A Cross Provincial Comparison
Of Health Care Policy Reform in Canada

The Reform of Front-line Services in Quebec: The Implementation of Family Medicine Groups (FMGs) and New Terms of Remuneration for General Practitioners

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Introduction

After Quebec establishment of the Medicare system, a legacy of the Castonguay-Nepveu Commission, initiatives to structure front-line health services in the province gave rise to three different organizational models. As of the 1970s, CLSCs (Centres locaux de services communautaires – Local Community Service Centers) and private practices were the main portals to the health care system. After the Clair Commission Report[1] was filed, however, the government favoured the development of a new means of organization: the family medicine group (groupe de médecine de famille – FMG). This structure, introduced in 2001, was designed to profoundly modify the paradigm and philosophy of how services were organized, mostly by changing the remuneration system for the payment of doctors, modifying case management and

recommendations of the report of the Commission of Study of Health and Social Services (the Clair Report, December 2000) (MSSS, 2003, p. 15). Faced with the co-existence of two portals to front-line services, namely, CLSCs and private practices, the Clair Commission had indeed proposed changes to how services were structured, thereby introducing the concept of FMGs.

According to the government documents we consulted, several factors argued in favour of FMGs. To begin with, problems with access to medical services meant that patients had trouble finding a family doctor. Furthermore, fragmented services left the patient rather than health care personnel responsible for making links between the various medical professionals working on his or her case. The

FMG activities, operations and services

The Ministry of Health and Social Services defined FMGs as follows:

> Organizations made up of family doctors who work collectively, in close collaboration with nurses. A FMG regroups the full-time equivalent of 6 to 12 doctors (FTE-FMG), whereby several doctors may share the equivalent of one full-time position. FMG members also work in close collaboration with other health and social service professionals, especially social workers and pharmacists. Operating in a FMG facilitates communication between professionals and helps services be more integrated (MSSS, 2002, p. 5).

The implementation of FMGs was based on a pre-existing structure of front-line services. In order to form a FMG, doctors must come from one of three of the following kinds of institutions: a CLSC (CSSS), a private practice or a family medicine teaching unit (seignement en médecine familiale) (MSSS, 2003). Doctors choosing to work together must sign an association agreement. After that, they must enter into service agreements with their local CLSC (now Centre for Health and Social Services CSSS) and sign onto an agreement uniting the FMG and the Regional Board (now the Local Health and Social Services Networks Development Agencies [de services sociaux ADRLSSS]). They must also adhere to the specific agreement on remuneration of the Quebec Federation of General Practitioners (FMOQ) (MSSS, 2003).

With respect to their duties towards their patients, FMG general practitioners must provide services that include the evaluation, diagnosis and treatment medical condition, the consideration of related issues and appropriate monitoring. They are especially responsible for providing these services to clients who suffer from complex diseases or a chronic disorder. They must coordinate their services with those of other health care system entities and direct patients towards outside resources.

FMGs have considerable potential to improve the health of the population by providing an interprofessional approach and by practicing the aspects of disease prevention and health promotion (MSSS, 2003, p. 30). They must exercise preventative clinical procedures with a view to furthering various strategies for health promotion, public information and education in accordance with the principles of Welfare Policy (la Politique de la santé et du bien-être PSBE).

With respect to accessibility, FMGs must provide patients with appointments within a reasonable delay. There must also be certain periods of time, on weekend and holidays, where doctors can be seen on a walk

The nurse works in close collaboration with the doctors. This collaboration is key to progress on the three axes of the transformation of the network, namely, case management, accessibility to services and continuity of care for the public (MSSS, 2003, p. 51). The nurse takes part in interviews and screening, in the systematic monitoring of patients with special needs, in patient care, patient education, and disease prevention and health promotion activities. The nurse is also responsible for liaison with the other entities in the health care sector (MSSS, 2002 and 2003). In addition to nurses, FMGs may also use the services of other health professionals, such as nutritionists, psychosocial experts, physiotherapists and pharmacists. FMG operations are supported by administrative personnel.

The expected results

For patients, the achievement of the objectives targeted by the establishment of FMGs is expected to improve the quality of services offered, which is in turn expected to enhance the general state of health of registered participants. For the professionals involved, FMGs represent more of an alternative

The evolution of the practice of medicine and its operating environment

The idea of reforming front-line services in Quebec also originated with the realization of the changing nature of the practice of medicine.

From about 2000 onward, older general practitioners mostly worked alone in private practices, principally on a walk-in basis. Young doctors tended to have more diversified, but less organized, practices: they worked in both emergency rooms and medical clinics or in fields specialized in specific pathologies that required particular competency.

context before presenting their concept of the front-line team at the forums as a possible solution to the problem of overcrowding.

To mitigate overcrowding, the action plan of the Forum on the Emergency Room Situation (Forum sur la situation dans les urgences

Although the conclusions of the report amounted to neither more nor less than a business plan for medical practices, the Secor report

The decision-making agenda: The central role of the

population-based responsibility and integration. In this way, the FMG model consisted, in fact, of a English model of patient care.

Throughout the inquiry process, the Clair Commission was also largely inspired by the work performed by the FMOQ and its physician-members. The Commission looked for ways to dovetail the initial proposal of the FMOQ, as elucidated in the Secor report, with the concerns of the commissioners (FMG-01). Discussions took place between commissioners and doctors who came to present their practice methods at the Commission. The Commission also reviewed the work done by the MSSS. In short, working from a number of different initiatives, the commission identified a certain number of common elements that came together under the FMG .

As the program developers themselves have said, the Clair Commission did not invent a new model. Rather, it tried to regroup and give form to a number of existing models in order to create a model specifically adapted to Quebec.

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The concept was then presented to the public in order to give impetus to the project of reforming front-line a number of public forums that would foster the exchange of ideas, thus consolidating support for the main outlines of the program.

The commission tested some of its principal recommendations on important actors in the health care system in order to assess their political feasibility. The idea was to propose at least one front-line service model in order to have a basis for discussion: adjustments could always be made later (FMG-07).

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This is as much as to say that the interplay between the two committees, one of which was political and the other operational, was not always optimal and gave rise to conflicts.

The professionals and clinicians in charge of the dossier took on the task of executing the model proposed by the Clair Commission. During the development phase of the concept, the Commission had been primarily interested in the English and American models. During the execution phase, however, MSSS managers mainly studied models from Sweden and Ontario. Observation missions were sent to both places to study how organizational methods took place concretely, on the ground. Thus, the models that had inspired the initial concept gave way to others when it came to getting the system running.

With respect to their basic components, the Ontario Family Health Networks and Family Health Groups models were practically identical to the model proposed by the Clair Commission. Like the model proposed in Quebec, the Ontario models were founded on a mixed remuneration system, around-the-clock access and patient registration. These models would have the greatest influence on the MSSS realization of the FMG concept in Quebec.

In summary, the MSSS played a central role in the realization of the FMG model. It did not, however, have much room to manoeuvre.

judged essential by the Clair Commission

In the end, the minister admitted to having underestimated the strength of the resistance on the part of the medical federations.

The swiftness of execution

In his report, Clair stated that the Commission is aware that the organization of primary care medical services structured around Family Medicine Groups and CLSCs cannot be implemented rapidly everywhere. We believe it should be carried out gradually, with family physicians and CLSCs that are interested in implementing this kind of project (Emerging Solutions, 2001, p. 53). The goal was to put several FMGs in place with the help of the most interested doctors, a process that would then serve to demonstrate to the rest that the model worked (FMG-09).

In reality, however, the government, wanting to move forward rapidly with the establishment of FMGs, chose another course altogether. Because of this, the project was quick indeed to get off the ground. The government

For another thing, the personality of the then-minister of health and social services also had an impact on the implementation strategy that came to be chosen. The minister did not necessarily have the leadership and the credibility necessary to bring the project to term.

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possible that he underestimated the amount of work required to t

functional project on the ground. Many aspects of the model had to be negotiated with the professionals.

The thorny issues

Registration and around-the-clock access

Of all the innovations proposed by the FMG project, registering patients with general practitioners was undoubtedly the most contentious. The government

a given general practitioner an intrinsic element of the practice of general medicine in Quebec.

The FMOQ, however, had reservations about registration. While registration was well adapted to rural regions, where the clientele was captive to a shortage of doctors, the situation was different in urban areas where doctors were more numerous: in these areas, registration might lead to competition for patients.

In addition, registration was perceived as an affront to the autonomy and freedom of choice of patients and doctors. Formerly, the relationship between the two individuals was based on a tacit understanding: the doctor had the responsibility to follow a given individual and the patient recognized the general practitioner as his or her attending physician. With registration, this relationship would become formalized: a signed agreement,

While fee-for-service payment was a widespread practice

Montreal: more solo practices, little or no case management, more walk-in clinics and a multi-ethnic clientele

Others believe that the important proportion of Montreal doctors in the FMOQ membership facilitated the resistance movement.

especially in the pre-

between the minister and the FMOQ with respect to the introduction of FMGs. The FMOQ decried the government precipitation in wanting to push forward with the project before details of the system were quite clear. This confrontation had a significant impact on subsequent negotiations on the development of the model and the interim agreement on remuneration: contrary to the FMOQ, the minister was in a hurry to arrive at an agreement.

External factors

The emergency room crisis in Quebec and the policies implemented in order to address the issue, laid bare the importance of the accessibility of front-line services and influenced the development of the FMG model as a result. The impact of politics on the progress of the project was also significant, because it took place in a pre-election period. Between the announcement of the project and its implementation, a number of ministers succeeded each other (Marois, Trudel, Legault and Couillard), a circumstance that could not help but influence the way the project was handled.

Conclusion

The difficulty of changing the remuneration system

What should have been an opportunity to change the remuneration system for doctors in order to introduce a mixed model and elements of capitation, resulted instead in only minor changes to the fee-for-service payment system.

Towards alternative models?

Even if the government original intention to implement the model proposed by the Clair Commission throughout Quebec

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Some see it as an attempt to complete the reform begun in the 1970s with the establishment of the CLSCs (FMG-02). They see FMGs as a trial and do not expect them to solve all problems with front-line services.

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In summary, the model works well in dynamic environments where general practitioners already formally communicate with each other and where working together is likely to help compensate the lack of medical staff: this is the case in many rural areas. The model is less conclusive in those areas with the most significant problems of organization and provision of front-line services, like Montreal and other urban centres. Having said this, the fact that the FMG model survived the change of government in 2003 is proof of its success.

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The future

At the present time, FMGs are a model in transition. Several of our sources felt that the government will have

improvement of services, but also in light of changes to professional practices.

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In closing, political will is going to be necessary if the model is to withstand the test of time.

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January 16, 2001

Paper and online publication of the C
Emerging Solutions: report and recommendations .

February 26, 2001

Health Minister Pauline Marois announces the government
cessible seven days a week, 24 hours a day throughout the province of Quebec.

March 8, 2001

Bernard Landry is designated Premier of Quebec and names Rémy Trudel to the position of Minister of State for Health and Social Services. Pauline Marois becomes Minister of State for the Economy and Finance.

April 4, 2001

The federal government announces the creation of the Commission on the Future of Health Care in Canada presided by Roy Romanow, sole commissioner and New Democrat ex-premier of Saskatchewan.

April 11, 2001

Publication of Caring for Medicare: Sustaining a Quality System , final report of a study commissioned by the Government of Saskatchewan.

April 26, 2001

On a visit to the Permanent Commission on Social Affairs

June to December 2001

Preliminary and sporadic discussions between the Ministry of Health and the FMOQ on the definition of the components and principal implementation stages of FMGs.

November 2001

Creation of a work committee made up of MSSS and FMOQ representatives with the mandate to define the points of negotiation for the establishment of FMGs.

December 2001

Beginning of negotiations between the MSSS and the FMOQ on the operating conditions and the terms of employment and remuneration for general practitioners working in FMGs.

December 2001

Publication of a report entitled, A Framework for Reform , by the Premi
Health presided by ex-Premier of Alberta John Mazankowski.

December 11, 2001

Announcement by the MSSS of the implementation of five more FMGs.

January to June 2002

The MSSS and the FMOQ organize working meetings with the doctors in charge of the first designated FMGs.

January 30, 2002

Cabinet shuffle and appointment of François Legault as the new minister of health and social services.

March 4, 2002

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March 11, 2003

One-year extension of the general agreement on the terms of remuneration of general practitioners signed by the MSSS and FMOQ in December 2002.

March 12, 2003

Calling of general elections in Quebec.

April 14, 2003

Election of the Quebec Liberal Party to the head of the Quebec Government.

April 29, 2003

A CROSS-PROVINCIAL COMPARISON OF HEALTH CARE POLICY REFORM IN CANADA

RESEARCH TEMPLATE

Province: Quebec

Case study: Alternative payment plans – Primary care reform – Family Medicine Groups (FMGs)

Category	Subcategory	Data
Institutions	Structures (esp. federal government and/or department or legislative committee mandates)	Stakeholders had been talking about the need to reform front line services in Canada since the early 1990s. Both the federal government and the provinces were involved. The province of Quebec had become interested in the issue of reform… when? The FMOQ laid the groundwork for an initial model for the organization of front line services by commissioning a report from the firm *Secor* on how work was organized in private clinics. In... Some of the ideas from the *Secor* report were used by the Clair Commission to create its own model as outlined in the Commission's final report (2002). The MSSS was made responsible for the execution of the FMG model, using the outlines of the model as set out in the recommendations of the Clair Commission report. The MSSS appropriated the project. A Working Group and an Implementation Support Team were set up at the MSSS. Provincial health ministers (PQ and QLP) also played a preponderant role in the promotion of the FMG model: for them, the plan was politically expedient.

		service provision model had created problems of accessibility. The goal was therefore to develop a policy that would restructure the practice of general medicine (maximize practices and interventions by working in collaboration). The emergency room crisis and resulting policies also had an impact on the development of the FMG model. With respect to means of remuneration, traditional ways of operating also influenced the FMG model. Indeed, means of remuneration have changed very little, although the idea is to use capitation to make eventual changes to the system. The first step is taking place presently, with contracts, registration and administrative time.
	Policy networks *(overlaps with Interests)*	Several actors, including the FMOQ (and the general physicians of Montreal in particular), did not particularly stand to gain from the implementation of the FMG model (the basic premises of the model were contested: registration and follow-up of patients)

		position on the need to reform front line services, as well as the best means of teaching family medicine. At the MSSS, certain researchers (Yvon Brunelle wouldn't like this...) had documented what had been done elsewhere about the reform of front line services and different means of remuneration.
	Elected officials	The health minister and the Cabinet took great interest in the model proposed by the Clair report because certain aspects of the model seemed politically profitable: around-the-clock access, monitoring of patients. It was for this reason that they wished to implement the model very quickly (Marois) and that things began to get out of hand (Trudel). They were very conscious of public complaints about accessibility. FMGs

	Other	Not addressed by our sources.