain compromises, the clinic continues to operate as a physician-led entity, with family physicians maintaining full decision-making authority. While the implementation of the pilot was shaped by ongoing negotiations with health authorities, interviewees explained that they have adopted a cooperative and flexible approach, accommodating clinic needs. Family physicians thus maintained significant control over how the pilot was designed and implemented in their clinic.

As a result, the hybrid model functioned as a compromise that enabled collaboration while preserving core elements of physician autonomy, an outcome widely viewed as essential to sustaining physician engagement.

4.1.3. Promotion of patient-centered care

Private clinics operate under financial constraints that prioritize efficiency and sustainability. Physicians frequently cited financial considerations as key to decision-making. As illustrated by the following quote, this left little room for patient-centered thinking:

“There was a [SHA] manager, he’s gone now, he would say to me, ‘well, you’re helping your patients.’ And I would say ‘yes, but this is a private business. If we can’t pay bills, the door is closed. This isn’t SHA business where you can run at deficit and still open your doors.’ [...] We can’t do that in a private clinic. We have to pay the bills.” (Family Physician).

The introduction of public funding created space for greater attention to patient needs in decision-making. Interviewees described expanded services, improved access to care, and new team-based practices, such as morning huddles, all contributing to higher quality, more continuous care. Physicians reported increased capacity to follow patients over time and to adopt a more patient-centered approach. As reflected in this quote, patients also reported greater personalized attention and continuity of care: “I felt like they were actually looking out for [me]. It wasn’t ‘Here, take these meds, we’ll see you in a couple months’, you know? [...] There’s a ton of follow-up where I believe that wasn’t happening before.” (patient). Several of the interviewed patients echoed this sense of personalized attention and continuity of care. Family physicians also reported feeling more able to follow their patients over time and to adopt a more patient-centered approach.

In addition, involving the SHA in decision-making also facilitated stronger population-health approaches. The clinic and the health authority jointly monitored key performance indicators such as “third next available appointment”, wait times for and use of specific services, and patient satisfaction. These data guided decision-making. Furthermore, by collecting its own data on the healthcare facilities and services, the SHA gained knowledge about the healthcare needs of the patient population and the challenges facing the healthcare system. Such first-hand information helped both the SHA and the clinic develop a deeper understanding of the local healthcare landscape and adjust the services offered at the clinic according to the patients’ needs. As one SHA representative noted, routine monitoring of service-use data enabled the health authority and clinic to adjust staffing in response to patient demand:

“The BHC at the clinic had 98 referrals last month. [...] At this other clinic, the BHC has had 12 referrals in the same period. So, we’re going to pull her over to the high-demand clinic one day or two more a week.” (SHA representative).

This illustrates how SHA’s involvement in privately delivered primary care enables a level of system-wide coordination and responsiveness that individual clinics would not be able to achieve on their own, ensuring that resources can be directed to where they are most needed.

Finally, the involvement of the SHA seemed to better connect the clinic with other healthcare services such as home care, public health, and mental

health services, which tended to work in silos. For example, having the BHC co-located at the clinic helped develop personal relationships and improve data and system integration between the clinic and public mental health agencies. As a result, the participants described the clinic as being better integrated into the larger healthcare system, supporting continuity of care for patients.

4.2. Challenges of the hybrid model

Despite these benefits, participants identified three key challenges associated with the hybrid model: (i) physician distrust of public authorities as an impediment to uptake; (ii) incompatibility with FFS payment under some conditions; and (iii) structural and operational barriers.

4.2.1. Physician distrust of public authorities

While the clinic's medical group acknowledged the need to shift the care model to benefit both patients and physicians, they expressed concerns about the health authorities becoming involved in their business operations. Beyond fears about loss of autonomy, interview data revealed deep tensions between the professional culture of private practice and the institutional culture of the SHA. Physicians pointed to differences in visions for care delivery and, more importantly, in operational approaches. They described SHA's management of its own facilities as inefficient, slow, and overly bureaucratic. At first, the prospect of integrating SHA personnel accustomed to different management practices raised concerns about a potential loss of efficiency within the clinic:

“We did not want the SHA and the way that they tend to run clinics and their businesses in our clinic because we don't feel that's efficient and how we want our healthcare system and our clinic to run. So that was like an overarching theme that we knew as physicians: ‘OK, when SHA is going to come into our clinic, we did not want that culture to be brought in with that.’” (Family Physician).

This comment suggests that cultural and operational misalignment between private clinics and public health authorities may represent a significant barrier to further adoption of public-private hybrid arrangements.

These concerns reflect longstanding distrust of the health authority, rooted in physician perceptions that centralized institutions lack understanding of local realities: “I honestly feel like we don't have much trust in that, that the bigger institutions don't necessarily know what we need, even in our own province.” (Family Physician). While trust developed over time between family physicians and SHA representatives, participants noted that such distrust could discourage uptake of hybrid models in other contexts.

4.2.2. Incompatibility with fee-for-service payment model

Several physicians viewed the FFS payment model as incompatible with the public-private hybrid arrangement because of its influence over task delegation. It was explained that expanding nurses' roles may require physicians to relinquish certain quick and financially advantageous

procedures, creating an economic disincentive when these tasks constitute a significant proportion of their income.

Interviewed physicians indicated that the clinic's physician group had accepted this short-term financial risk, viewing it as an opportunity to benefit their practice over the longer term. They reported that gains in professional satisfaction and patient outcomes would outweigh the loss of billable activities. When asked how the new team-based care model affected billing under a FFS payment model, one family physician explained:

"For chronic disease management appointments, it doesn't affect [billing]. It adds some efficiency if they [the nurses] go in, and as we still go in, we're still having our visit that we bill the government for. For other things like removal of sutures and PAPS, we just let that go. There's no billing that comes because we're not seeing the patient and we just kind of take it as like that point of serving the practice." (Family Physician).

This quotation illustrates that financial considerations remain a central criterion in physicians' decisions on what tasks to delegate.

Such concerns may become even more pronounced in contexts where patient demand is lower and where delegation could directly affect income. One physician put it this way:

"If you go out to a scenario where my wait time was very short and I was servicing my practice really well, I might not want to delegate more

because then I might have open spots in my day that then would affect my billings.” (Family Physician).

These dynamics indicate that FFS payment structures influenced clinical decision-making during the pilot and could constrain the expansion of task-sharing under certain conditions. As explained by interviewees, this could potentially override other important factors such as the clinical appropriateness, the potential to improve care quality and access, and the optimization of each provider’s scope of practice.

4.2.3. Structural and operational barriers

The implementation of the pilot project at the clinic unfolded in a pragmatic and largely improvisational manner. Operational and logistical aspects such as workflow organization, data sharing arrangements, and allocation of workspace were mostly established in practice, while formal contractual questions were addressed along the way. This meant that administrative constraints did not impede the early stages of implementation.

However, at later stages, interviewees noted that operationalizing the hybrid model required navigating regulatory, contractual, and technical barriers associated with two systems that traditionally operated in silos and followed distinct organizational logics. They encountered barriers linked to the absence of formal agreements and the rigidity of existing contractual frameworks. One interviewee contrasted this experience with that of another, more top-down pilot project, where these issues became major obstacles to

the first stages of implementation: “They're running into issues trying to do some of this co-location and EMR sharing, because contracts are stating: ‘Don't’.” (SHA representative)

Financial arrangements within the hybrid model are also complex. In Canadian FFS environments, physician billings serve not only as income but also as the main source of funding for a range of practice-related expenses, including staff salaries, clinic space, equipment, and administrative support. Within this context, the integration of publicly funded staff generated additional costs for the clinic. That prompted the development of financial arrangements whereby health authorities contributed to overhead and operational expenses, which involved continuous negotiations between family physicians and health authorities along the pilot implementation.

In addition, the introduction of non-physician roles also reshaped family physicians' clinical work and, as a consequence, billing patterns. On the one hand, some physician-delivered activities became delegated to the nurses and were no longer directly billable. On the other hand, the arrival of nurses also increased the efficiency of some patient encounters (with nurses doing some initial assessment or forms completion) and generated other billable services (such as nurses' requests or other coordination activities). The financial implications of these new arrangements are therefore not straightforward and warrant careful assessment.

Finally, managing staff funded by public and private sources introduced ambiguity around supervision, performance, and decision-making authority.

Nurses reported confusion about authority, particularly given the absence of on-site SHA leadership. Participants emphasized the importance of monitoring these dynamics to prevent tension and support team cohesion as hybrid models evolve.

5. Discussion

This study examined a pilot project of a public-private hybrid model of primary care implemented within a physician-led private practice. The findings highlight both the potential and limitations of hybrid arrangements as pathways for advancing team-based care in settings where the private practice model is dominant. In this section, we consider the broader implications of these findings for primary care reform.

5.1. From local innovation to system-level change: can hybrid models act as catalysts?

Implementing team-based care in private practices is challenging. Resources are often limited, and without external support, the costs of hiring, coordinating and sustaining interprofessional teams can outweigh the perceived benefits, making change difficult to initiate (17).

The hybrid model examined here functioned as a catalyst for organizational change for the clinic, enabling it to overcome long-standing obstacles to adopting team-based care by alleviating financial and organizational constraints. The model allowed physicians to adopt collaborative practices while retaining the autonomy associated with private

practice. The findings suggest that hybrid models may offer a pragmatic solution to physician shortages and unmet patient needs, particularly in rural or semi-rural areas. By leveraging existing private infrastructure and supplementing it with publicly funded professionals, hybrid arrangements can expand service capacity and improve access to care.

However, the extent to which the public-private hybrid arrangement can act as a catalyst for change at a larger scale hinges on their scalability and sustainability, which present significant challenges. First, our findings show that misaligned institutional logics (namely, the autonomy-driven, entrepreneurial orientation of private practices *versus* the emphasis on standardization and bureaucratic accountability within government health authorities) can fuel distrust and complicate the development of collaborations between the two groups of actors.

As Kreindler et al. (18) cautioned, such partnership reforms can pose an identity threat for family physicians by compelling them to participate in bureaucratic enterprises. They showed that securing physician engagement in healthcare reforms requires trust-building as well as strategies that acknowledge family physicians' professional identity (18) and the central role of medical practice and professional autonomy in primary care delivery. On the contrary, policy initiatives frequently falter when health authorities underestimate the importance of financial and clinical autonomy of physicians, which is core to their professional identity (9,10,18).

In the case of the studied clinic, the success of the pilot project hinged heavily on physician leaders acting as champions for change. Beyond providing logistical support, these champions helped secure physician buy-in within the private practice and sustained engagement over time. Attention to the champion's role, including how such leaders are identified and supported, is therefore essential to effective implementation (19).

Second, the bottom-up and locally driven nature of the studied initiative appears to have been essential both in tailoring the model of care to the needs of the clinic's patient population, and in fostering physician engagement. In scaling up the model across Saskatchewan, we argue that a one-size-fits-all approach is unlikely to adequately address the diversity of local needs, and that flexibility in implementation will be required to adapt team-based care models to the specific characteristics of individual communities and of primary care settings. A more centralized approach to implementing team-based care within existing private practices, such as in the case of Quebec's FMG model (13), may limit such contextual adaptation and contribute to implementation challenges.

5.2. Team-based care in private practices: (in)compatibility?

Beyond the conditions required for successful implementation, our findings point to more fundamental tensions related to how team-based care is enacted within physician-led private practices. Shared power and leadership are foundational attributes of interprofessional teamwork within primary care settings (20,21), and the principle of shared decision-making is

a cornerstone of effective team-based care models (22). This raises the question of the compatibility of team-based models of care with physician-owned and physician-governed contexts. Indeed, such settings inherently instill power imbalances between providers and might contribute to positioning non-physician team members as support staff rather than equal partners in care delivery. Professional hierarchies among healthcare providers tend to limit participation and influence of non-physician team members in decision-making (23). These dynamics constitute an important challenge to the implementation of team-based care (20,24).

As shown in the Results section, the hybrid model was explicitly designed in a way that preserved physicians' clinical, organizational, and governance autonomy, which was viewed as essential to sustaining their engagement. While this preservation of autonomy facilitated the acceptability of the model, it results in power imbalances becoming a structural feature of the model itself. In this sense, hybrid models may simultaneously enable private practices to take a first step toward a change in their model of care while limiting the chances to develop a fully collaborative, team-based care approach.

These structural constraints are further reinforced by the persistence of FFS payment models, which have been identified as a key barrier to the broader implementation of team-based care. While it did not appear to significantly hinder the initial development of the studied initiative, evidence from similar public-private models, such as Quebec's FMG model (12,13),

suggests that FFS remuneration can constrain participation in team-based care by limiting incentives for collaboration.

These tensions become especially important when considering scaling up hybrid models beyond pilot settings, as challenges related to professional participation may be amplified in broader system-level adoption. Importantly, the success of early adopters does not necessarily translate into successful scale-up: while early adopter practices are often regarded as successful, broader dissemination of team-based care models has frequently proven difficult (25,26). Prior research suggests that this challenge is partly due to differences in how care teams conceptualize their work and organize decision-making. In particular, Wagner et al. (26) have shown that successful early adopters tend to share specific “mental models” of practice and practice change, characterized by a broader distribution of tasks, responsibilities, and cognitive functions across team members, whereas later adopters tend to retain more physician-centric models of practice.

These barriers may become more pronounced for later adopters of the model or in contexts where implementation is more centrally driven, hindering both physician engagement and the sustainability of the model. Without changes to both payment structures and governance mechanisms, hybrid models risk maintaining delegated forms of practice rather than enabling fully collaborative care.

Ongoing attention is therefore needed to identify which mechanisms most effectively foster meaningful participation by non-physician team members

and support movement toward more fully shared models of care. Future research could usefully examine how the cognitive dimensions of team functioning unfold in physician-led private practices, where the conditions for developing more fully team-based models of care may be particularly constrained.

5.3. A path toward more accountability in primary care?

Public-private hybrid models also raise important questions about accountability in primary care in different regards. By transferring publicly funded resources within those private businesses, these arrangements blur traditional lines of responsibility and challenge existing accountability frameworks and extend public accountability expectations to private actors.

For example, a key question concerns the extent to which hybrid models can support local health authorities' goals of ensuring that every citizen is attached to a primary care provider, and under what conditions. Although the model studied here has enhanced access and service delivery for already attached patients, this has not yet translated into increased patient attachment at the community level. Monitoring these initiatives will therefore require the establishment of more concrete objectives, along with appropriate evaluation frameworks and accountability mechanisms. Another example is that tailoring care to local needs and contexts will require adopting a population health approach, which in turn calls for some degree of system steering and the establishment of accountability mechanisms.

Questions therefore arise about how accountability will evolve in these new hybrid arrangements and how it aligns with private practice physicians' core values of autonomy and entrepreneurship. To sustain physician engagement, or in other words to ensure the "acceptability" (28) of reform efforts, these new hybrid arrangements must balance respect for professional independence and autonomy with expectations of accountability and quality improvement (27). These challenges highlight the importance of examining how governance and reporting mechanisms are negotiated in hybrid models.

Beyond the local level, accountability to citizens for the performance of the healthcare system is a significant gap in Canada's primary care landscape (10,28). One contributing factor is that primary care is publicly funded but largely delivered through private practices, a structural arrangement that has long allowed providers to operate with limited formal obligations to ensure they are meeting the needs of the populations they serve:

"Most family physicians in Canada are private contractors who carry no obligations or accountability for the breadth of services they provide, the location of their practices, their hours of operation, their staffing mix, the patients they accept or their ability to meet local population needs." (29)

Despite decades of recommendations from expert commissions and policy initiatives aimed at strengthening accountability in healthcare (9,30,31), Canadian provincial and territorial governments have struggled to implement mandatory requirements for primary care physicians (10). This accountability gap has serious implications, particularly during crises when public

authorities are expected to respond and community-responsive care is most needed.

We argue that public-private hybrid models have the potential to introduce new accountability dynamics within the healthcare system, warranting close examination. On one hand, these arrangements may create opportunities to embed accountability if public funding is tied to explicit expectations (for example in terms of service volume, patient profiles) supported by measurement and monitoring mechanisms that inform decision-making and quality improvement. The Results section showed how new funding arrangements incrementally integrated population-health considerations into decision-making while being attentive to private practice logics.

On the other hand, hybrid arrangements also carry risks. First, private organizations' priorities may come to exert greater, albeit indirect, influence over local service delivery. Second, hybrid models risk further blurring lines of responsibility, making it more difficult to determine who is accountable for care delivery and outcomes. Third, questions arise as to how these arrangements can reconcile distinct accountability frameworks and expectations across public and private actors. Public accountability is typically rooted in external expectations such as democratic governance, transparency, and responsiveness to societal needs, whereas private accountability is often grounded in internal priorities such as efficiency, profitability, and professional ethics.

Understanding how accountability is negotiated and enforced is critical to assessing the legitimacy and effectiveness of hybrid healthcare governance. Further research is needed to examine how accountability operates in hybrid primary care arrangements, and the factors that shape its strength and effectiveness.

6. Conclusion

The transformation of primary care in Canada, as in many other countries, requires approaches that reconcile physician autonomy with the growing need for collaborative, team-based care. The public-private hybrid model piloted in Saskatchewan offers valuable insights into how this balance might be achieved within healthcare systems where the private practice model is dominant.

This qualitative case study highlights both the promise and limits of such hybrid arrangements. On one hand, the integration of publicly funded non-physician team members can act as a catalyst for organizational change that is widely recognized as necessary but difficult to implement in private practice settings. By alleviating financial and organizational constraints, the hybrid model provides a pragmatic pathway for advancing team-based care.

On the other hand, the conditions that enabled such local innovation may not be easily sustained at scale, and the model's transformative potential therefore remains conditional. Our findings highlight tensions arising from misaligned institutional logics, payment structures, and the power

imbalances that are structurally embedded within the model. In scaling up the model, particular attention should be paid to these factors, as they may constitute significant barriers. In addition, the mode of implementation and the level of physician engagement play a critical role in shaping outcomes. Finally, the ability of these initiatives to fulfill health authorities' mandates (such as improving access and responsiveness to population needs) depends on the establishment of appropriate governance and accountability mechanisms. Further attention is therefore needed to the conditions under which hybrid models can support meaningful system-level change.

The implications of these findings extend beyond Saskatchewan and may be particularly relevant in jurisdictions where primary care remains heavily reliant on independent practitioners. However, a limitation of this study lies in its focus on a single site, which may reflect a particular subset of private practices, especially those more inclined to adopt innovation. This case may therefore be somewhat distinctive as part of a group of early adopters, whose motivations, capacities, and organizational cultures may differ from other practices. In addition, the emphasis on entrepreneurial and organizational autonomy observed among participating physicians may not fully reflect broader trends within the evolving family medicine workforce, where preferences for different models of practice are increasingly heterogeneous.

Author Contributions Statement

HM supervised the research. All authors contributed to the conception and design of the work. CD collected and analyzed the data. All authors

participated in the interpretation of data and the writing of the manuscript. All authors read and approved the final manuscript.

Ethics declaration

Ethical approval was obtained from the Behavioral Research Ethics Board (BREB) of the University of Saskatchewan. All procedures involving human participants were conducted in accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2022), the national standard governing research ethics in Canada, and with the 2024 revision of the Declaration of Helsinki. All participants provided informed consent prior to taking part in the study.

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Author(s) Conflicts of Interest

Dr. Harrison provides family medicine services in private practice at the clinic site studied in this research. To mitigate potential bias, the study design was finalized before data collection; data extraction and analysis were

conducted by coauthors who do not have any relationship to the clinic; and interpretations were reviewed collaboratively by all authors. The authors report no other conflicts of interest.

Consent for publication

Not applicable

Data availability

Data generated and analyzed during the current study are not publicly available due to privacy and anonymity considerations. Sharing the data could compromise the confidentiality of participants and violate ethical guidelines.

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