Elaboration and Implementation of Family Medicine Groups (FMGs): An Opportunity for Primary Care Renewal in Quebec?

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Background: FMGs

- In Quebec, since the 1970s, primary health care services were historically organized around two models: CLSCs and medical clinics
- In 2001-2002, a third organizational model emerged: Family Medicine Groups (FMGs)

Characteristics of FMGs
- ✓ 6-12 general practitioners (GPs)
- ✓ Multidisciplinary practices (collaboration with nurses)
- ✓ Patient registration
- ✓ Patient follow-up
- ✓ Responsibility for a given population

Objectives of FMGs
- ✓ To improve access to GPs and the continuity and quality of care
- ✓ To reinforce professional collaboration
- ✓ To implement a global approach to health (prevention and promotion)
- ✓ To give new legitimacy and value to the work done by GPs

Research Objectives

- ✓ To describe the policy-making process around the development and implementation of FMGs
- ✓ To draw lessons learned

Theoretical Framework

- We analyzed this reform at three key moments in the policy-making process (Kingdon, 1995):

  ✓the government agenda
  ✓the decision-making agenda
  ✓the choice of a policy

Methodology

✓The data was gathered using 13 semi-structured interviews with key decision-makers
✓Interview were transcribed and coded with QSR-NVivo
✓The relevant literature (grey and scientific) was analyzed

Results

The government agenda: Factors contributing to the emergence of the issue (1990-2000)

✓Growing interest in primary care reform in OECD countries in the1990s
✓Recognition of the limits of existing primary care organizational models in terms of accessibility, collaboration and continuity of care
✓Changing trends in the practice of medicine
✓Calls for reform by GPs and the research community

The decision-making agenda: The Commission of Inquiry into Health and Social Services (Clair Commission) (2000)

✓The Clair Commission helped put the issue of primary care reform on the radar screen of the Quebec government
✓It was a research process that resulted in the development and definition of the broad objectives and characteristics of the FMG model
✓The model was informed by international (UK, USA) and Canadian experiences (Ontario)
✓The Commission focused on developing recommendations to ensure that the implementation of FMGs would be politically feasible
✓Overall, the work of the Commission contributed to building a social consensus around the need for reform and this new model for primary care delivery

The choice of a public policy (2001)

✓Two months after the report was made public, the government announced that FMGs would be implemented across the province
✓The government demonstrated strong political will to proceed with this reform, due to electoral considerations
✓The Ministry of Health and Social Services was put in charge of the operationalization of the broad characteristics of the model developed by the Clair Commission

Overview of the implementation

✓The government wanted the implementation to proceed rapidly
✓Difficult negotiations about implementation between the Ministry of Health and the family physicians' union ensued

✓Many features of the model were contested, especially the following:

Patient Registration

✓Fear that it could lead to competition between GPs to attract patients
✓Seen as restraining patients' right to choose and their autonomy
✓Perceived by GPs as a tool that could be used to introduce capitation payment

➢*Following negotiations, patient registration was put in place but enrolment targets were significantly lowered*

Payment Plans

✓The Clair Commission had recommended a mixed approach with capitation, fee-for-service and salary
✓Changes to payment plans were seen by the Commission as a tool to transform professional practices
✓GPs resisted changes to payment plans

➢*Following negotiations, GPs working within FMGs kept fee-for-service payment with only minor changes to remuneration (compensation for patient registration and the management of vulnerable patients)*

Alternative Models

✓The Montreal region called for alternative models to be put in place to suit the reality of local medical practices (walk-in clinics, multiethnic clientele)
✓The standardized model and approach were criticized

➢*Despite negotiations, exceptional models were not implemented in Montreal*

Conclusion

✓The FMG is an innovative model to strengthen primary care
✓The implementation strategy chosen by the government, however, hampered the development of FMGs:
  ➢Negotiation with GPs about the features of the model were difficult (confrontational negotiation strategy)
  ➢The strategy was to implement a standardized model quickly rather than use a flexible model with a gradual approach to implementation.
  ➢The process lacked political leadership

✓Following negotiations with GPs, the original features of the model were diluted, making it relatively unattractive for GPs especially in terms of financial incentives
✓Overall, the FMG is a reform that did not challenge core institutionalized agreements with physicians in terms of payment plans and the organization of medical practices

FMGs: Where are we now?

✓New models have started to emerge in Montreal
✓Implementation has been easier in rural than in urban areas (lack of resources has forced GPs to collaborate)
✓As of August 2006, 113 FMGs have been accredited. The initial target was to have 300 FMGs by 2005

REFERENCE
Kingdon, J.W., Agendas, Alternatives, and Public Policies (New York: Harper Collins College Publishers, 1995).

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