

# Primary Care Reform: Can Quebec's Family Medicine Group Model Benefit from the Experience of Ontario's Family Health Teams?

Les réformes des soins de première ligne :  
Est-ce que le modèle des groupes de médecine  
de famille au Québec pourrait bénéficier de  
l'expérience Ontarienne dans le modèle  
des équipes de santé familiale ?



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### Abstract

Canadian politicians, decision-makers, clinicians and researchers have come to agree that reforming primary care services is a key strategy for improving healthcare system performance. However, it is only more recently that real transformative initiatives have been undertaken in different Canadian provinces. One model that offers promise for improving primary care service delivery is the family medicine group (FMG) model developed in Quebec. A FMG is a group of physicians working closely with nurses in the provision of services to enrolled patients on a non-geographic basis. The objectives of this paper are to analyze the FMG's potential as a lever for improving healthcare system performance and to discuss how it could be improved. First, we briefly review the history of primary care in Quebec. Then we present the FMG model in relation to the four key healthcare system functions identified by the World Health Organization: (a) funding, (b) generating human and technological resources, (c) providing services to individuals and communities and (d) governance. Next, we discuss possible ways of advancing primary care reform, looking particularly at the family health team (FHT) model implemented in the province of Ontario. We conclude with recommendations to inspire other initiatives aimed at transforming primary care.

### Résumé

Depuis plusieurs années, l'idée de réformer les services de première ligne comme stratégie d'amélioration de la performance du système de santé fait consensus au Canada parmi les politiciens, les décideurs, les cliniciens et les chercheurs. Toutefois, ce n'est que plus récemment que de réelles initiatives de transformations ont été entreprises dans différentes provinces canadiennes. À cet égard, le modèle de Groupes de médecine de famille (GMF) mis en place au Québec apparaît comme une initiative prometteuse pour améliorer l'organisation des services de première ligne. Un GMF est un regroupement de médecins qui travaillent en étroite collaboration avec des infirmières pour dispenser des services auprès de personnes inscrites, sur une base non géographique. L'objectif de cet article est d'analyser le potentiel du modèle GMF comme levier d'amélioration de la performance du système de santé de même que de discuter des voies possibles d'amélioration de ce modèle. Dans un premier temps, nous présentons un bref historique de l'organisation des services de première ligne au Québec. Ensuite, nous décrivons le modèle GMF au regard des quatre fonctions clés des systèmes de santé identifiées par l'OMS soit (a) le financement, (b) la génération de ressources humaines et technologiques, (c) la prestation de services individuels et collectifs et (d) la gouvernance. Nous discutons par la suite des voies possibles pour faire progresser la réforme en nous inspirant particulièrement du modèle *family health team* (FHT) implanté dans la province de l'Ontario. Nous concluons en proposant des recommandations qui pourraient inspirer d'autres initiatives de transformation de services de première ligne.

**T**HE IMPORTANCE OF PRIMARY CARE SERVICES IN HEALTHCARE SYSTEMS IS WIDELY recognized. As the main point of entry into the system, their position is one of strategic coordination that has a ratchet effect on all other system components. Studies have suggested that the performance of the entire healthcare system hinges on having a primary care system that is well organized and fully integrated into the rest of the system (Starfield et al. 2005).

In Canada, the responsibility for organizing primary care services has historically been left to community-based private medical practices owned by a physician or a group of physicians. This situation stands in sharp contrast to that of institutions, such as hospitals and community centres, which form an integral part of the public system. Until quite recently there was very little investment made to support primary care services provided in private practices, although physicians were reimbursed by the public health insurance system for these services. It was therefore not surprising that several commissions (Clair 2000; Kirby 2002; Romanow 2002) concluded that primary care services in Canada were poorly organized and that this lack of organization had an impact on provincial healthcare systems. Thus, over the past several years, Canadian politicians, decision-makers, clinicians and researchers have reached consensus on the idea that reforming primary care services is a key strategy for improving healthcare system performance. However, it is only fairly recently that substantive initiatives have been launched in various Canadian provinces aimed at transforming primary care services (Hutchison 2008). In Quebec, the government proposed the implementation of family medicine groups (FMGs) as a solution to improve healthcare services organization and delivery.

The aim of this paper is to analyze the FMG model's potential as a lever to improve overall healthcare system performance. As suggested by Champagne and colleagues (2005), we consider performance to be a generic concept that encompasses the notions of efficacy, efficiency, productivity and quality, as well as other indicators encountered when evaluating healthcare organizations, such as funding, resources, payment modalities and governance. It is from this standpoint that we analyze the FMG model and discuss ways in which it might be improved. We begin with a brief history of primary care services organization in Quebec. We then present the FMG model in terms of the four key functions of healthcare systems as identified by the World Health Organization (WHO): (a) funding (including the distribution of monetary funds), (b) generating human and technological resources, (c) providing services to individuals and communities and (d) governance (Murray and Frenk 2000). This framework is useful for identifying and discussing the levers for action that governments could employ to reorganize primary care services. We discuss potential options for improving the reform of primary care services in Quebec, using the family health team (FHT) model implemented in Ontario as a point of reference. Many observers consider the FHT model to be among the most promising in Canada at this time (Glazier and Redelmeier 2010). Moreover, according to a recent Commonwealth Fund survey, Ontario's performance ranks higher on a number of primary care indicators than that of Quebec (CSBE 2010). We conclude with recommendations for enhancing the development of primary care organizational models.

## History of Primary Care Services Organization in Quebec

In Quebec, public funding of healthcare services began with hospitals. In 1957, Canada's federal government proposed a hospital insurance program to be funded jointly with the provinces, to which Quebec subscribed starting in 1961 (Bergeron and Gagnon 2003). Consequently, the healthcare system's first foundations were based on a hospital-centred perspective that provided institutional support to specialists for their clinical activities. It was only later, in 1971, that the Quebec government agreed to provide coverage for medical fees not included in the universal hospital insurance scheme (Gaumer and Fleury 2007). Quebec's health insurance authority, the Régie de l'assurance maladie du Québec (RAMQ), created at that time, became the sole public agency authorized by government to pay for services provided by physicians participating in the system (Lévesque and Bergeron 2003). The state publicly insured payment to physicians, including fees to support operating costs. Thus, private practices were managed by physicians who were self-employed. Initially, these private practices had very few links with the state.

Starting in the early 1970s, the government launched an ambitious reform project by creating local community services centres (CLSCs). These primary care organizations were entirely public, in terms not only of funding, infrastructure and resources, but also of governance. The CLSC model was particularly innovative with regard to governance because it was under the hierarchical responsibility of the Ministry of Health and Social Services (MSSS), and also because it incorporated the social service component into the provision of healthcare services. A variety of professionals work in CLSCs: physicians, nurses, occupational therapists, physiotherapists, nutritionists, psychologists and social workers. CLSCs provide both preventive and curative services, as well as support services such as home care. Originally, CLSCs were meant to be the main entry point into the healthcare system. However, physicians' associations vehemently opposed the practice conditions associated with this innovation, particularly the fact that CLSC physicians were salaried. Few family physicians (20%) have elected to practise in these facilities, and only a small proportion of the population identifies them as their source of primary care services (Bourgueil et al. 2007). At the same time the CLSCs were being implemented, a network of private practices developed rapidly, with the support of Quebec's association of general practitioners, the Fédération des médecins omnipraticiens du Québec, but without any direct control of their activities from the state (Pomey et al. 2009). Today, 147 CLSCs and 800 private practices make up Quebec's primary care network (Lévesque et al. 2007).

Given the CLSCs' relative failure to attract enough physicians and the limitations of primary care services organization at that time, the Clair Commission in 2000 proposed a new primary care organization model, the family medicine group (FMG). A FMG is a group of physicians working in close collaboration with nurses in providing services to enrolled patients on a non-geographic basis. On average, one FMG serves around 15,000 people and has around 10 physicians, two nurses and two administrative support staff. Services are provided Monday through Friday, with and without appointment. On weekends and holidays, a minimal level of walk-in services is available. An on-call telephone response service is staffed by a

physician 24 hours a day, seven days a week, outside of the FMG's working hours for enrolled patients who meet various vulnerability criteria (e.g., elderly, chronically ill) (CSBE 2009).

The FMG model appears to be better accepted by the medical community than the CLSC was. This wider acceptance may be due to the model's greater compatibility with the values of the medical profession, but more specifically to the fact that a fee-for-service remuneration system is maintained. In addition, the majority of FMGs required no new infrastructure because they were created from existing private practices. Since the FMG policy was inaugurated in 2002, the number of accredited practices has been increasing steadily. In April 2011, there were 223 accredited FMGs in Quebec, enrolling more than 25% of the province's population. Nevertheless, the introduction of this new model was not devoid of criticism. Indeed, the model's limitations were quickly identified and adjustments were recommended to improve its impact on the population and the system's overall performance (CSBE 2009).

## Characteristics of the FMG Model

In this section we present the different characteristics of the FMG model in terms of the four functions of healthcare systems as identified by the WHO: (a) funding, (b) resource generation, (c) provision of individual and collective services and (d) governance (Murray and Frenk 2000). We will use this framework to structure our discussion around these levers of action and to assess FMGs' potential for improving primary care services in Quebec.

### *1. Funding as a lever of transformation in the FMG model*

In Quebec, all physicians affiliated with the public system are remunerated by the RAMQ. While nearly all physicians are individually funded by these public funds, most primary care organizations are private enterprises, neither owned nor governed by the state. Thus the provision of medical services by physicians is primarily a private production funded by a public payor. In private practices, administrative activities and rental costs are indirectly funded through physicians' fee-for-service remuneration, because these fees are upwardly adjusted to take into account the practices' operating expenses. In the case of CLSCs, which are public establishments, the ministry provides a global budget. In the FMG model, direct public funding is added to cover specific aspects of operating expenses such as client enrolment. Thus, private medical practices that elect to become FMGs receive additional funding for operating costs, giving them a dual character with respect to funding. They become "public/private" organizations in which a portion of the medical practice's operating costs is directly funded by the ministry, with a large portion still assumed by the physicians (Lévesque et al. 2007). These financial incentives compensate in part for the fact that reimbursement rates for operating costs in private practices have not increased at the same rate as in public establishments, thereby creating an even greater gap between the two types of settings (Hutchison 2008).

Having FMG status confers a certain number of financial subsidies and fee adjustments. A funding envelope is allocated annually, managed by the regional health and social services

agency. The subsidies are calculated based on the number of patients enrolled and cover the salaries of administrative staff and part of the FMG's rental costs for additional space for the staff and nurses. This funding envelope represents \$270,000 on average for a FMG with around 15,000 enrolled patients (MSSS 2008).

The FMG model also provides physicians with additional means of remuneration. A large proportion of remuneration continued to be fee for service, but amounts were added to enhance working conditions in FMGs (Pomey et al. 2009). For instance, doctors working in FMGs receive \$10 per registered patient. Around-the-clock phone access is paid at \$58 per day and the doctor in charge of the FMG receives approximately \$350 per week. The average cost of supplementary remuneration for a FMG is \$275,000 (Bourgueil et al. 2007).

## *2. Resource generation as a lever for change in FMGs*

One of the most enticing characteristics of the FMG model is the opportunity to obtain additional human and material resources. On the one hand, a key feature of the FMG model is that it is based on the work of a group of physicians. Group practice is considered an essential step for addressing issues of accessibility and of service continuity, integration and quality (Beaulieu 2004).

In addition to group medical practice, the FMG brings nurses into private medical practices, where they had previously been only marginally present. Barely 10% of private practices had hired nursing staff, usually only part-time and for technical tasks and in support of medical practice (MSSS 2008). The FMG model calls for the hiring of nurses based on the number of patients enrolled. For example, a FMG with approximately 15,000 enrolled patients receives funding to hire two nurses (70 hours/week). The introduction of nurses into FMGs produced a real change of medical practice in private clinics, by fostering closer collaboration between physicians and nurses. According to a study by the Ministère de la santé et des services sociaux (2008), developing this collaboration took time: for a climate of mutual confidence to be created, for nurses' competencies to be recognized and for the division of responsibilities to be clearly established. Within two to three years after accreditation as a FMG, physicians were sharing clinical activities with nurses more frequently, and nearly all of them regularly referred patients to the nurses. Nurses' activities complemented those of the physicians, and they had a broader and more autonomous role in FMGs, in comparison with the rest of the system. Nurses provided support to medical care given by the physicians, particularly in following chronically ill patients (Beaulieu et al. 2006). According to Beaulieu and colleagues' evaluative study (2006), after a period of adjustment, nurses became much more independent, having their own clientele and doing work that was both more diversified and more complex, often referred to as non-traditional.

Obtaining FMG status also allowed the practices to receive funding for two administrative support staff (secretary and administrative technician) for 10 full-time physicians. These resources were applied, to varying degrees, to patient registration (especially the secretary) and to relationships with the CLSC, regional health and social services agencies, as well as

the MSSS (administrative technician) (Beaulieu et al. 2006). Likewise, the FMG contract provided for the acquisition of computer resources. However, the information systems originally promised were slow in being implemented, and disappointed professionals saw this drawback as a major failure. Only the e-mail system and computer equipment were improved, while access to diagnostic test results, electronic patient records and electronic prescribing have not fully materialized (Beaulieu et al. 2006).

Finally, the FMG model has facilitated physician recruitment and retention. According to the MSSS study (2008), FMG practices were able to attract new physicians and replace departing physicians much more easily than were other practice settings. One factor that may have explained the FMG model's appeal to young physicians compared with traditional practices was that the physicians share much more than the costs of space and secretaries. In particular, physicians see the possibility of sharing more equitably the constraints involved in ensuring accessibility and continuity of care (Bourgueil et al. 2007).

### *3. The change in provision of services to individuals and communities in FMGs*

To obtain FMG accreditation, medical practices must contractually commit to extend their hours of operation, make family physicians more available through working in groups, share activities with nurses and improve medical follow-up of patients. Physician members of a FMG must define the mechanisms by which their group practice will divide the tasks and responsibilities to ensure patient management and follow-up. They are strongly encouraged to share their activities with nurses. This interprofessional collaboration is facilitated by the use of care protocols and the establishment of collective prescriptions. Collective prescriptions (delegated acts) are mechanisms by which the physicians in a practice all sign a care protocol that allows nurses to carry out tasks related to diagnosis and treatment.

Client enrolment is another fundamental element of the FMG model that has changed the provision of individual services. Physicians working in a FMG are jointly responsible for the care of enrolled patients. For family medicine services, priority is given to people who are enrolled. Outside of the FMG's regular hours of operation, enrolled persons who present with urgent conditions are assured of receiving a quick response. This service offer involves working in collaboration with the Info-Santé service (a telephone consultation service) and the 24/7 on-call nurse in the CLSC's home care program, and setting up a 24/7 telephone on-call system staffed by the FMG members. At this time, there is little information available regarding the FMG model's impact on preventive care provision.

### *4. Governance aspects of FMGs*

Generally speaking, in Canada, physicians in private medical practices are not formally obliged to produce a defined set of services for their patients, and they are accountable only for services provided for which they have been paid (Hutchison 2008). No regulatory body has any jurisdiction over the organization of primary care medical services, with the exception of provincial colleges of physicians and surgeons, which are responsible for the quality of

medical practice. Consequently, medical practices have largely been left to their own devices, guided essentially by a professional logic in both their development and their governance (Pineault et al. 2009).

The FMG model changed this situation by introducing a contractual relationship between physicians and the Ministry of Health and Social Services, represented by the regional health and social services agencies. FMGs are organizations based on voluntary participation, in which a group of physicians commit to provide a defined range of services to an enrolled clientele. In exchange for this commitment, as mentioned in the discussion above, the group benefits from added human, material and financial resources. Physician members of a FMG must sign a contract of association that sets out the orientations, the functioning and the responsibilities of each party. The physicians must define the services they offer, particularly with respect to the FMG's days and hours of operation and on-call periods, as well as the support services provided outside the FMG. Once its proposal has been ratified by the MSSS, the FMG's offer of service becomes the basis of a contract. The group signs an agreement with a local health and social services centre (CSSS) partner that addresses the attachment of nurses to the FMG. CSSSs are new local organizations resulting from the merger of long-term care centres, CLSCs and, in most cases, an acute care hospital (Breton et al. 2010). Nurses assigned to a FMG maintain an employment link with the CSSS, but are under the functional authority of the FMG. Maintaining the nurses' institutional link creates a more formal alliance and encourages collaboration among FMGs and between FMGs and the public institutions in that region.

FMGs are accredited for a period of three years, at the end of which they must begin the process of renewing their accreditation. In this renewal process, the FMGs' offer of service is verified and potentially adjusted. This process is also an occasion for setting medium-term objectives for the FMGs. In return, FMGs expect the contracts signed with the CSSSs to bring additional resources. Thus, FMGs' sustainability depends on an agreement negotiated between private practices and the state that is regularly re-evaluated. This formula provides better accountability for primary care service organizations.

### Discussion

The FMG model is thus a policy approach that uses financial levers, supplementary injections of human and material resources, elements of change in professional practices, and governance approaches to modify the organization of primary care services. Several studies have shown that the model has had some success. In a survey of patients followed by an FMG, Beaulieu and colleagues (2006) observed significant improvements in accessibility, physician–nurse coordination, comprehensiveness of care and knowledge of the patient. A study carried out by the MSSS (2008) showed an increase in the number of patients who could communicate easily with the FMG, were able to access medical services in urgent cases or outside the FMG's hours of operation, reported being very satisfied with the quality of their relationship with their physician, considered that their physician's knowledge of their situation had improved,

and finally, spoke with their physician about their consultations with specialists. With regard to effects on service utilization, it appeared that patients followed by FMGs received nearly all their general medical services from the FMG, whereas the comparable rate in non-FMG practices was 70% (MSSS 2008). However, no effect was demonstrated on the use of emergency rooms or on avoidable hospitalizations.

Despite the FMG model's positive effects, there is still room for improvement. In this section, we discuss potential avenues of development in light of the four levers presented earlier in this paper. We next look to the most recent primary care model instituted in Ontario, the family health team (FHT), considered to be among the most promising models in the world (Glazier and Redelmeier 2010). The FHT model is based on a multidisciplinary team that offers a wide range of services, including more hours of access for an enrolled client base. Most physicians are paid under a blended remuneration formula that combines capitation, salary, fees for service and pay-for-performance bonuses, and their practice is supported by a computerized information system. To date, nearly 150 FHTs have been set up in Ontario, in which nearly 720 physicians work, serving a population of nearly one million persons (Rosser et al. 2010).

### *1. Increase the FMG model's impact by changing the physician remuneration system*

With respect to funding, the FMG model has been tentative about introducing payment modalities other than fee for service. In fact, physicians working in FMGs housed in private practices are still largely paid fee for service, even though they also receive a small amount based on client enrolment and, very rarely, an amount for certain other activities. Other payment modalities, such as capitation and payment on a sessional basis, could be adopted to respond better to diverse population needs. The combining of remuneration modalities could help curtail the potentially deleterious effects of fee-for-service payment that encourages unnecessary medical visits and discourages collaboration with other professionals. In Ontario, physicians working in FHTs are paid mostly by capitation (60%). The rest of their income (40%) comes either from fee for service for non-enrolled patients (~30% of their clientele) or payment-for-performance bonuses for preventive activities (Glazier and Redelmeier 2010). Having adopted the concept of patient enrolment, the FMG model has the potential for incorporating a blended model of remuneration (CSBE 2009).

### *2. Increase interdisciplinarity in the FMG model*

The FMG model introduced nurses into private practices where they had previously been only marginally present. FMGs prioritized the development of physician–nurse collaboration in private practices and the strengthening of links with other professionals in the broader public network. Here again, the Ontario experience is helpful. The FHT model saw the introduction of a wide range of healthcare professionals, including registered nurses, nurse practitioners, social workers, pharmacists, psychologists, nutritionists and others. These professionals are paid directly by the FHT. The FHT model could thus inspire FMGs' future evolution towards a broader interdisciplinary team (Beaulieu 2004). However, several questions remain.

For instance, the issue of what disciplines would best respond to the needs of different patient populations should be better understood. Is an interdisciplinary approach always best, and does it justify the cost? To the extent that new remuneration schemes are introduced, as previously discussed, the FMG model could prove to be an excellent foundation on which to build up a broader interdisciplinary approach to the management of chronic illness or mental health problems. Some authors consider any remuneration model based solely on fee for service to be a flawed approach to interdisciplinary practice (Beaulieu et al. 2006; Lévesque et al. 2008). As mentioned earlier, physicians in Ontario's FHTs are predominantly paid by capitation.

The first cohort of nurse practitioners specialized in primary care (around 50) is now entering the workforce in Quebec. The government's objective is to have 500 trained nurse practitioners in Quebec. These nurses are able to do some of the tasks of generalist physicians, such as prescribing certain medications and doing certain diagnostic examinations. They can also perform a number of treatments and procedures, such as suturing wounds and draining abscesses. Therefore, FMGs would appear to be a suitable setting for nurse practitioners. In addition, FMGs that hire nurse practitioners will receive substantial financial support (\$60,000 annually per nurse practitioner) for supervising their practice. This measure, negotiated by the physicians with the MSSS, helps compensate for the effects related to fee-for-service remuneration in FMGs. By way of comparison, Ontario relies on a network of 1,240 primary care nurse practitioners. There are even FHTs managed entirely by nurse practitioners.

### *3. Increase the FMGs' information systems resources*

As we have seen, the FMG model provides funding for the acquisition of computer equipment. However, unlike the FHT model, the FMG model does not yet include the implementation of an electronic medical record system. According to Glazier and Redelmeier (2010), using electronic records allowed FHTs to increase the efficiency of both clinical activities and communications. Quebec is lagging in the implementation of electronic medical records, which are fundamental to support professionals' clinical practices. Also, with electronic records it would be possible to introduce pay for performance to encourage certain types of activities. Without such a system, it is impossible to incorporate these incentives into FMGs.

### *4. The FMG as a basis for better service provision through better clinical governance*

With regard to services provided to individuals and communities, the FMG model is often criticized as a closed model with significant disparities between services provided to patients who are enrolled and those who are not. In this context, one government objective should be to increase enrolment (CSBE 2009). Implementing more FMGs would help achieve this objective. Moreover, because FMGs receive supplementary professional support in the form of nurses, physicians should be able to see more patients each year. Nevertheless, much remains to be done to formalize the activities for which physicians and nurses will be jointly responsible. Likewise, the potential introduction of nurse practitioners into FMGs will need a period of adaptation as collaborative working relationships are developed with the physicians and

nurses already in place. Having nurse practitioners in FMGs should also allow increases in client enrolment. In Ontario, adding nurse practitioners to FHTs made it possible to increase physicians' active patient rosters by about 800 patients per year (Rosser et al. 2010). On average, FHT physicians now follow nearly 2,200 patients per physician per year.

Finally, with regard to governance, the FMG model introduces a contractual relationship between the MSSS and private practices by offering benefits in exchange for commitments related to the organization and delivery of medical services. According to Lamarche (2008), physicians are willing to give up some autonomy in the organization of their clinical practice in exchange for conditions that improve their practice and facilitate their professional lives. Moreover, physicians are willing to accept more formal organizational structure if it allows them to have a medical practice that is more compatible with fundamental professional values (Royal College of Physicians of London 2005). The FHT model also includes a contractual relationship between the state and physicians. Gradual implementation of the FMG model could strengthen the Quebec government's capacity to set up transparent mechanisms of governance and of performance monitoring, to see how well private practices are meeting the population's medical care needs. For example, nearly 25% of people in Quebec currently have no family physician (Pineault et al. 2009). The government could provide incentives and support to physicians in FMGs who would take on a targeted number of new patients annually.

Likewise, significant improvements are needed to develop better clinical governance that would plan services proactively and monitor them frequently to ensure they meet the needs of individuals and of the population being served. To do this, clinicians need to be able to identify not only who their patients are, but also their main characteristics and needs.

The FMG could be an ideal setting in which to apply continuous quality improvement. It would also be important to establish protocols defining the kinds of services to be provided in relation to the community's needs. These goals can be achieved only if there is an information system in place to support practice. Tools should be developed to help professionals better manage their clinical activities and service planning. As well, several international models have highlighted the need to incorporate clinical audits and performance feedback mechanisms. However, given Quebec's significant delays in implementing even electronic medical records, it is surely utopian to imagine that physicians could have clinical practice profiles any time soon.

##### *5. Medical home: An innovative concept to guide the FMG model's evolution?*

In the literature, the "medical home" concept is often described as the vision towards which primary care organizations should ideally be converging (Association of American Medical Colleges 2008; CFPC 2009). This concept is now internationally considered to be a model that improves primary care and patients' access to services. A 2007 survey comparing health-care experiences in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States concluded that "having a 'medical home' that is accessible and helps coordinate care is associated with significantly more positive experiences" (Shoen et al. 2007). The medical home concept is defined as

a patient-centred medical care setting where: 1) patients have a personal family physician who provides and directs their medical care; 2) care is for the patient as a whole; 3) care is coordinated, continuous and comprehensive with patients having access to an inter-professional team; 4) there is enhanced access for appointments; 5) the practice includes well-supported information technology, including an electronic medical record; 6) remuneration supports the model of care; and 7) quality improvement and patient safety are key objectives. (CFPC 2009)

This approach is based on the existence of an ongoing relationship between the patient and the family doctor.

The College of Family Physicians of Canada further defines the medical home as [a] medical office or clinic where each patient would have: (i) Her or his own family doctor; (ii) Other health professionals working together as a team with the patient's own family doctor; (iii) Timely appointments for all visits with the family doctor and with other primary care team members; (iv) Arrangement and coordination of all other medical services, including referrals to consulting specialists; (v) An electronic medical record. (CFPC 2007)

The FMG model implemented in Quebec has several features in common with the medical home. However, as discussed in this paper, there is room for improvement. The FHT model has more of the medical home characteristics (Glazier and Rodelmeier 2010). This approach serves as the basis for primary care improvement in various countries. Most medical associations have adopted this concept, in particular, the American Academy of Family Physicians and the College of Family Physicians of Canada.

### Conclusion

The Quebec government has adopted an incremental approach by building upon physicians' voluntary decision to have their practices accredited as FMGs. The requirements for becoming a FMG encourage medical practices to adopt certain characteristics that can potentially improve healthcare system performance. This gradual approach to changes in funding, resource allocation, service provision and governance appears to be useful for prompting movement in the preferred direction. The two models discussed in this paper introduce mixed models of remuneration. However, the FMG model retains most of the features of fee-for-service, in comparison to the FHT model, which is mainly capitation-based. Both models propose a group medical practice in collaboration with other professionals working in their offices. The FMG model introduces nurses, while the FHT goes further by embracing a broader interdisciplinary team. A major shortcoming of the FMG model is the absence of electronic medical records, unlike the FHTs, which successfully implemented them. The two models are based on an enrolled client base, which significantly transforms how services

are organized. Finally, with respect to governance, both models are contractual. This makes it possible to negotiate for some activities to be carried out in exchange for certain benefits. This is a useful lever for negotiating changes to respond better to actual health needs.

We believe that to improve the FMG model, an essential next step is to bring in electronic medical records. After that, capitation should be increasingly introduced and eventually become the primary method of physician remuneration. Finally, a broad interdisciplinary team should be created to manage an increased roster of clients collaboratively. Thus, we recommend a progressive approach in which the different features of the FMG model are gradually improved. In fact, this was the strategy used in Ontario, which started with family health groups, followed by family health networks and most recently, family health teams and family health organizations.

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