

**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's 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<sup>1</sup> 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 introducing a multidisciplinary approach to medical practice.

After giving an overview of the principal characteristics of this restructuration of the practice of medicine in Quebec, we analyze the main stages that led to the implementation of this reform of front-line services. We pay special attention to the following questions: 1) Why did Quebec decide to use the FMG model to reform front-line services? And 2) Why did Quebec decide in favour of what were, all things told, only minor modifications to the fee-for-service remuneration system for general practitioners working in FMGs?

## Methodology

The data collected for this project come from 13 semi-structured interviews conducted between September 2004 and May 2005 with key actors who helped design and implement FMGs in Quebec. Our sources were former ministers of health and social services, members of the Commission of Study of Health and Social Services (the Clair Commission), administrators from the Quebec Federation of General Practitioners (*Fédération des médecins omnipraticiens du Québec* -- FMOQ), experts, general practitioners working in FMGs and professionals from the Ministry of Health and Social Services (MSSS). The interviews were transcribed, coded and analyzed. We also performed an analysis of the grey literature and the scientific literature in addition to various government reports, briefs and notices published on the subject by different entities.

## What is a FMG?

A document written by the MSSS states that “the establishment of family medicine groups (FMGs) testifies to the determination to change how health care services are organized in Quebec and follows up on the

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<sup>1</sup> The Commission of Study of Health and Social Services was in session from June to December, 2000.

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 lack of available medical care outside regular working hours increased the use of emergency services, which were seen by the public as a guaranteed means of access to services. Problems also existed with respect to the deployment of medical expertise: because services were not organized coherently, doctors were assigned tasks for which their expertise was not necessary. In addition, multiple consultations with more than one doctor complicated the possibility of long-term follow-up, led to the duplication of services and encouraged direct access to specialists. And medical practices increasingly restricted to certain precise activities played a part in the ongoing erosion of the role of the family doctor (MSSS, 2002 and 2003).

### ***Its goals***

The initiators of the FMG project saw the creation of FMGs as the solution to problems with the way services were organized and delivered. The new system was expected to accomplish the following:

- Provide all Quebecers with access to a family doctor;
- Increase the accessibility of services;
- Reinforce overall management, continuity of care and the monitoring of registered patients;
- Improve the delivery of services and the quality of care;
- Develop complementarity with other health care system entities, including the CLSCs<sup>2</sup>;
- Appreciate and enhance the role of family doctors (MSSS, 2002 and 2003).

While the clientele targeted by the new system consisted, in general, of all Quebecers wishing to register with a FMG, special focus was placed on patients with special needs (*la clientele vulnérable*) whose medical condition required more systematic monitoring.

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<sup>2</sup> After the implementation of Law 25 in 2004, the CLSCs merged with residential and long-term care facilities (*Centres d'hébergement et de soins de longue durée* - CHSLD's) and in some cases with hospital centres (HC's) in order to form a new local entity: Centres for Health and Social Services (CSSS's).

## ***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 (*unité d'enseignement en médecine familiale* – UMF) (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 [*l'Agence de développement de réseaux locaux de services de santé et 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 of the patient's 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 Quebec's Health and 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-in basis. Outside of regular hours, FMGs can enter into agreements with other entities in order to provide their patients with access to services at those times. For clients in a precarious medical condition, around-the-clock on-call medical services must be available. FMG practitioners must also participate in the

medical activities identified as priorities by the Regional Department of General Practice (*Département régional de médecine générale* -- DRMG) (MSSS, 2002).

### ***How FMG doctors are remunerated***

Most of the remuneration paid to FMG doctors is by means of fee-for-service payments. Because, however, the principle of FMGs is based on the registration of members for whom the general practitioners and support staff are responsible, the general practitioner also receives \$7 per patient registered. An additional sum of \$7 per visit is paid for patients considered part of the vulnerable clientele, that is to say, patients with special needs (0 to 5 years old and age 75 and up). A doctor who chooses to be on call around-the-clock is also paid a given sum.

To compensate time spent on administrative matters, the doctor in charge of the FMG receives a weekly sum of \$100. In addition, an annual time bank (3 hours per year for each full-time equivalent position) is budgeted to compensate for time spent on doctor-nurse communication and the development of interprofessional collaboration.

Finally, in order to better support needs arising out of the FMG operating system, the MSSS has committed to financing the purchase of computer equipment that will give FMGs the instruments necessary to disseminate clinical data. The MSSS also pays the salaries of nurses and administrative assistants.

### ***The principal actors***

Doctors and nurses are the principal actors in the FMG system. Family doctors “retain their professional autonomy. Their participation in a FMG sets in motion a new working relationship that helps guarantee a better distribution of medical personnel” (MSSS, 2003, p. 47). The role of the family doctor consists of planning the use of a range of health care services, ensuring the care and follow-up of patients, and employing a global clinical approach that includes disease prevention and health promotion activities. He or she must also treat patients and develop his or her medical expertise. He or she can share tasks and responsibilities by delegating certain tasks to nurses, as long as to do so does not contravene current legal obligations<sup>3</sup> (MSSS, 2002 and 2003).

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<sup>3</sup> In 2002, the Act to amend the Professional Code and other legislative provisions as regards the health sector (Bill 90) decreed the reorganization of professional responsibilities and how regulated tasks were shared between specific groups, including doctors and nurses.

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 to the traditional philosophy of the practice of medicine: as such, they enhance traditional medical practice as it is conducted in private practices, CLSCs or in UMFs. Overall, the expected benefits of the program can be evaluated in terms of the innovations inherent to the FMG model: professional collaboration, case management, the dissemination of clinical information and patient registration.

Sustained interdisciplinary collaboration, at the very least between the doctor and the nurse, “fosters client satisfaction and the establishment of collegiality and trust between professionals” (MSSS, 2003, p. 27). Monitoring and case management will ensure continuity and the integration of services. In addition, access to computer technology will facilitate the exchange of clinical data, helping efforts to improve the quality of services (MSSS, 2003).

The core of the idea behind FMGs is registration of the population. The MSSS writes that “registration is a fundamental component of the FMG concept. Registration is a... mutual agreement between the family doctor and the patient, supported by the Regional Board and the MSSS” (MSSS, 2003, p. 33). In this sense, registration is the cornerstone of continuous improvements to continuity and accessibility. In order to provide all Quebecers with a family doctor, the government has estimated that general practitioners must enter into an agreement with and register between 1000 and 2200 patients each (MSSS, 2002). There are drawbacks, however: even as registration has the benefit of giving greater responsibility to professionals as well as the public, some patients can perceive it as an obstacle to their freedom of choice of physician, and some general practitioners can see it as an increase in their responsibility for their clientele (MSSS, 2002 and 2003).

## **The government agenda: The emergence of the problem of how to organize front-line services (~1990-2000)**

To thoroughly understand where the FMG model came from and how it developed, it is necessary to study the events in Quebec that led to the emergence of the problem of how to organize front-line services and helped forge a social consensus on the need to reform this sector. While it is obvious that the issue emerged from the convergence of multiple factors, we retain only a few of the main ones here.

### ***Realization of the partial failure of the CLSC model***

The preoccupation with organizing front-line services dates from the creation of CLSCs in the 1970s, when decision-makers tried to create a portal to medical and social services (FMG-01). The evolution of the CLSC network was hampered by a number of stumbling-blocks. To begin with, CLSCs found themselves quickly check-mated by private practices that were better placed to recruit medical staff.

*"For 20, 30 years, the CLSCs have tried and tried and it still doesn't work. We still have 75 % of doctors outside the health care system who are getting paid by the State" (FMG-04).*

Furthermore, the proliferation of variations on the initial model created disparities in the services offered from one CLSC to the next.

*"The problem with the CLSCs was that we could never make them into a striking force because no two were alike" (FMG-06).*

It became evident, then, that the system was made up of two networks that operated in parallel. Not having succeeded in interesting doctors in the CLSC model (especially with respect to remuneration), the MSSS had, in the 1980s, slowly begun to abandon it.

*"We had our CLSC network and we had the network of private practices, and they were like two networks that worked in parallel" (FMG-08).*

*"So I think that one of the decisive elements, and I don't know when it happened, was when we gave up investing in the CLSCs" (FMG-06).*

*"That's why I don't think we would be wrestling with today's reforms of FMGs if we had done the job right... 25, 30 years ago" (FMG-06).*



## ***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.

“The practice of medicine was kind of evolving and that more or less conflicted with what we thought was necessary for... with what people wanted and what an objective analysis told us about the reality in the clinics” (FMG-07).

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. Furthermore, the increasing number of women in the medical profession brought up new concerns with respect to workloads and the way in which work was organized, because of women’s tendency to prefer practices that are less active or less demanding (*Conseil médical du Québec*, 2001, p. 19). In addition, obvious problems with the coordination and integration of care had the tendency to aggravate public dissatisfaction because those services offered failed to adequately meet public needs. All these factors, together with the aging of the population, staff shortages and the increased complexity of patients’ medical conditions, posed an immediate risk of overturning discipline and plunging the profession of family medicine into a state of crisis (FMG-01).

## ***The emergency room crisis***

When Pauline Marois took office as Minister of State for Health and Social Services in early 1999, she made a tour of the most influential actors in the network. Following her tour, she decided to make overcrowding in emergency rooms a priority of her mandate.

Indeed, towards the end of the 1990s, Quebec was experiencing the counter effects of a major restructuration of the health care system. One such repercussion was the recurring problem of emergency room overcrowding, a direct consequence of problems of accessibility and the lack of continuity of care in front-line services.

This issue led the MSSS to hold two national forums on emergency rooms, both of which focussed on the search for solutions and stimulated further reflection within the Department of Medical and University Affairs (*Direction des affaires médicales et universitaires*) of the MSSS in 1999. Indeed, department professionals had become interested in the Ontario model for front-line services and worked to adapt it to the Quebec

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*) recommended better follow-up for victims of chronic disorders and vulnerable clientele and greater coordination between front-line services and the emergency room (MSSS, 1999, p. 17). The hypothesis of the Forum was that if services were reinforced upstream, that is to say, on the front line, then patients would have alternatives to the emergency room and problems downstream would be less severe.

### ***The pro-change position of the medical corps***

As early as 1996, the Quebec Federation of General Practitioners (*La Fédération des médecins omnipraticiens du Québec – FMOQ*) began to work on the problem of how to reorganize the practice of medicine in Quebec (FMG-01). In that context, it proposed the creation of a Regional Department of General Medicine (*Département régional de médecine générale – DRMG*)<sup>4</sup> for each Regional Board. This proposal was taken up and implemented by the MSSS.

In 2000, The College of Family Physicians of Canada filed a report entitled, “Primary Care and Family Medicine in Canada: A Prescription for Renewal”. The report proposed a model for front-line services based on family practice networks made up of interdisciplinary teams (CMFC, 2000).

The same year, the FMOQ published the recommendations of a study conducted by Secor, a private firm. Right from the outset, the report revealed that “many doctors who are in possession of their own private practice are discouraged and worried about the future. They wonder what role will be left for private doctors’ offices in the wake of the many changes that have taken place and will continue to take place in the health care and social service system” (Secor, 2000, p. 103). The FMOQ’s recommendations were firmly in favour of a model that would reorganize the practice of medicine into private practices, which they felt were the principal locations where front-line services were provided. Indeed, most of the report’s recommendations focussed on the development of an entrepreneurial environment, ensuring the promotion and profitability of private practice and encouraging general practitioners to develop business plans (Secor, 2000, p. 132-134).

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<sup>4</sup> Working under the Agencies, the mandate of the DRMGs is to propose and implement medical staffing plans and plans for the regional organization of medical services, including an integrated network for on-call medical services (Act respecting health services and social services).

Although the conclusions of the report amounted to neither more nor less than a business plan for medical practices, the Secor report paved the way for the main principles that would later characterize the FMG model. Namely, the report recommended the improvement of accessibility, continuity and case management by having doctors' offices reorganize themselves within integrated networks (Secor, 2000, p. 132-133). With the filing of the Secor report, then, the FMOQ took a public position with respect to the direction it hoped that the transformation of front-line services would take (FMG-01).

"And the consensus among those involved, at least insofar as the internal reorganization of the practice of medicine was concerned, was quite large, it was a pretty solid consensus, so really there was this idea that groups of doctors were responsible for a given population, working as an interdisciplinary team, no longer on their own, the doctor who was somewhat of an independent entrepreneur, etc" (FMG-08).

### ***Research activity and the stance of educational institutions***

At the same time that the medical profession was growing aware of the issues, the stance of the scientific community helped raise awareness among network participants, making research one of the elements that set off the process of reform.

"The Health Transition Fund (HTF) was a \$150 million fund which from 1997-2001 supported 140 projects across Canada to test and evaluate innovative ways to deliver health care services" (Health Canada, 2004). Because research into primary health care was a priority, projects conducted in Quebec proposed solutions that built upon changes to the organization and practice of front-line services.

At the same time, the directors of family medicine of Quebec's four universities published an article on the role of the general practitioner and the population health approach. Within university teaching facilities for family medicine, especially family medicine teaching units (*unités d'enseignement en médecine familiale* – UMFs), researchers had also studied ways to modify teaching methods and principles in the field of family medicine.

### ***The dawn of the debate within the MSSS***

In the late 1990s, the reorganization of front-line services was also a hot topic at the MSSS. Faced with the nation-wide realization that it had become necessary to reorganize services, the MSSS had begun to record examples of reforms undertaken in Great Britain and Ontario pursuant, in the latter case, to the filing of the Sinclair report.

## **The decision-making agenda: The central role of the Clair Commission (2000)**

Former members of the party in power have gone so far as to admit that as early as 1999-2000, the government had a pretty clear idea of what would be necessary in order to reform front-line services. Because the financial situation at the time was not amenable to the injection of new funds, however, the government chose to create a commission of inquiry to take stock of the situation and propose possible solutions.

*"They asked Michel Clair, among others, to examine the whole system, the entire operations, and to propose ways to better adapt it. That was their response. When you don't know what to do, you form a committee. They didn't know what to do anymore because there was an easy answer, but it took money and there wasn't any. This was at the end of the budget cuts" (FMG-05).*

In June 2000, Health Minister Pauline Marois formed the Commission of Study for Health and Social Services under the leadership of Michel Clair. While the need to reform the organization of front-line services seemed to make consensus throughout Canada and Quebec, there was less agreement on the best means to achieve such a reform. The proceedings of the Clair Commission would serve to better orient the debate on the issue: indeed, our information shows that the deliberations begun by the commissioners would be the element that gave rise and form to the FMG model that would later be recommended for adoption and implementation throughout Quebec. Even if, formally speaking, discussion of the issue had begun some time before, the real authorship of the FMG model belongs to the commissioners.

### ***The Commission's proceedings***

While it is true that the use of research data played an important role in the development of the model, it is interesting to note that the method adopted by the Clair Commission, which would eventually give birth to the FMG project, went further than that: it constituted a research approach in the strict sense of the term. The commissioners explored existing organizational models for front-line services both abroad and in Canada. In order to do so, they undertook reconnaissance visits of establishments, reviewed the literature and created panels of experts. The commission took particular interest in two cases: the British model of General Practitioner (GP) Fundholders, and the American Health Maintenance Organization (HMO) model, especially Kaiser Permanente. These two foreign models had certain elements in common: firstly, a solid organization based on the sharing of material and human resources, and secondly, an emphasis on

population-based responsibility and integration. In this way, the FMG model consisted, in fact, of a compromise between American HMO's and the 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 term "FMG".

*"Is it essential that they be called "family medicine groups"? No. They could be called something else. What matters are the fundamental characteristics of the program" (PR-07).*

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.

*"Clair came to us with the model of family medicine groups. It was hardly original, but it had the merit of being adapted for Quebec, in Quebec" (FMG-05).*

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

*"We wanted there to be an exchange of ideas, we wanted people to take our ideas further, so that when we laid them out in our report, our ideas, they would have already been circulated, they would have already garnered some support" (FMG-07).*

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).

*"What we really accomplished was to crystallize and express an idea, I would say, and get it out in the public arena and put it on the government agenda. That was our real contribution" (FMG-07).*

"And it was packaged, if you know what I mean, and it was brought to the political arena when the report commissioned by the government of the time was filed" (FMG-07).

"In the end our approach was something like that, to say: let's suggest something and we'll change it as we go along" (FMG-07).

### ***The main recommendations of the Clair Commission***

Writing about how the program would work, the commissioners' final recommendation was that "the organization of a primary care network constitute the main foundation of the health and social services system... [that] this network be created on the basis of the current dual reality of CLSCs and physicians' offices" (Emerging Solutions, 2001, p. S.VI).

"So we just tried to have a concept that was extremely operational rather than theoretical or categorical. I'd say that our concern was with operations. After that, whether it is a coop, a CLSC or a private practice, that was a non-issue insofar as I was concerned. The main thing was that the population benefit from care by a team of front-line professionals" (PR-07).

To reach this goal, FMGs had to allow general practitioners to work collectively with the support of clinical nurses and to have the responsibility for a well-defined registered population. The report proposed a mixed remuneration system consisting of three elements: capitation according to the number of patients registered, a base amount and fee-for-service payment.

The establishment of FMGs was to be entrusted to clinicians from various professions, regrouped under the tutelage of a reputable doctor recognized by his peers. The commission also recommended that the implementation of the model in Quebec be both gradual and voluntary: to accomplish this, they proposed mechanisms that were flexible and adaptable (CESSSS, 2000, p. 52-53). The idea was not to introduce pilot projects but rather to issue an invitation to tender before negotiating details with the FMOQ (FMG-02).

"We thought we should start off several models. We didn't want an agreement with the FMOQ either, apart from saying: We'll evaluate the models and see which ones are the most promising, so that the agreements to be reached between the FMOQ, the ministry and all that, allow for the emergence of the greatest possible number... of models" (PR-07).

## **The choice of a policy: 2001-2002**

The concept of FMGs was by far the most popular element of the Clair report and was among the first to be taken up by the government.

### ***The development and realization of the model***

The Clair report was officially submitted to Health Minister Pauline Marois on December 18, 2000. The government appropriated it very quickly. As soon as February 2001, less than two months after the report had been submitted, Marois announced the government's intention to proceed with the implementation of FMGs.

"I told you that the machine got rolling... the government was very quick to take over the Clair Report and commit to putting it into place. The politicians realized that what people liked, among other things, was the notion of around-the-clock access" (FMG-01).

After Mrs. Marois was replaced by Rémi Trudel as Minister of Health and Social Services in March 2001, Trudel informed the Council of Ministers that FMGs would be the first recommendation he would put into place. There was significant political will to go ahead with the project. The government's strategy was made up of several elements.

### **Entrusting the MSSS with the execution of the project**

The project was rapidly entrusted to the Ministry of Health and Social Services. Those in charge of the dossier set up two implementation systems as well as a management committee. The Ministry Working Group (*Groupe de travail ministériel* -- GTM), composed of representatives from different professional orders and unions (FMOQ) in addition to university professionals, was responsible for providing recommendations to the minister: this entity played a political role. The Implementation Support Team (*Groupe de soutien à l'implantation* -- GSI) was made up of clinicians (doctors) and professionals (nurses, social workers and pharmacists). Its role was "to help develop the overall FMG concept, including the role of the professionals involved, the agreements and the operating tools" (MSSS, 2003, p. 17). The mandate of this group was more operational. Finally, a management committee made up of deputy ministers, CEO's and a team of coordinators was made responsible for managing the proceedings and seeing to the overall consistency of the project (MSSS, 2003).

"At the same time, the minister had a problem because politically, he wasn't sure how to handle it, so he formed a ministerial committee, a ministerial committee that

answered directly to the ministry with... one of Trudel's political aides was on the committee as his representative" (FMG-04).

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's 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.

"Yes, I think that they had a role to play, defining the model, but my impression was that they still had their hands tied in many ways. Not just by the Treasury Board but also by the Department of Labour Relations and by... in other words, the machine was very quick to tell them what they could and couldn't do" (FMG-07).

## **Negotiating and implementing simultaneously**

Clair recommended that an implementation support group "under the authority of the MSSS, would be a "champion" of this primary-case vision. It would collaborate closely with the DRMGs and regional boards to specify operating conditions and identify the factors of success; stimulate and foster the development of projects; help with the organizational and operational aspects of projects; intervene with various authorities to iron out difficulties; and ensure continuous evaluation of projects" (Emerging Solutions, 2001, p. 53). In other words, Clair proposed a flexible implementation procedure, originating with and supported by the medical community. In contrast, the strategy of the MSSS was to develop the most detailed, centralized model possible, without discussing it with the key actors affected by the reform. In other words, the implementation strategy adopted by the MSSS ignored a number of the conditions for implementation



judged essential by the Clair Commission. Rather than negotiate details of the project with the FMOQ prior to implementation, then, the government chose to conduct negotiations and implement FMGs at the same time.

*"We chose the route of implementing and negotiating at the same time: we weren't going to wait until we negotiated the fine details of salaries and remuneration" (FMG-05).*

Feeling that it was being kept at a distance from the negotiations, the FMOQ was not particularly enthusiastic about this strategy.

*"The Federation felt somewhat left out, so we kind of had to make up for that, and sit down, the people here at the ministry had to sit down with the people from the Federation and start to negotiate a number of procedures, well, everything that had to do with remuneration. Everything that might impact doctors' remuneration had to be negotiated with the Federation, that was a must" (FMG-08).*

*"So we knew that there would eventually be changes or that changes would have to be negotiated between the ministry and the federation in order to legitimate that way of operating" (FMG-09).*

The FMOQ lost no time in denouncing the government's justification of the project and made it clear that without its support, the reform would not take place. In a news bulletin published in 2001, the Federation declared, "FMGs are not a panacea! The FMOQ does not believe that FMGs are the only way to organize general medicine in Quebec" (FMOQ, 2001, p. 1). The Federation demanded that the MSSS clarify the conditions under which doctors would on-call around-the-clock for the at-risk clientele and insisted that the MSSS specify salary parameters. In summary, the FMOQ's position was that it would not accept "the implementation of FMGs without negotiating operating conditions and terms of remuneration" (FMOQ, 2001, p. 3).

This strategy helped foster the feeling among doctors of political meddling and governmental control of medical personnel.

*"It was a difficult dossier to bring home, I think, one of the most difficult I would say, because there were a lot of legal parameters, lots of contracts, I mean, FMGs signed contracts with each other, and then there was a proliferation of contracts. It really threw off the Federation, they were really worried that doctors wouldn't be satisfied, it meant real changes, and all that ..." (FMG-11).*

*"It meant that in areas where things were already underway, where general practitioners were already engaged and discussing things among themselves, it was a*

welcome move. There was still the problem of doctors' paranoia about being controlled by the government" (FMG-06).

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 wished to capitalize on a number of elements, including around-the-clock access, a concept that it considered to be politically advantageous. There were, however, a number of procedures to be negotiated.

"..., people criticized how quickly it got started, and it's true that it was quick to get off the ground, if it hadn't have happened so quickly it might not have happened at all" (FMG-09).

"I was surprised because in my opinion, they should have taken a little more time and gone further in their analysis of the conditions under which the FMGs should be established. Like remuneration and the organization of work. Except that obviously it was a concept that was popular with the public" (FMG-07).

"But then came a year where, you know, they talked, the minister started to look nuts, they had announced the FMGs and then all of a sudden, oops! Nothing else happened. Sure, we explained to him, we're negotiating, we're negotiating, and then they put pressure on the negotiations. Bad idea! Because putting pressure on the negotiations played into the hands of the federations" (FMG-10).

The feeling of urgency was fuelled by certain contextual factors. For one thing, the establishment of FMGs had been announced in the pre-election period. Because of that, the FMG project became a key issue for the re-election of the PQ (Parti Québécois) government.

“..., all of a sudden there comes a politician who needs it to work right away, and then he screws it up because hey! It's a good idea, so he grabs it from you and he pushes it through and it's been done all wrong” (FMG-10).

“Everything we said, he did the opposite. So... but I have to say that it was bad timing. I'm not sure that he would have respected it anyway, because for him, there was a window of opportunity, plus there were the elections, and he was afraid” (FMG-04).

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.

“Now, what explains the fact that the announcement took place in May 2001, why was it absolutely necessary to announce everything then and already estimate that there would be 300 in four years, I think it was because of the personality of the minister in office. Personally I see no other reason for the hurry to make a sudden announcement” (FMG-08).

In addition, some sources brought up the minister's lack of understanding of the complexity of the job. It is possible that he underestimated the amount of work required to turn the Clair Commission's proposal into a functional project on the ground. Many aspects of the model had to be negotiated with the professionals.

“They needed to be negotiated, those aspects, we had to define them, negotiate them and everyone needed to be in agreement on what they meant, plus the project needed a legal framework, family medicine groups didn't exist as a legal entity. So there was a tremendous amount of work to be done beforehand, plus negotiations, plus discussions, before they could say, Ta-da! Let's start the movement and we want 20 up and running in 6 months” (FMG-08).

“Yes, on the dossier, etc., and then came the political pressure. They had to make some [FMGs], they had to make some, but they were in a hurry, and so on and so forth. Mrs. Marois left, but then Trudel took over, he wanted 20, Landry wanted 100, he wanted 300, and so on. And it was a mess, because... it was much more complicated than I would have thought, much more complicated than that” (FMG-10).

“I don't think that the politicians grasped the complexity of the thing. For them it had turned into an interesting proposition” (FMG-10).

In this way, political pressures led to a trend towards the standardization of the FMG model.

## ***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's intention was to make registration of the clientele with 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.

"From the public's point of view, the culture in Canada is not in favour of registration. So, the democratic rhetoric was opposed to registration. And of course that found an echo in the professional rhetoric of doctors, who continue to be very, very reticent with respect to registration" (FMG-02).

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, in the form of a contract, would identify the physician as the patient's one and only family doctor and set forth the services offered and the conditions attached to the patient's registration.

Specifically speaking, the patient would agree to "consult [his] family doctor or, in the absence of the doctor, another doctor from the groupe de médecine de famille, except in emergency or when travelling or otherwise staying outside of his area of residence" (MSSS, 2003, p. G2). Even though registration was voluntary, then, the agreement would curtail the patient's freedom of choice. Furthermore, did doctors run the risk of finding themselves pursued in a court of law, were the patient to decide that the services offered were not adequate or had not been respected or otherwise failed to meet his or her expectations?

"There was the fear and now, people don't bring it up anymore, but the fact was that the patient was signing something, the patient could call us anytime, and then he could sue us if, let's say, we didn't fulfill his needs because hey, a contract was involved. Whereas before, there had been an unspoken understanding, but no agreement... now, you were signing something" (FMG-04).

In one of its bulletins, the FMOQ squarely enunciated the fundamental issues with registration: “the Clair Commission suggests that patients register with a FMG. What are the doctor and the patient committing to when they take part in the registration process? What will the registration procedure look like? What happens to patients who don’t wish to register? And what if there are too many patients?” (FMOQ, 2001, p. 2).

Selling the concept of registration to doctors was made even harder by the fact that some doctors actually felt that there could be a fit between registration and payment by capitation: in contrast, the medical associations looked on this concept with extreme disfavour. Furthermore, the FMOQ demanded that financial incentives be included if registration were to occur.

“At the very beginning, it was out of the question, people didn’t want to register the clientele because for them it was a simple equation: registration/capitation. And the word capitation was still scary, of course. People think about the British model, maybe that’s it, where capitation = fund holding. But they could also conceive of capitation without necessarily the possibility of managing every detail. So they saw it as interference, a loss of professional autonomy, and so on” (FMG-09).

The MSSS was also determined to make around-the-clock access an essential element of the FMG model. Following negotiations with the FMOQ, the original idea was diluted into making such access available only to victims of a chronic disorder and to patients with a severe loss of autonomy.

“The question of around-the-clock access – because we talked about it earlier – was slowly... watered down because we really *focussed* on monitoring and we were able to convince the ministry that 24-hour access should be available mainly to people living at home with a severe loss of autonomy as well as to certain unstable patients” (FMG-01).

## **Remuneration**

The Clair Commission had been adamant about the necessity to incorporate a mixed remuneration system into the establishment of FMGs. It wrote that “the family physician who works in a *Family Medicine Group*, an office or a CLSC, would be paid according to a mixed system: an amount based on the number of people registered and their health and social characteristics; a lump sum for participation in certain programs (CHSLD, emergency, CLSC programs, vulnerable population groups, etc.), according to contracts or agreements; and a fee-for-service amount either for specific prevention activities or to support productivity in high-volume activities” (Emerging Solutions, 2001, p. 52). The change to the remuneration system was considered to be the cornerstone of the reform of professional practices and the organization of front-line services.

"When you want to bring about a change in practice, you have to think about the conditions that will be the most helpful to bringing that about. And remuneration is one of those conditions" (FMG-06).

"It [the government] wants to make them do things without paying extra. That's not to say that doctors will only do something if they are paid for it, but they shouldn't be penalized either" (FMG-04).

While fee-for-service payment was a widespread practice in Quebec, some general practitioners were also paid by other means, such as salaries for doctors in CLSCs, an hourly fee for multidisciplinary teams, and a daily amount supplemented by a percentage of services for other professionals (FMG-01). With the introduction of FMGs, however, the goal of the MSSS was to reconsider doctors' terms of remuneration in order to introduce the aspect of capitation at the negotiations of the interim agreement on remuneration. The objective was not necessarily to introduce across-the-board capitation, but rather to progressively decrease the proportion of fee-for-service payment.

In the beginning, the FMOQ staunchly opposed to the introduction of capitation, seeing it as a threat to doctors' autonomy. The FMOQ pointed out the difficulty of implementing the principle of capitation in a system where patients were free to consult the doctor of their choice. The strategy of the FMOQ was to negotiate better terms of remuneration for general practitioners without foregoing the fee-for-service mode of payment.

"We put together a bargaining table and we put it on the table as an option. People had the option of choosing capitation, and some doctors might have chosen that. Yet again, though, the Federation of General Practitioners opposed it because they were afraid of where it could lead, they were afraid it might become widespread as a practice. We put it out there... at the negotiations" (FMG-05).

The negotiations of the interim agreement on remuneration began around June 2001 and the FMOQ and the MSSS arrived at an agreement in 2002. The government had very little leeway because its hands were tied, so to speak, by the financial constraints imposed by the Treasury Council. The arrived-at solution was a compromise on a system of mixed remuneration: a large proportion of remuneration continued to be fee-for-service, but other amounts were added to enhance working conditions in FMGs. In short, remuneration bonuses were granted without additional professional obligation on the part of doctors working in FMGs.

"It's one thing to say that we would pay 100% by capitation, that was unthinkable, I mean, it really wasn't the model we had in mind. We thought more in terms of a mixed payment formula, but even when you talk about the mixed formula, well, do you mean 80-20, 40-60, 30-70? You know, we really had to keep on going in order to

try to figure out which would be the formula, in the end, that would give us the most advantages and still be acceptable to the doctors" (FMG-08).

"But when it came time to decide how to apply that, with a percentage of services, say 30 % or 50 %, and... the loose organizational structure of the FMGs meant that a patient, I mean the patient always has the freedom to consult the doctor of his choice, the doctor too has the right to work wherever he wants, he can go work in the walk-in clinic next door to his FMG, that's not forbidden either. So it's complete freedom for everyone really" (FMG-11).

All in all, changes to the remuneration system were minor. Specifically, the new measures were as follows:

- The sum of \$7 for registration of the patient (only for doctors in FMGs);
- The sum of \$7 for the care of patients considered part of the vulnerable clientele (ages 0 to 5 and age 75 and over) (per visit/per patient) (for all doctors, whether or not in FMGs);
- An annual time bank of 3 hours for each full-time equivalent (FTE) position to compensate time spent on interprofessional communication and collaboration (only for doctors in FMGs);
- The sum of \$100 per week for management duties, payable to the doctor in charge of the FMG (only for doctors in FMGs);
- An amount for doctors who choose to be on call around the clock (for territories where this service did not already exist) (for all doctors, whether or not in FMGs).

This agreement allowed doctors to continue to practice in a financially stable environment. The interim agreement was valid for 3 years.

It is important to note that the remuneration of general practitioners in Quebec has never been regulated by a definitive agreement. Rather, more than 2500 agreements regulate remuneration for the sector. Because salary negotiations are centralized (FMOQ), any sum paid by the government to a general practitioner working in a FMG was also required to be paid to all other general practitioners in the province. This situation substantially weakened the structure of financial incentives that the MSSS had originally wished to put into place in order to attract doctors to FMGs.

"And especially that those doctors, who participated, let's say, in FMGs, didn't feel that they were the fall guys, I mean one on hand here's a system that keeps operating without any restrictions, making money hand over fist, and across the street is another system with constraints, still making money but with constraints, [the doctor] has to be on call, [he] has to follow the clientele, and [he] doesn't really have any major gains compared to the first system ..." (FMG-04).

"But what happened was that the Federation was negotiating at the same time, and of course the negotiators here at the ministry gave \$7 for vulnerable patients, they gave it to all doctors. So that was a little like throwing cold water on the project, because what was left as an incentive after that? \$7 for registration" (FMG-08).

Doctors working in private practice, then, also received the amount allocated for the case management of patients with special needs. Another source of controversy, however, was the issue of the amount paid for patient registration: there was no system of incentives or restrictions were the patient and the doctor to violate their agreement.

"Just \$7... I know that it's \$7, but if you have 2000 patients, it winds up being a lot of money just the same, I'm not denying that, but it's not a significant amount that would mean that, if the patient, after a year, weren't happy because you hadn't followed him, because you weren't not available, he could leave, it wouldn't change much" (FMG-04).

"How can we dream up a remuneration system that is essentially based on loyalty between two partners: the patient and his doctor, where one of the partners has no responsibility and the other is penalized if.... is penalized, actually, for the disloyalty of the first?" (FMG-01).

The question of the delegation of tasks to nurses, lauded in the FMG model, was similarly problematic because general practitioners were afraid of losing revenue were they to transfer responsibilities to nurses.

"Right now, the tasks we delegate to nurses are those that earn us the most money. In the present system, the most rewarding tasks, financially speaking, are the easy ones that a nurse could do. So in that respect the financial incentives are backwards, completely backwards. And for me, the whole notion of financial incentives is fundamental. It's fundamental" (FMG-07).

"In fact, that's what happens outside the big cities: the doctor is in such demand that even if the nurse were to see patients, he wouldn't lose out. But if you are somewhere where things are a little more competitive, the fact that your patients are seen by the nurse and you don't see the patients, well you don't make money" (FMG-04).

In closing, many saw the changes to the terms of remuneration in FMGs, which were, all things told, minor changes only, as proof of a lack of political will to resolve the issue. If the FMG model of medical practice is not valued, politically and by means of financial incentives, there is fear that it will disappear altogether.

"So in my opinion, the political pressure meant that there was no real deliberation about what we wanted to do, on what kind of system of remuneration we were going to have" (FMG-07).



"Because then you're getting into a history of centralized negotiations with the Treasury Board, you're into the political balance of power, there is an economic status quo that dates from the 1970s, and I get the feeling that there are very few administrations that are willing to put themselves ..., to take the risk of going up against the medical profession" (FMG-07).

"The main pitfall with respect to remuneration, with FMGs, I think, will come when we talk about the permanent... negotiations" (FMG-01).

## **Links with the CLSCs**

General practitioners who wanted to form a FMG had to hire nurses. The MSSS, however, had decreed that FMG nurses would have to come from the CLSCs because their familiarity with the network would give the FMGs better working relations with the network of front-line social services. This decision, however, was not without critics. Some of those involved believed it to be politically motivated.

"When the minister came up with the FMG project in 2001, it was very important that people create relationships with the CLSCs" (FMG-04).

"But what I think happened - and this is just my interpretation - I think that there was a political decision, probably because of pressure, because of pressure by the Association of CLSCs because obviously, the CLSCs felt betrayed, somewhat, by the idea of FMGs" (FMG-04).

"At the beginning, lots of people said that they found it too complicated, working out agreements and it's true that it was complicated because we were forcing them to sit down together, to look each other in the eyes, to come to an agreement, then to make a link with the CLSCs, and all that, so it's true that it was complicated in the beginning. But it kick-started the relationship, it forced them to talk to each other. In the end they told us that it made them talk to each other and work out how to get organized" (FMG-09).

## **The case of Montreal**

At the time that the FMG model was being implemented in various territories, the project ran up against difficulties with the general practitioners of the Montreal area, who were reticent to adopt it. As soon as the project was announced, the University of Montreal began lobbying the DRMG, the Regional Board and the MSSS in order to press its position on the issue. The DRMG's position was to reject the initial model proposed by the MSSS, working instead on developing its own version of a model adapted to the situation in Montreal. The argument it used to support its position was the unique reality of medical practice in

Montreal: more solo practices, little or no case management, more walk-in clinics and a multi-ethnic clientele with as many different issues as countries of origin.

"And it's true that the way doctors practice in Montreal is very different from how they practice elsewhere in Quebec. So it's different, and the needs are different, and... there's a large clientele that comes in just for the day, to Montreal, to the walk-in clinics, but the main clientele is in the downtown core" (FMG-10).

"Without a doubt, it's in Montreal that it goes most against the grain. There are a tremendous amount of doctors... I don't have the figures, but it's obvious that there is a huge number of general practitioners whose practices are probably not all that sought-after" (FMG-02).

Despite the obvious need for continuity and patient care, medical resources were scarce, making the project unattractive from a political point of view.

In this way, Montreal resisted implementation of FMGs. A stand-off took place in the fall of 2002 between the president of the FMOQ and the minister of health on the subject of FMGs in Montreal. The minister's position was that there would be no exceptions for the Montreal area. The FMOQ, in contrast, wanted to work out an alternative model adapted for Montreal, without jeopardizing a negotiated agreement on increased remuneration in the future.

"But in the Montreal area, it was turned down point-blank right from the start. The DRMG didn't want it. They wanted to keep having walk-ins, and they won. They won, it took three or four years. They have just signed the agreement. They call them clinical networks" (FMG-10).

"Well, the truth is that in Montreal they wanted no structure at all, they were really very, very averse" (FMG-11).

Some players believe that the resistance stemmed from the way the minister handled the dossier, from his determination to operate independently of the DRMG.

"It was too bad in Montreal because the way that Mr. Trudel did it, of course, it was to handle the whole thing from the top down, completely top down, whereas the vision of Mr. Clair was that the DRMGs of the area be involved, there were more choices ..." (FMG-02)

"And what's more, is that it completely by-passed the DRMG. Even if, in the end, the fact was that the DRMG would have to sign the agreement. No. It was very... it was very poorly done, it was... everyone says so, now. Obviously, it was a very poor way of beginning" (FMG-02).

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

"The majority of doctors in the FMOQ are from Montreal, and the majority of doctors in Montreal are in private practice... so when it's time to make decisions and vote for the leaders of the FMOQ, they're the ones who decide" (FMG-07).

The first FMG implemented in Montreal was a university FMG made from the fusion of a CLSC and a UMF. At the time of writing, there are only 11 accredited FMGs on the entire island of Montreal.

## **Analysis of the reform process**

### ***Institutional factors***

Ever since the early 1990s, both the federal government and the Government of Quebec recognized the need to reform front-line services in Canada. Discussions and research took place to decide on the best way to proceed. In Quebec, the groundwork for an initial model for the organization of services was laid by institutional actors, such as medical associations. In the late 1990s, one such association, the FMOQ, commissioned a report from Secor, a private firm, to study how work was structured in private practices. Secor's report was to provide the first contours of the FMG model.

Later, the Clair Commission took up a certain number of ideas from the Secor report while simultaneously considering other Quebec professionals' experiences with the reorganization of front-line services. In its final report, the Commission proposed the foundations of an organizational structure that would later constitute the cornerstone of the FMG model. It is clear, then, that the Commission did not create the parameters of FMGs from scratch. Its role, rather, was to help make the model public, allowing innovations to emerge and causing the issue to be put on the governmental agenda. In this sense, it played a principal role in getting the project off the ground.

Once the initial outline of the model had been completed, the MSSS assumed responsibility for its execution and quickly took over the project. An implementation working committee and a follow-up committee were rapidly created to oversee the project's implementation, but they were closely supervised by the political body. Quebec's health ministers played a preponderant role in the promotion of the model because some of its innovations, mainly the improved accessibility to services, appeared to be politically advantageous,

especially in the pre-election period. Because of this context, the establishment of FMGs quickly became a priority for the PQ government.

### ***Ideational factors***

Several sources inspired the FMG model. Firstly, foreign experiences, especially those from Great Britain (GP Fundholders – for the aspect of patient care), Sweden and the United States (Kaiser-type HMO's – for their continuity of care mechanisms), provoked ideas in the the commissioners from the Clair group who developed the project. Concrete experiences elsewhere in Canada, however, especially in Ontario (Primary Health Groups), were to have the greatest influence on the development of the Quebec FMG model as put into operation by the MSSS. Indeed, the general features of the two models are similar: the size of the groups, accessibility, registration, continuity, case management and interprofessional collaboration. So while the proceedings of the Clair Commission had included organizing expert forums on foreign and Canadian experiences with restructuring front-line services, the initial project as proposed by Clair was reworked during the execution phase by the MSSS. Research results were another source of inspiration for the model's design.

The government was quick to follow up on the recommendations of the Clair Commission with respect to FMGs because there seemed to be consensus among the players on the general values and central principles expressed in the model. Indeed, the government as well as the public and the medical profession all hoped to find a solution to the problem of accessibility and were agreed on the need for more equity, improved continuity of care, better disease prevention and health promotion, improved case management and greater interprofessional collaboration. It is true that the Clair Commission, in its handling of the project's development, had worked to find consensus on the main principles. This initial exercise of agreement-finding having been made, the more concrete development of project parameters was rendered that much easier.

But when it came time to translate the general principles of the concept into a concrete means of operating, difficulties materialized and differences of opinion began to emerge. Because of resistance, the government had to decrease emphasis on elements that ought to have been key characteristics of the model: registration, case management, and changes to the remuneration system.

It is true that the act of implementing FMGs was no mean task, given how the health system had evolved since 1970. The implementation of a new reform needed to take this reality into account. Considerable

effort had originally been made to build the CLSC network, with a view to making it the single portal to front-line medical and social services. Afterwards, however, it became clear that front-line medical services were mostly provided by private practices, doctors having turned their noses up at the CLSC model. The introduction of FMGs confirmed this trend, going so far as to risk the very existence of the CLSC network. The CLSC model of service provision had created problems of accessibility in an environment short of doctors. The goal was therefore to create a policy that would structure the practice of family medicine while also stimulating doctors to work in collaboration.

### ***Interest group factors***

In general, the public wanted better access to services and monitoring by general practitioners. The public's demands, however, lacked cohesion. Some patients' rights groups were favourable to the proposal of FMGs, but made no specific requirements with respect to their implementation. In contrast, the *Coalition Solidarité Santé* denounced the privatization of services that the FMG model would bring about by virtue of the fact that it mostly involved private practices.

University researchers and experts were very active in the development and promotion of the FMG model: they were especially present at hearings with the Clair Commission. This constituency promoted the consideration of foreign and Canadian experiences in the development phase. University medical faculties adopted a common position not just on the need to reform the provision of family medical services, but also on the need to reform teaching methods in UMFs.

The Minister of Health and the government took great interest in the model proposed by Clair because some of its elements were politically lucrative: for example, around-the-clock access and case management. They were aware of public's difficulty in accessing services and for that reason they wanted the FMGs to be implemented rapidly. From their point of view, FMGs seemed a concrete solution that would show the public that they meant business. MSSS bureaucrats were made responsible for executing the general principles of the FMGs as presented in the Clair Commission report. The MSSS appointed a general practitioner to head the implementation taskforce, composed principally of bureaucrats. This nomination caused friction within the MSSS, where staff was not used to working with doctors.

The FMOQ and the general practitioners it represents were without a doubt one of the principal actors in the dossier. The FMOQ was particularly opposed to the FMG model and contested some of its basic principles (registration and case management), mostly because they were not accompanied by attractive financial incentives. Resistance was especially strong in the Montreal area. In 2002, a confrontation took place

between the minister and the FMOQ with respect to the introduction of FMGs. The FMOQ decried the government's 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's original intention to implement the model proposed by the Clair Commission throughout Quebec has not proved feasible, the experience of the establishment of FMGs has showed that variations of the generic model can indeed operate in some areas. It is possible to have different types of collectives that take regional differences into account while also retaining the basic elements of the model, namely, the innovations specific to FMGs. This is what is presently taking place with the introduction of clinical networks in the Montreal area.

### ***A significant reform***

Most of our sources indicated that even if it is not always seen that way, the establishment of FMGs constitutes a major reform that is allowing the community to restructure the provision of front-line services and ensure continuity of care. It is also leading to a renewed appreciation of the practice of family medicine, helping to put general practice back on track (FMG-01).

"Yes, it's a major reform, but I'm not sure that it will be seen that way" (FMG-01).

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.

"I can't blame the government for having come up with the idea, because I tell myself that..., in that network, in that huge machine, at some point in time you have to shake it, you have to face it and say: That's it (...). Is there another way to do that? You hope so. Then when you're... thinking about it or evaluating it, you say: yes, there would be another way of going about it, but we weren't ready" (FMG-06).

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.

"I don't know if you know this, but reforms, with a change of government, they're very difficult. The FMGs passed the test, at least that time ..." (FMG-10).

## ***The future***

At the present time, FMGs are a model in transition. Several of our sources felt that the government will have to accept variations of the initial model and evaluate the model's success not only in the light of the improvement of services, but also in light of changes to professional practices.

"On the other hand, what I'm seeing right now is that when you don't keep up the effort, things are quick to go by the wayside, because we aren't dealing with laws or obligations, you know, it was a choice, it took... stimulation of the community to keep it going" (FMG-06).

"I tell myself, OK, the structure has just been shaken up all over again, and we just finished working on it, we haven't worked much on clinical projects yet, we still... we want it to be about clinical projects, but when exactly is that vision going to finally be put into place like it's supposed to?" (FMG-06).

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

"So I think that the structural elements will be what will bring us in that direction. Of course, it also depends on political will and the negotiations and the agreements that the government can come to with the medical associations. But, once again, family medicine groups are born of professionals' own experiences" (PR-07).



## References

Bonneau, Vincent; Bowen, Micheline; Gauthier, Anne *et al.* 2004. *Évaluation de la mise en place de la première vague des FMG*. Présentation Powerpoint inédite, Québec: Ministère de la Santé et des Services sociaux/Direction de l'évaluation, 87 p.

Collège des médecins de famille du Canada. 2000. *Soins de première ligne et médecine familiale au Canada: une ordonnance de renouvellement*. Document de discussion. In CMFC. [En ligne].

<http://www.cfpc.ca/French/cfpc/communications/health%20policy/primary%20care%20and%20family%20medicine/default.asp?s=1> (page consultée le 10 décembre 2005).

Commission d'étude sur les services de santé et les services sociaux. 2000. *Emerging Solutions: report and recommendations*. Québec: Gouvernement du Québec/CSSSS, 454 p.

Conseil Médical du Québec. 2001. *Avis sur la réorganisation des services médicaux de 1<sup>re</sup> ligne*. Québec: CMQ, 91 p.

Fédération des médecins omnipraticiens du Québec. 2001. "Les family medicine groups: il ne faut pas jeter le bébé avec l'eau du bain!", *Nouvelles de la FMOQ*, 21(2), p. 1-4.

Gauthier, Anne et Tremblay, Jenny (MSSS/Direction de l'évaluation). 2005. "Évaluation de l'implantation et des effets de la première vague des FMG". Présentation au 14<sup>e</sup> colloque annuel de la SQEP, Montréal: novembre 2005, 41 p.

Ministère de la Santé et des Services sociaux. 1999. *Relever ensemble le défi des urgences: Plan d'action*. Québec: MSSS, 31 p.

Ministère de la Santé et des Services sociaux. 2002. *Groupe de médecine de famille: Document synthèse*. Québec: MSSS, 18 p.

Ministère de la Santé et des Services sociaux. 2003. *Devenir un FMG: Guide d'accompagnement*. Québec: Groupe de soutien à l'implantation des family medicine groups (GSI)/MSSS, 70 p.

Santé Canada. 2004. "À propos du Fonds pour l'adaptation des services de santé". In *Santé Canada*. [En ligne] [http://www.hc-sc.gc.ca/hcs-sss/finance/htf-fass/about-afpropos/index\\_f.html](http://www.hc-sc.gc.ca/hcs-sss/finance/htf-fass/about-afpropos/index_f.html) (page consultée le 10 décembre 2005).

SECOR. 2000. "La pratique du médecin omnipraticien dans un réseau de services intégrés: Positionnement des cabinets privés – un cadre d'orientation", *Le médecin du Québec*, 35(3), p. 103-134.

Turgeon, Jean; Anctil, Hervé et Gauthier, Joël. 2003. "L'évolution du Ministère et du réseau: continuité ou rupture?" dans Lemieux, V.; Bergeron, P.; Bégin, C.; Bélanger, G. (dir.) *Le système de santé au Québec: organisations, acteurs et enjeux*. Québec: Les Presses de l'Université Laval, p. 93-116.

## Appendix 1: Chronology of the family medicine group reform<sup>5</sup>

From 1991 to 1997

- Reform of the organization of primary care and front-line services in Great Britain.

From March 1995 to July 2000

- Publication by the Ontario College of Family Physicians of a series of documents on the state of family medicine and the organization of primary care in Ontario.

From April 1996 to March 2000

- Proceedings of the Health Services Restructuring Commission presided by Doctor Duncan Sinclair.

From February 1999 to April 2001

- Establishment of the first Family Health Networks (“primary care networks” or “family health networks”), pilot projects of the Ministry of Health and Long-Term Care of Ontario and the Ontario Medical Association, in seven areas (including eight projects in the Hamilton area alone).

June 1998

- Creation by the Quebec Government of the “Regional Departments of General Practice” (DRMGs).

February 2000

- Publication by the Quebec Federation of General Practitioners (*La Fédération des médecins omnipraticiens du Québec -- FMOQ*) of the synthesis of a report conducted by SECOR, a private firm, entitled, “*La pratique de l’omnipraticien dans un réseau de services intégrés. Positionnement des cabinets privés. Un cadre d’orientation*”.

June 15, 2000

- Creation by the Quebec Government of the Commission for Study of Health and Social Services.

October 2000

- Publication by the College of Family Physicians of Canada of the ‘living document’, “Primary Care and Family Medicine in Canada: A Prescription for Renewal”.

December 15, 2000

- Conclusion of the proceedings of the Commission of Study for Health and Social Services.

December 18, 2000

- Submission of the final report, “Emerging Solutions: report and recommendations” to Pauline Marois, Quebec minister of state for Health and Social Services.

January 11, 2001

- Resignation of Quebec Premier Lucien Bouchard.

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<sup>5</sup> This chronology was initially prepared by Marc Rioux of the *Centre de recherche en droit public* of the University of Montreal. It has been modified by the research team.

January 16, 2001

- Paper and online publication of the Commission of Study for Health and Social Services' "Emerging Solutions: report and recommendations".

February 26, 2001

- Health Minister Pauline Marois announces the government's intention to create "family medicine groups" by 2004. These groups will be accessible 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 (*Commission permanente des affaires sociales*) that was studying the credits allocated to the Ministry of Health and Social Services, Health Minister Trudel declared that the first ten FMGs would be created before June 2001.

May 18, 2001

- The Ministry of Health and Social Services issues an invitation to tender in order to solicit applications for the first FMG projects.

May 24, 2001

- Minister Trudel announces the appointment of Dr. Jean-Guy Émond, general practitioner and founder of the family medicine teaching unit of the Enfant Jésus Hospital in Québec, to the head of the FMG Implementation Support Team created by the MSSS.

June 12, 2001

- FMOQ press conference during with the FMOQ president, Dr. Renald Dutil, denounces the precipitation, lack of transparency and lack of collaboration of the MSSS in the imminent establishment of the first family medicine groups.

June 14, 2001

- Minister Trudel announces the nomination of the first 13 FMG projects to be implemented in 13 of Quebec's 16 health regions.

June 21, 2001

- Adoption by Quebec's National Assembly of Draft Bill 28, an Act amending the Act respecting health services and social services and other legislative provisions.

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 Premier's Advisory Council on 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

- Meeting between the FMG Implementation Support Group of the MSSS, FMOQ representatives and the general practitioners in charge of the first FMGs.

March 11, 2002

- Distribution by the FMOQ of the "Association Agreement with a View to Operating a Family Practice as part of a Family Medicine Group (FMG)" and the "Explanatory Guide to the Legal Aspects of Forming a FMG, its Relationships with a Regional Board and Other Network Partners and Certain Aspects of a FMG involving a CLSC".

June 3, 2002

- Distribution by the MSSS of a working document on nurses in FMGs.

June 4, 2002

- Announcement of the signing between the MSSS and the FMOQ of an interim specific agreement on the terms of employment and remuneration of general practitioners working in FMGs.

June 14, 2002

- Adoption of the Act to amend the Professional Code and other legislative provisions as regards the health sector (Bill 90), whose proposals include changes to the practice of nursing by reorganizing how regulated tasks were shared between doctors, nurses and nursing aides.

August 2, 2002

- Publication by the Department of Medical and University Affairs of the MSSS of the document, "Model Agreement between the Family Medicine Group and the CLSC".

August 15, 2002

- Publication by the Department of Medical and University Affairs of the MSSS of the document, "Nurses in the Family Medicine Group".

August 28, 2002

- Publication by the Department of Medical and University Affairs of the MSSS of the document, "The Family Medicine Group. A Synthesis".

September 30, 2002

- Publication by the MSSS of the model "Standard Agreement between a Regional Board and a Family Medicine Group".

October 2002

- Publication by the FMOQ of the "Special Agreement for the Determination of Certain Terms of Employment and Remuneration Applicable, in an Interim Period, to Doctors Working in the Context of a Family Medicine Group (FMG)".

October 2002

- Publication of the report, "The Health of Canadians – the Federal Role", written by the Standing Senate Committee on Social Affairs, Science and Technology presided by Senator Michael J. L. Kirby.

November 19, 2002

- Unveiling by Minister Legault of the "Plan for Health and Social Services. Making the Right Choices" in which the government commits to inaugurating close to 100 FMGs in 2003 and 300 FMGs by 2005 throughout the province.

November 28, 2002

- Publication of the final report of the Commission on the Future of Health Care in Canada entitled, "Building on Values: The Future of Health Care in Canada".

November 29, 2002

- Accreditation by the MSSS of the six first FMGs to begin operations "in FMG mode".

December 14, 2002

- Ratification by the delegates of the Council of the FMOQ of the extension of the general agreement negotiated with the MSSS on the terms of remuneration of general practitioners.

From January 21 to April 4, 2003

- Announcement by the MSSS of the accreditation of five more FMGs and the adhesion of some accredited FMGs to the specific agreement, signed in June 2002, between the FMOQ and MSSS on the terms of employment and remuneration of FMG general practitioners.

February 21, 2003

- The Quebec Government announces its intention to invest \$556 million in front-line services, \$50 million of which is earmarked for the establishment of some 100 FMGs in 2003-2004 and for the funding of a second wave of implementation of family medicine groups.

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

- Appointment of neurosurgeon Philippe Couillard as Minister of State for Health and Social Services.

May 15, 2003

- Inauguration of the FMG of Verdun by Health Minister Couillard, who reiterates the government's support for the establishment of FMGs province-wide.

July 9, 2003

- Health Minister Couillard declares that the FMG model will be neither extended to nor imposed upon areas on the Island of Montreal. It will be replaced by other models for the organization of front-line services.

July 15, 2003

- The MSSS announces the accreditation of five more FMGs.

September 19, 2003

- The MSSS announces the accreditation of five more FMGs.

September 25, 2003

- Minister Couillard halts the establishment of new FMGs.

January 16, 2004

- The MSSS announces the accreditation of 12 more FMGs.

Between February 2004 and March 2006

- Announcement of the accreditation of 69 more FMGs, bringing to 108 (as of February 2006) the number of FMGs in operation.



**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)	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ The province of Quebec had become interested in the issue of reform... when?</li> <li>▪ The FMOQ laid the groundwork for an initial model for the organization of front line services by commissioning a report from the firm <i>Secor</i> on how work was organized in private clinics. In...</li> <li>▪ Some of the ideas from the <i>Secor</i> report were used by the Clair Commission to create its own model as outlined in the Commission's final report (2002).</li> <li>▪ 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.</li> <li>▪ A Working Group and an Implementation Support Team were set up at the MSSS.</li> <li>▪ 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.</li> <li>▪ The implementation of FMGs quickly became a priority of the PQ government.</li> </ul>
	Policies (esp. specific domestic court decisions and/or international agreements)	<ul style="list-style-type: none"> <li>▪ Until that point, front line medical services were offered mostly in private clinics, whereas social services were offered mostly in CLSCs. The model for the reform of front line services had to take that reality into account (CLSCs include few doctors).</li> <li>▪ In an environment characterized by a shortage of doctors, the existing</li> </ul>



		<p>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).</p> <ul style="list-style-type: none"> <li>▪ The emergency room crisis and resulting policies also had an impact on the development of the FMG model.</li> <li>▪ 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.</li> </ul>
	Policy networks ( <i>overlaps with Interests</i> )	<ul style="list-style-type: none"> <li>▪ 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). The lack of impetus stemmed from the fact that the model's objectives were not backed by meaningful financial incentives.</li> <li>▪ Professional associations proved to be quite powerful.</li> <li>▪ The public wanted better access to and follow-up by general practitioners.</li> <li>▪ The FMOQ and the government fought over the nature of the FMG project and the speed with which it should be implemented. There was a lack of consensus on these points.</li> </ul>
	Other	<ul style="list-style-type: none"> <li>▪ Not addressed by our sources.</li> </ul>
Interests	Societal interest groups	<ul style="list-style-type: none"> <li>▪ The public wanted improved access to services, but demands were unorganized.</li> <li>▪ Certain patient advocacy groups were favourable to the proposal, but did not voice specific demands as to its execution.</li> </ul>
	Policy entrepreneurs (including researchers)	<ul style="list-style-type: none"> <li>▪ University researchers were very involved in the development of the model and in its promotion. Their research had informed them on what had taken place elsewhere in the domain.</li> <li>▪ The various faculties of medicine in the province had adopted a common</li> </ul>

		<p>position on the need to reform front line services, as well as the best means of teaching family medicine.</p> <ul style="list-style-type: none"> <li>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.</li> </ul>
	Elected officials	<ul style="list-style-type: none"> <li>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).</li> <li>They were very conscious of public complaints about accessibility. FMGs seemed a concrete solution to the problem that would also allow them to demonstrate that they taking action on the issue.</li> </ul>
	Civil servants	<ul style="list-style-type: none"> <li>Bureaucrats from the ministry of health were left to interpret and execute the overall principles of the FMGs as presented by the Clair Commission.</li> <li>The MSSS found a general practitioner to lead the implementation group, which was formed principally of bureaucrats. There was occasional friction between the organizational culture of the MSSS and the professional culture of the GP (there are few doctors at the MSSS).</li> <li>Strong leadership on the part of the general practitioner.</li> </ul>
	Other	<ul style="list-style-type: none"> <li>Not addressed by our sources.</li> </ul>
Ideas	Knowledge / beliefs about what "is"	<ul style="list-style-type: none"> <li>Work at the ministry was based on what had been done elsewhere in the world (i.e.: Great Britain and elsewhere in Canada). Notwithstanding, the Ontario model (primary care groups) was the principal source of inspiration.</li> <li>Work was also based on the findings of university researchers on the reform of front line services. This research was facilitated by grants by the Health Transition Fund.</li> <li>The Clair Commission had based its work on different models, and had invited experts to discuss the issue.</li> <li>Finally, the government followed up on the model proposed by the Clair</li> </ul>

		report. Work started with the objectives and the principles of the model, but those aspects of the model that were more contentious (registration, follow-up and monitoring, changes to means of remuneration) were de-emphasized.
	Values / views about “what ought to be”	<ul style="list-style-type: none"> <li>▪ There seemed to be consensus on the values expressed in the FMG project and on its general principles.</li> <li>▪ The government, the public, the doctors, and the ministry all wanted to find a solution to the problem of accessibility. They were agreed on the need for more equity, greater collaboration between the various professionals, more promotion/prevention, better follow-up, etc.</li> <li>▪ Differences of opinion emerged, however, with respect to the ways to that these concepts were best executed.</li> </ul>
	Combined (e.g., commission recommendations)	<ul style="list-style-type: none"> <li>▪ Determining influence of the Clair Commission.</li> </ul>
	Other	<ul style="list-style-type: none"> <li>▪ Not addressed by our sources.</li> </ul>
External events	Release of major report (e.g., commission)	<ul style="list-style-type: none"> <li>▪ The Clair Commission report generated interest about the model.</li> <li>▪ Afterwards, the MSSS published documents on the matter: an implementation guide, reports on preliminary evaluations.</li> </ul>
	Political change (e.g., election, cabinet shuffle) – provincial and national	<ul style="list-style-type: none"> <li>▪ Between the time that the idea of FMGs first emerged and the time that family medicine groups first began to be implemented, the ministry of health changed hands several times: Marois received the Clair report and announced the future creation of FMGs, Trudel began to put the groups into place and Legault and Couillard continued the project. Everything took place very quickly.</li> </ul>
	Economic change (e.g., recession)	<ul style="list-style-type: none"> <li>▪ Not addressed by our sources.</li> </ul>
	Technological change (e.g., MRI scans)	<ul style="list-style-type: none"> <li>▪ Not addressed by our sources.</li> </ul>
	New disease (e.g., SARS)	<ul style="list-style-type: none"> <li>▪ Not addressed by our sources.</li> </ul>
	Media coverage (e.g., deaths on the waiting list)	<ul style="list-style-type: none"> <li>▪ Problem of accessibility to a general physician</li> </ul>

	Other	▪ Not addressed by our sources.
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