

## Quebec's Family Medicine Groups: Innovation and Compromise in the Reform of Front-Line Care\*

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### Abstract

*At their origin, public healthcare systems were designed mainly for the treatment of acute illnesses. For many years, therefore, public health care focused on services offered in healthcare establishments and primary care was allowed to evolve on the periphery of hospitals, with doctors free to follow their own conception of how best to provide and follow up on care. As hospital costs grew, however, and new challenges regarding the provision of care began to emerge, governments felt increasingly responsible for organizing the front line (Nolte and McKee 2008). How doctors would be called upon to participate in the new configuration of services—particularly in Canada, where physicians function as independent entrepreneurs—is the subject of this article, which investigates the decision to introduce family medicine groups (FMGs) to the province of Quebec.*

### Introduction

In recent years, the organization of front-line services and primary care has become a focal point for several healthcare systems in the Western world (Saltman et al. 2006; Starfield 1998). One of the main reasons has been the population's need for an integrated medical care system that addresses disease prevention, health promotion and social support in addition to standard curative care (Hofmarcher et al. 2007). This need has been accentuated by aging populations and by the increasing prominence of chronic diseases in the range of pathologies for which

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patients seek treatment (Lafortune and Balestat 2007)—and by the resulting rise in cost (Sassi and Hurst 2008).

At their origin, public healthcare systems were designed mainly for the treatment of acute illnesses. For many years, therefore, public health care focused on services offered in healthcare establishments and primary care was allowed to evolve on the periphery of hospitals, with doctors free to follow their own conception of how best to provide and follow up on care. As hospital costs grew, however, and new challenges regarding the provision of care began to emerge, governments felt increasingly responsible for organizing the front line (Nolte and McKee 2008). How doctors would be called upon to participate in the new configuration of services—particularly in Canada, where physicians function as independent entrepreneurs—is the subject of this article, which investigates the decision to introduce family medicine groups (FMGs) to the province of Quebec.

## Background

Canada's Medicare healthcare system is the legacy of a compromise that took place nearly 50 years ago in the province of Saskatchewan. In the summer of 1962, the Government of Saskatchewan's attempts to establish a public healthcare insurance system for selected services had led to an intense struggle between the government, the North American medical establishment, and the province's physicians. Fearing that a publicly financed system would mean a significant loss of income and government interference in medical decisions, doctors brought services to a halt with the 1962 Saskatchewan Doctors' Strike—this, despite Premier Tommy Douglas' promise that the province would pay doctors' going rate (Campbell and Marchildon 2007). After negotiation, Saskatchewan's doctors accepted public payment on condition that the State renounce all right to control their activities: what McMaster University health research expert John Lavis calls the "core bargain" (Lavis 2004).

Saskatchewan's compromise would be scaled up in 1964, when the Royal Commission on Health Services recommended nationwide adoption of Saskatchewan's model of public health insurance (Royal Commission on Health Services 1964). In 1966, the Liberal minority government of Lester B. Pearson created the program in question, with the federal government paying 50% of costs and provinces paying the other half. The system was standardized in 1984 with the adoption of the Canada Health Act (Government of Canada 1985), which gives Canadians the right to universal, free access to "medically necessary" services: that is, any healthcare service provided by a qualified physician. In Canada, such physicians include thousands of family doctors who function as independent practitioners, billing State authorities directly under a fee-for-service system and answering only to the provincial and federal medical orders that are responsible for monitoring the profession and protecting the public (Beaulieu et al. 2008).

In recent years, however, this segregation of roles has begun to be called into question. Significant increases in healthcare costs, the realization that the quality of care has been lacking and the recognition that public protection is not necessarily assured by medical professionals who act as both judge and jury, has caused governments to claim their right to intervene not only as regards healthcare costs but also with respect to the organization and delivery of medical care (Romanow 2002). While most State interventions have addressed supply—for example, caps to the number of students admitted to faculties of medicine—(Hudon et al.

2009)—in the past decade, provincial commissions such as the Saskatchewan Commission on Medicare (2001) and the Alberta Framework for Reform (2002) as well as federal studies such as the Kirby Report (2002) and the Romanow Report (2002) have all underlined the desirability of governments' intervening specifically to centre health care around front-line services in order to improve population health and welfare.

In Quebec, front-line reform dates to the 1970s. In 1967, the Castonguay-Nepveu Commission had led to the establishment of provincial Medicare, under which front-line care had been structured with mixed results (Commission d'enquête sur la santé et le bien-être social 1967). As a result, Quebec's decision-makers, managers and healthcare professionals undertook various initiatives to restructure the front line. These initiatives left the province with three main organizational models: CLSCs (*Centres locaux de services communautaires* – Local Community Service Centres), family practice units (general practitioner training clinics principally located in hospitals), and private practices.

Despite the great expectations inspired by their innovative structure, CLSCs never succeeded in fulfilling one of the most important aspects of their mandate: to act as Quebecers' first point of contact with Quebec's healthcare system. This is largely due to the fierce competition to which CLSCs were subjected by private medical practices, which in Quebec have always attracted the most physicians (Bozzini 1988; Turgeon et al. 2003). The Fédération des médecins omnipraticiens du Québec (FMOQ) reports that in 2006-2007, of the 60% of Quebec's general physicians who practiced principally on the front line, 62% worked mainly in private practice<sup>1</sup> (Fédération des médecins omnipraticiens du Québec 2008). Research by a private firm hired by the FMOQ shows that "general practitioners in private practice value their autonomy, the entrepreneurial nature of their activities, and the simplicity of the management required. ... They want their practice to be considered a business and not a public entity" (SECOR 2000: 121 - translation ours). Policy-makers had originally hoped to attract family physicians to CLSCs by showcasing the CLSCs' multidisciplinary environment and by paying CLSC doctors a salary rather than fee-for-service amounts. But true multidisciplinary within the CLSCs has had difficulty taking root (Turgeon et al. 2003) and the disparity in services offered from one CLSC to another, due to CLSCs' democratic approach to the development of their services, has created inequity between regions and territory and impeded patients' access to care (Bozzini 1988). Viewed broadly, these elements explain the dominance of the private practice model, which was already evident in the 1980s and which was reinforced by the Rochon reforms at the turn of the 1990s. By promoting the shift to outpatient care without investing savings in the front line, Rochon expanded the market for primary care services and private practices grew proportionately.

Faced with this fragmentation of its front-line care model and the ill effects on patient satisfaction and the access to care, in 2000, the Parti Québécois government named the latest in a series of commissions to study the future of the provincial healthcare system. Among other recommendations, the Clair Commission<sup>2</sup> (Commission d'étude sur les services de santé et les services sociaux 2000) proposed a new organizational model for the provision of primary care: the family medicine group (FMG). With this model, the Commission aimed to profoundly modify the paradigm and philosophy of how services were organized, mostly by adjusting doctors' remuneration system, making changes to case management practices and introducing a truly multidisciplinary approach to the practice of medicine. At the same time, the FMOQ published a study that declared the advantages of reorganizing the front line so as to promote more continuous and integrated care (SECOR 2000).

Until now, research on Quebec's front-line services has most often been approached from three angles: the organization of medical practices (Geneau et al. 2008), patients' experiences (Haggerty et al. 2007), and the performance of Quebec's primary healthcare system vis-à-vis its objectives (Commissaire à la santé et au bien-être 2009; Haggerty et al. 2008; Haggerty et al. 2004; Pineault et al. 2005). The FMG model, meanwhile, has been mainly studied from a legal perspective (Rioux 2008) or in terms of its effect on interprofessional collaboration (Beaulieu et al. 2006). Regarding the political process that caused the FMG model to emerge and be retained, however, little has been published.

As a first step towards filling this gap, this article studies the evolution of the relationship between doctors and the State: more specifically, how the decision to implement FMGs can be seen as both an innovation and a compromise that allowed the government to participate in the organization of front-line care while respecting doctors' professional autonomy. Exploring this question will allow us to analyze how the relationship between physicians and the State has changed over time and evaluate whether Medicare's "core bargain" has been modified as a result.

Data for the study come from 13 semi-directed face-to-face individual interviews with key actors who helped design and implement FMGs in Quebec. All interviewees had an excellent understanding of the policy, having either helped design, adopt or implement it or having been part of an organization that participated in the process. Our sources consisted of former ministers of health and social services, members of the Commission of Study of Health and Social Services (the Clair Commission), FMOQ administrators, public policy experts, general practitioners working in FMGs and civil servants from Quebec's Ministry of Health and Social Services (*Ministère de la santé et des services sociaux* – MSSS) or related organizations. In addition we analyzed the grey and the scientific literature published by government agencies and various organizations.

## What is an FMG?

The Ministry of Health and Social Services defines an FMG as follows: "A group of doctors who, for the benefit of registered persons, work closely with nurses in a setting conducive to the practice of family medicine" (Ministère de la Santé et des Services sociaux 2009). FMGs comprise "the full-time equivalent of 6 to 12 doctors ... [who also] work in close collaboration with other health and social services professionals, especially social workers and pharmacists. Operating in an FMG facilitates communication between professionals and helps services be more integrated" (Ministère de la Santé et des Services sociaux 2002 - translation ours). The objectives of the FMG model are to (1) provide all residents of Quebec with access to a family doctor; (2) increase the accessibility of services and enhance the quality of care; (3) improve management, the continuity of care and the monitoring of registered patients; (4) augment complementarity with other healthcare system entities; and (5) promote and enhance the role of the family doctor (Ministère de la Santé et des Services sociaux 2002, 2003).

The backbone of FMGs is registration, a mutual agreement between the family doctor and the patient (Ministère de la Santé et des Services sociaux 2003) that is designed to act as the cornerstone of ongoing improvements in continuity and accessibility. General practitioners working in an FMG may register between 1000 and 2200 patients each (Ministère de la Santé et des Services sociaux 2002) and must coordinate their services with those of other healthcare

system entities, directing patients towards outside resources when appropriate. FMGs must provide their patients with appointments within a reasonable delay and ensure periods of time at night, on weekends and during holidays when doctors can be seen on a walk-in basis, whether at the FMG or at an entity with which the FMG has an agreement to provide care. For clients in a precarious medical condition, those suffering from a complex disease and those with a chronic disorder, on-call medical services must be available during extended hours. Nurses play a pivotal role in the FMG system, participating in interviews and screening; in the systematic monitoring of patients with special needs; in patient education and care; and in disease prevention and health promotion activities. The nurse also liaises with other actors in the healthcare sector. In addition to nurses, FMGs may employ nutritionists, psychosocial experts, physiotherapists, pharmacists and other health professionals.

Because FMGs build upon the pre-existing structure of front-line services, only entities already offering general medicine services—CLSCs (now Centres for Health and Social Services – *Centres de santé et de services sociaux*, or CSSS<sup>3</sup>), private practices and family practice units (UMFs)—may become FMGs. Doctors choosing to work together in an FMG must sign an agreement of association, enter into a service agreement with their local CSSS and sign an agreement with the Regional Board (now the Local Health and Social Services Networks Development Agency – *l'Agence de développement de réseaux locaux de services de santé et de services sociaux*). They must also agree to the remuneration scheme negotiated by the FMOQ (Ministère de la Santé et des Services sociaux 2003).

## Development and Adoption of the FMG model

To understand where the FMG model came from, we must consider the principal events that led to the problem with front-line services and helped forge a social consensus on the need for reform.

As previously stated, the evolution of the CLSC network was hampered by several stumbling blocks. To begin with, soon after their creation, CLSCs were quickly checkmated by the allure of private practices, which “were rapidly extended over the whole Quebec territory by a modernizing medical elite who confronted the social-democratic legislators and technocrats on their own terrain by offering citizens a widely accessible system of primary care” (Bozzini 1988: 357). Furthermore, the disparities in the services offered from one CLSC to the next led to problems of access. In the mid 1980s, a publication on the future of CLSCs recommended that CLSCs reduce the number of programs they offered and concentrate their mission on a few areas (Ministère de la Santé et des Services sociaux 1987). But it soon became evident that Quebec’s healthcare system consisted of two networks that operated in parallel, and rather than continue to expand the CLSC network as originally intended, the MSSS chose, in the 1980s, to do no more than maintain it (Bourque 1988).

“The problem with CLSCs is that they were never able to have a real striking force given that the service offer was so different from one CLSC to another.”  
(Interviewee #6, translation ours)

Meanwhile, the practice of medicine was changing. By the end of the 1990s, older general practitioners mostly worked alone in private practice. Young doctors, in contrast, were taking a more diversified and less organized approach, working in both emergency rooms and medical

clinics or in specialized fields. The increasing number of women in the medical profession was bringing up new concerns with respect to workloads and the way in which work was organized (Conseil Médical du Québec 2001). The lack of coordination and integration of care were aggravating public dissatisfaction and were compounding problems of an aging population, staff shortages and the increased complexity of medical conditions.

At the same time, Quebec was experiencing the repercussions of a major restructuring of the healthcare system. One such repercussion was recurrent emergency room overcrowding. When Pauline Marois took office as Minister for Health and Social Services in early 1999, one of her priorities was to reduce emergency room overcrowding. Among the administration's methods (Ministère de la Santé et des Services sociaux 1999) was the reform of the front line.

More cognizant that any other player of the extent of the problem, Quebec's medical community had already begun to prepare for reform. As early as 1996, the FMOQ had debated how to reorganize the practice of medicine in Quebec and proposed the creation of a DRMG<sup>4</sup> for each Regional Board. Next, in 2000, the College of Family Physicians of Canada suggested a model for front-line services based on family practice networks made up of interdisciplinary teams (The College of Family Physicians of Canada 2000). Also in 2000, the FMOQ endorsed a private study that recommended developing an entrepreneurial medical environment, ensuring the promotion and profitability of private practices and encouraging general practitioners to develop business plans (SECOR 2000). Based on these recommendations, the FMOQ advocated a service organization model that reorganized the practice of medicine into private practices within integrated networks in order to improve accessibility, continuity and case management. These recommendations would pave the way for the main characteristics of the FMG model.

“And the consensus among those involved ... was pretty solid. ... [for] this idea that groups of doctors were responsible for a given population, working as an interdisciplinary team, no longer on their own” (Interviewee #8, translation ours)

As early as 1999-2000, the government had a fairly clear idea of what would be necessary to reform front-line services, and in June 2000, Health Minister Marois and the Parti Québécois administration requested Michel Clair, former National Assembly minister and ex-president of the Treasury Board, to head the new Commission of Study for Health and Social Services. This commission was charged with crystallizing solutions and generating political support for the reform of the healthcare system in general and front-line services in particular. The Clair Commission would prove to be a seminal institution for many aspects of health care in Quebec; our research suggests that the roots of Quebec's FMGs lie nowhere more than in the Commission's deliberations.

The commissioners explored organizational models for front-line services both in Canada and abroad, reconnoitering establishments, reviewing the literature and creating panels of experts. They took particular interest in two cases: Great Britain's General Practitioner (GP) Fundholders, and the American Health Maintenance Organization (HMO) model. These two models had two elements in common: a solid organization based on shared material and human resources and an emphasis on population-based responsibility and integration.

Throughout its inquiry, the Clair Commission looked for ways to dovetail the FMOQ's proposal with commissioners' concerns. Doctors presented their preferred practice model at Commission hearings, and the Commission reviewed the work of the MSSS. Thus working from different angles, the Commission identified various elements that coalesced in the FMG concept. In other words, the Clair Commission did not invent a new model. Rather, it regrouped and gave form to existing ideas.

"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."  
(Interviewee #5, translation ours)

The concept was presented to the public as tool to reform front-line services. Accordingly, the Commission held a series of public forums:

"We wanted there to be an exchange of ideas, we wanted people to take our ideas further, so that when we laid [our ideas] out in our report, they would have already been circulated, they would have already garnered some support."  
(Interviewee #7, translation ours)

The commission also tested its principal recommendations on important actors in the healthcare system. The idea was to propose at least one front-line service model as a basis for discussion: adjustments could always be made later.

### **The Commission's proposed model**

Writing about how FMGs should work, the commissioners reasoned that "[Given that] the organization of a primary care network constitute[s] the main foundation of the health and social services system, ..., this network [should] be created on the basis of the current dual reality of CLSCs and physicians' offices" (Commission d'étude sur les services de santé et les services sociaux 2000: 42). In the words of one commissioner,

"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 co-op, 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." (Interviewee #7, translation ours)

To reach this goal, FMGs had to allow general practitioners to work collectively, supported by clinical nurses. Practitioners also had to be responsible for a well-defined, registered population. The establishment of FMGs was to be entrusted to various types of clinicians, regrouped under the authority of a reputable doctor recognized by his peers. As for remuneration, the Commission proposed a mixed system consisting of three elements: capitation for registered patients, a base amount, and fee-for-service payments. The Commission also recommended that the implementation of FMGs be gradual and voluntary and use flexible mechanisms. As stated in the final report:

“We propose a vision and goals but do not expect to have defined everything in detail before this vision can be implemented. Rather than imposing a single, detailed model everywhere, let’s move forward with those who share this vision and want to achieve it. Let’s support them, facilitate their work, define the ways and means with them as we proceed, evaluate the activities and adjust accordingly. In other words, let’s act, move forward, evaluate and adjust. This strategy, recommended to the Commission by several international experts, is, in their view, the key to the successful transformation of the health network in many countries.” (Commission d’étude sur les services de santé et les services sociaux 2000 : 54)

Rather than introducing pilot projects, then, the Commission suggested issuing an invitation to tender before negotiating details with the FMOQ.

The Clair report was officially submitted to Health and Social Services Minister Pauline Marois on December 18, 2000, and the government appropriated it very quickly. According to government documents, several factors argued in favour of the FMG model. More and more patients had trouble finding a family doctor, and fragmented services left the patient responsible for linking the medical professionals working on his/her case. The lack of available medical care outside regular working hours increased the use of emergency services, and because services were not organized coherently, doctors lost time performing tasks for which their level of expertise was not necessary. In addition, multiple consultations with more than one doctor complicated long-term follow-up, duplicated services and sub-optimized patients’ access to specialists. Finally, the increasing specialization of medical practices was eroding the role of the family doctor (Ministère de la Santé et des Services sociaux 2002, 2003).

For these reasons, in 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. After 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 of Clair’s recommendations that he would put into place.

The project was rapidly entrusted to the Ministry of Health and Social Services, which promptly set up two implementation teams and a management committee. The Ministry Working Group (*Groupe de travail ministériel*), composed of representatives of professional orders and unions as well as university experts, 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 and other 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” (Ministère de la Santé et des Services sociaux 2003). The mandate of this group was thus operational. Finally, a management committee made up of deputy ministers, chief executive officers and coordinators was responsible for managing the proceedings and seeing to the overall consistency of the project (Ministère de la Santé et des Services sociaux 2003). The interplay between the first two entities, one of which was political and the other operational, was not always optimal and conflicts arose.



The professionals and clinicians in charge of the dossier took on the task of determining how the model would function. During the development phase, the Clair Commission had been primarily interested in English and American experiences. During the execution phase, MSSS managers mainly studied models from Sweden and Ontario, sending observational missions to study how organization took place. Ontario's Family Health Networks and Family Health Groups models were practically identical to the FMGs proposed by the Clair Commission. Like Quebec's model, Ontario's 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.

### **When ideals confront reality**

Since the government needed doctors to be on board with the reform, the key features of the FMG model had to be negotiated. The three thorniest issues that opposed the government to the FMOQ (which represented general practitioners) were also three of the model's most fundamental aspects: registration, extended-hours access and doctors' remuneration.

The government was determined to make registration of the clientele with a given general practitioner an intrinsic element of the practice of general medicine in Quebec. But the FMOQ felt that while registration was well adapted to rural regions where the clientele was captive to a shortage of doctors, in urban areas where doctors were more numerous, it risked causing doctors to compete for patients. In addition, the FMOQ perceived registration as an affront to doctors' autonomy and patients' freedom of choice and as an unwelcome increase in doctors' responsibilities (Ministère de la Santé et des Services sociaux 2002, 2003). By the end of negotiations, however, the FMOQ had accepted the principle and registration became a distinctive feature of Quebec's new FMGs.

As for accessibility, the FMOQ refused outright to allow extended-hours access for registered patients to become an essential element of the FMG model. Accordingly, extended-hours access was watered down from access for all registered patients to access only for those registered patients who were victims of a chronic disorder and had a severe loss of autonomy. Furthermore, FMGs were free to enter into agreements with other front-line providers in a given territory to provide extended access on nights and weekends.

Doctors' remuneration was the most difficult feature to negotiate. Quebec's medical associations suspected that the proposed capitation formula for registered patients was a precursor to eliminating fee-for-service payments altogether. It is true that the FMG model was designed to phase out at least part of the fee-for-service system. In this regard, the Clair Commission recommended 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.” (Commission d'étude sur les services de santé et les services sociaux 2000 : 52)

The Commission considered changes to the provincial remuneration system to be the cornerstone of the reform of professional practices and the organization of front-line care. But when negotiations opened, the FMOQ opposed capitation staunchly, defending fee-for-service and pointing out the difficulty of implementing capitation in a system where patients were free to consult the doctor of their choice.

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 MSSS had very little leeway because its hands were tied by financial constraints imposed by the Treasury Board. As negotiations advanced, its goal shifted from across-the-board capitation to a progressive decrease in the proportion of fee-for-service payments. The FMOQ, in contrast, wished to protect established remuneration methods, at least in the beginning:

“We always said that our condition for any agreement was that during the experimenting period, during the transition period, people would be allowed to keep their existing remuneration method, with a few minor changes here and there.” (Interviewee #1, translation ours)

Hence, the final solution was a compromise: a large proportion of remuneration continued to be fee-for-service, but amounts were added to enhance working conditions in FMGs. For instance, doctors working in FMGs received \$7 per patient registered<sup>5</sup>. An additional sum was paid for vulnerable patients (patients 5 and under or 75 and over), and extended-hours availability was compensated at a surplus of \$52 per day of work. To recognize the time spent on administrative matters, the doctor in charge of the FMG received approximately \$300 per week, and 3 hours per week for each full-time equivalent position was budgeted to compensate doctor-nurse communication and interprofessional collaboration. The MSSS also financed the purchase of computer equipment and paid the salaries of nurses and administrative assistants.

It is important to note that the remuneration of general practitioners in Quebec has never been regulated by a definitive agreement but rather by over 2500 separate agreements. Because salary negotiations are centralized under the FMOQ, any sum paid by the government to a general practitioner working in an FMG must be paid to all other general practitioners in the province as well. Doctors working in private practice thus receive the same allocation for patients with special needs as do doctors working in FMGs. In this way, the interim agreement substantially weakened the attractiveness of the new FMG model insofar as doctors were concerned. It also failed to make provision for penalties in the event that the patient and/or the doctor violated the registration agreement. The question of the delegation of tasks to nurses, lauded in the FMG model, was also problematic because general practitioners were afraid of losing revenue by delegating responsibilities to nurses. In summary, the changes to the terms of remuneration and working conditions negotiated as part of the FMG model resulted in real salary increases in the order of 15% to 20% for FMG doctors but made no fundamental changes to doctors' remuneration system and failed to magnetize doctors to the FMG model as had originally been intended.

## Discussion and Conclusion

Our analysis of the interviews and the documentation traces the decision to create FMGs to two main actors: the FMOQ, which represented Quebec's general physicians, and the State. While

associations, researchers, experts and the general public were all given the opportunity to express an opinion, their influence on the decision remained marginal. Members of the public demanded better access to services and better monitoring by general practitioners, but their lack of agreement on specifics gave them little weight over the evolution of the model. University researchers and experts were active in the development and promotion of the FMG model, especially during the Clair Commission hearings, but were not at the table when the final decision was made. The Government of Quebec and the FMOQ were thus left to craft a policy that balanced a desire to innovate with the need for compromise.

The first feature we notice about the FMG policy-making process is the diffusion of ideas. Ever since the early 1990s, both the federal government and the Government of Quebec had recognized the need to reform front-line services. Discussions and research abounded on the best way to proceed and a range of actors proposed various ideas and solutions. These proposals did not stem from a coherent, organized campaign in favour of a given model, but were rather the product of an organic, generative process in which innovations were explored and different possibilities emerged. The subsequent release of two reports (the Clair Commission report and the SECOR report) caused new, more precise models to materialize as vehicles for the crystallization and dissemination of these reflections. The fact that the reports were published at the same time underlines the fact that both doctors and the government realized the urgency of addressing the three main issues: wide-spread dissatisfaction with the difficulty of accessing a family doctor, emergency room overcrowding due to the front line's incapacity to handle the patient load, and a lack of coordination and continuity of care.

That this realization led to innovation can be attributed to the way in which the Clair Commission endowed the FMG model with characteristics that diverted from Quebec's traditional medical philosophy—the introduction of contracts, a multidisciplinary environment, and so forth. Credit for the innovation's adoption itself must go to the choice of president of the Commission of Study of Health and Social Services and his working methods as well as to the State's compromise with general practitioners. More specifically, choosing as president Michel Clair, who had been Minister of Energy and Natural Resources under the Parti Québécois (1985), Director of the Quebec Association of Assisted Living Centres (1987-1994) and President and Chief Executive Officer of Hydro-Québec International (1997-2000), rendered the report's proposals particularly credible. The Clair Commission's *modus operandi* also helped ideas evolve about how to organize front-line care. For one thing, the Commission took care to leverage foreign experiences in order to ground the model in the best scientific evidence available. For another, it listened, considered, studied, and negotiated; it synthesized the material and solicited feedback; in short, it elevated the FMG model out of the specialized arena and secured the public support necessary to move the project through the implementation phase. As a result, the Commission did more than suggest an innovation: it worked to develop the political conditions necessary for implementation—it worked to secure the buy-in of the main stakeholders.

The extent to which the model is innovative became all the more apparent when doctors finally accepted patient registration and some extent of capitation. With this acceptance, the FMG agreement surpassed the historical relationship between doctors and the State and opened the door to the State asking doctors to adopt specific care practices and take responsibility for the health of their patient population. In Quebec's actual environment, where the National Assembly is debating the creation of a institute for excellence in health and social services that

would elaborate best practices guidelines for the care of patients with chronic disease (and indicators with which to monitor FMG doctors' adherence), this opening could have a determinative effect on the practices of general physicians (Institut national d'excellence en santé et services sociaux 2008).

Another innovation of the FMG model is the ubiquity of contracts: a contract associating doctors who work together in an FMG, a contract between the FMG and the CSSS, a contract between the FMG and the Health and Social Services Agency, and most uniquely, a contract between the registered patient and his/her physician. It is this latter that is the most ground-breaking and that doctors have had the most difficulty in accepting, not only because they fear legal recourse in the event that they should fail to respect their contractual commitment but also because patients are not penalized for consulting a doctor other than the doctor with whom they have signed a registration agreement, even though to do so causes the registered doctor to lose income. With regard to the former concern, however, it seems that both Quebecers and Canadians in general are slower to file for malpractice than are their neighbors to the south.

The State's compromise, meanwhile, was the product of significant ideological differences between the State and the FMOQ regarding remuneration methods and the organization of front-line care. The FMOQ felt that doctors should remain independent entrepreneurs paid by fee-for-service and that the State should intervene little if at all in their operations. In the past, doctors had found ways to network and increase both the range of services they offered and the hours in which they offered them, for example by facilitating patients' access to specialists by means of agreements between specialists and general practitioners. This system capitalized on the initiatives of individual physicians and involved neither patient registration nor changes in remuneration methods. The FMG model, in contrast, embodied responsibility for a given population, codified by registration and recognized by a per capita payment that was termed a "lump sum" ("forfait" in French) no doubt to sooth doctors' apprehensions. That the confrontation of these two concepts gave way to negotiations and an eventual compromise testifies firstly to the willingness of FMOQ negotiators to make concessions in order to improve the organization of front-line care and secondly to their realization that new modes of payment for FMGs, namely capitation and management fees, boosted general practitioners' revenues significantly, particularly for doctors who headed FMGs. Paid nurses and the purchase of computers contributed further to the financing of front-line care. Meanwhile, the use of capitation as a mode of remuneration lost much of its symbolic value by virtue of the fact that it applied not just to registered patients but to all vulnerable patients, and it was extended to all generalists, not just those working in FMGs. In short, the FMOQ may have accepted registration and capitation but it succeeded in protecting doctors' freedom to work either together in FMGs or solo in private clinics and in guaranteeing FMGs the latitude to partner with other clinics in order to provide care outside of normal working hours.

This said, the final configuration of FMGs enabled the State to exit a status quo that had dominated the healthcare landscape since the creation of Medicare. For the first time ever, the State convinced physicians to accept a new ideology marked by contracts between doctors, patients and the State. It did this by boosting physicians' remuneration and by valuing their operating methods without directly challenging their professional freedom: this strategy permitted doctors to save face. The victory was all the more impressive given that it took pace in a pre-electoral period during which health care was the principal campaign issue.

It will be interesting to observe whether this first shift in doctor-State relations will lead to a more authoritarian rapport whereby doctors will be required to account to the government for their care of patients. It will also be interesting to see whether this evolution in Quebec will impact other Canadian provinces (Hutchison 2008; Hutchison et al. 2001; Lamarche et al. 2003; Van Soeren et al. 2008; Wilson et al. 2004). Finally, the first wave of FMGs has already been evaluated (Ministère de la Santé et des Services sociaux 2008), but with time, more evaluations and historical perspective will allow the observer to assess whether initial objectives for FMGs are met and, what is perhaps most interesting of all, whether Quebec's new model for organizing front-line services will indeed deliver better and more cost-effective patient care.

## Endnotes

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- <sup>1</sup> Another 18% of general practitioners worked principally in FMGs, 19% worked principally in CLSCs and 1% worked in other settings (i.e. detention centres or network clinics, etc.) (Fédération des médecins omnipraticiens du Québec 2008).
- <sup>2</sup> The Commission of Study of Health and Social Services was in session from June to December 2000.
- <sup>3</sup> After the implementation of Bill 25 in 2004, CLSCs merged with residential and long-term care facilities (*Centres d'hébergement et de soins de longue durée* - CHSLDs) and in some cases with hospital centres in order to form a new local entity: Health and Social Services Centres (CSSSs) (Québec 2003).
- <sup>4</sup> Working under the new Local Health and Social Services Networks Development Agencies, the DRMGs have the mandate 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 (Québec 2008).
- <sup>5</sup> Remuneration has since increased. As of 2009, doctors receive \$8 per registered patient, around-the-clock access is paid \$56 per day of work (up from \$52 in 2003), and the doctor in charge of the FMG receives approximately \$338 per week (Régie de l'assurance maladie du Québec 2009).

## References

- Beaulieu, Marie-Dominique, Jean-Louis Denis, Danielle D'Amour, Johanne Goudreau, Jeannie Haggerty, Éveline Hudon, Guy Jobin, Lise Lamothe, Frédéric Gilbert, Hélène Guay, Guylaine Cyr, and Ronald Lebeau. 2006. L'implantation des groupes de médecine de famille: le défi de la réorganisation de la pratique et de la collaboration interprofessionnelle - Étude de cas dans cinq GMF de la première vague au Québec. Montréal: Chaire Docteur Sadok Besroun en médecine familiale.
- Beaulieu, Marie-Dominique, Marc Rioux, Guy Rocher, Louise Samson, and Laurier Boucher. 2008. "Family practice: professional identity in transition. A case study of family medicine in Canada." *Social Science & Medicine* 67:1153-63.
- Bourque, Denis. 1988. "La mise au pas tranquille des CLSC." *Nouvelles pratiques sociales* 1 (1):43-58.
- Bozzini, Luciano. 1988. "Local community services centres (CLSCs) in Quebec: Description, evaluation, perspectives." *Journal of Public Health Policy* 9 (3):346-75.
- Campbell, Bruce, and Gregory P. Marchildon, eds. 2007. *Medicare: Facts, myths, problems, promise* Halifax: James Lorimer & Company Ltd.

- Commissaire à la santé et au bien-être. 2009. Rapport d'appréciation de la performance du système de santé et de services sociaux. Améliorer notre système de santé et de services sociaux. Québec: Commissaire à la santé et au bien-être.
- Commission d'enquête sur la santé et le bien-être social. 1967. *Rapport / Commission d'enquête sur la santé et le bien-être social*. Québec: Éditeur officiel du Québec.
- Commission d'étude sur les services de santé et les services sociaux. 2000. *Report and recommendations: Emerging solutions*. Québec: Gouvernement du Québec.
- Conseil Médical du Québec. 2001. Avis sur la réorganisation des services médicaux de 1re ligne. Québec: Conseil Médical du Québec.
- Fédération des médecins omnipraticiens du Québec. 2008. Le profil de pratique des médecins omnipraticiens québécois 2006-2007. Montréal: FMOQ.
- Geneau, Robert, Pascale Lehoux, Raynald Pineault, and Paul Lamarche. 2008. "Understanding the work of general practitioners: a social science perspective on the context of medical decision making in primary care." *BMC Family Practice* 9 (12):1-10.
- Government of Canada. 1985. "Canada Health Act ( R.S., 1985, c. C-6 )".
- Haggerty, Jeannie, Raynald Pineault, Marie-Dominique Beaulieu, Yvon Brunelle, Josée Gauthier, François Goulet, and Jean Rodrigue. 2007. "Room for improvement: Patients' experiences of primary care in Quebec before major reforms." *Canadian Family Physician* 53:1056-57.
- . 2008. "Practice Features Associated With Patient-Reported Accessibility, Continuity, and Coordination of Primary Health Care." *Annals of Family Medicine* 6 (2):116-23.
- Haggerty, Jeannie, Raynald Pineault, Marie-Dominique Beaulieu, Yvon Brunelle, François Goulet, Jean Rodrigue, and Josée Gauthier. 2004. Continuité et accessibilité des soins de première ligne au Québec: Barrières et facteurs facilitants - Rapport final. Montréal: CHUM.
- Hofmarcher, Maria M., Howard Oxley, and Elena Rusticelli. 2007. Improved health system performance through better care coordination. OECD Health Working Paper No. 30. Paris: Organisation for Economic Co-operation and Development.
- Hudon, Raymond, Rachel Mathieu, and Elisabeth Martin. 2009. "Pouvoir médical et interventions législatives au Québec (2001-2008)." *Recherches sociographiques* 50 (2):255-81.
- Hutchison, Brian. 2008. "A Long Time Coming: Primary Healthcare Renewal in Canada." *Healthcare Papers* 8 (2):10-23.
- Hutchison, Brian, Julia Abelson, and John N. Lavis. 2001. "Primary care in Canada: so much innovation, so little change." *Health Affairs* 20 (3):116-31.
- Institut national d'excellence en santé et services sociaux. 2008. Rapport du comité d'implantation de l'Institut national d'excellence en santé et services sociaux (INESSS). Québec: Ministère de la Santé et des Services sociaux.

- Lafortune, Gaétan, and Gaëlle Balestat. 2007. Trends in severe disability among elderly people: Assessing the evidence in 12 OECD countries and the future implications. OECD Health Working Papers, No. 26. Paris: Organisation for Economic Co-operation and Development.
- Lamarche, Paul, Marie-Dominique Beaulieu, Raynald Pineault, André-Pierre Contandriopoulos, Jean-Louis Denis, and Jeannie Haggerty. 2003. Sur la voie du changement: Pistes à suivre pour restructurer les services de santé de première ligne au Canada. Ottawa: Fondation canadienne de la recherche sur les services de santé.
- Lavis, John N. 2004. "Political elites and their influence on health care reform in Canada." In *The governance of health care in Canada, Romanow Papers, volume 3*, edited by T. McIntosh, P.-G. Forest and G. P. Marchildon. Toronto: University of Toronto Press.
- Ministère de la Santé et des Services sociaux. 1987. Rapport du Comité de réflexions et d'analyse des services dispensés par les CLSC. Québec: Ministère de la Santé et des Services sociaux.
- . 1999. Relever ensemble le défi des urgences: Plan d'action issu du Forum sur la situation dans les urgences Québec: Ministère de la santé et des services sociaux.
- . 2002. Groupes de médecine de famille: Document synthèse. Québec: Ministère de la Santé et des Services sociaux.
- . 2003. Devenir un GMF: Guide d'accompagnement. Québec: Ministère de la Santé et des Services sociaux.
- . 2008. Évaluation de l'implantation et des effets des premiers groupes de médecine de famille au Québec. Québec: Ministère de la Santé et des Services sociaux.
- . 2009. *Groupe de médecine de famille. Qu'est-ce qu'un groupe de médecine de famille (GMF)?* Ministère de la Santé et des Services sociaux 2009 [cited October 1st 2009]. Available from <http://www.msss.gouv.qc.ca/sujets/organisation/gmf/index.php?accueil-fr>.
- Nolte, Ellen, and Martin McKee, eds. 2008. *Caring for people with chronic conditions: A health system perspective, European Observatory on Health Systems and Policies series* Maidenhead: Open University Press.
- Pineault, Raynald, Pierre Tousignant, Danièle Roberge, Paul Lamarche, Daniel Reinharz, Danielle Larouche, Ginette Beaulne, and Dominique Lesage. 2005. Collectif de recherche sur l'organisation des services de santé de première ligne au Québec: rapport synthèse. Montréal: Collectif de recherche sur l'organisation des services de santé de première ligne au Québec.
- Premier's Advisory Council on Health for Alberta. 2002. A framework for reform: Report of the Premier's Advisory Council on Health. Alberta: Premier's Advisory Council on Health (Commissioner Don Mazankowski).
- Québec. 2003. *Loi sur les agences de développement de réseaux locaux de services de santé et de services sociaux, L.R.Q., chapitre A-8.1*. Québec: Éditeur officiel du Québec.
- . 2008. *Loi sur les services de santé et les services sociaux, L.R.Q., chapitre S-4.2*. Québec: Éditeur officiel du Québec

- Régie de l'assurance maladie du Québec. 2009. *Aide-mémoire pour la facturation GMF*. RAMQ 2009 [cited October 1st 2009]. Available from <http://www.ramq.gouv.qc.ca/fr/professionnels/medomni/gmf/gmf.shtml>.
- Rioux, Marc. 2008. "La réforme des soins et services de première ligne au Québec: l'exemple des groupes de médecine de famille." In *Les réformes en santé et en justice: le droit et la gouvernance*, edited by P. Laborier, P. Noreau, M. Rioux and G. Rocher. Québec: Les Presses de l'Université Laval.
- Romanow, Roy J. 2002. *Building on values: the future of health care in Canada*. Ottawa: Commission on the Future of Health Care in Canada,.
- Royal Commission on Health Services. 1964. Royal Commission on Health Services: 1964: Volume I & 2.
- Saltman, Richard, Ana Rico, and Wienke G. W. Boerma, eds. 2006. *Primary care in the driver's seat? Organizational reform in European primary care*. Edited by J. Figueras, M. McKee, E. Mossialos and R. Saltman, *European Observatory on Health Systems and Policies Series*. Glasgow: Open University Press.
- Saskatchewan Commission on Medicare. 2001. *Caring for Medicare: Sustaining a quality system*. Saskatchewan: Commission on Medicare (Commissioner Kenneth J. Fyke).
- Sassi, Franco, and Jeremy Hurst. 2008. The prevention of lifestyle-related chronic diseases: An economic framework. OECD Health Working Papers, No. 32. Paris: Organisation for Economic Co-operation and Development.
- 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):103-34.
- Starfield, Barbara. 1998. *Primary care: Balancing health needs, services and technology*. Oxford: Oxford University Press.
- The College of Family Physicians of Canada. *Primary Care and Family Medicine in Canada: A Prescription for Renewal* 2000 [cited September 30th 2009. Available from <http://www.cfpc.ca/English/CFPC/communications/health%20policy/primary%20care%20and%20family%20medicine/default.asp?s=1>.
- The Standing Senate Committee on Social Affairs Science and Technology. 2002. *The Health of Canadians – The Federal Role*. Final Report. Canada: The Senate.
- Turgeon, Jean, Hervé Anctil, and Joël Gauthier. 2003. "L'évolution du Ministère et du réseau: continuité ou rupture." In *Le système de santé du Québec : organisations, acteurs et enjeux*, edited by V. Lemieux, P. Bergeron, C. Bégin and G. Bélanger. Sainte-Foy: Les Presses de l'Université Laval.
- Van Soeren, Mary, Christina Chorostecki-Hurlock, and Jane Sanders. 2008. "Primary healthcare renewal in Canada: A glass half empty." *Healthcare Papers* 8 (2):39-44.
- Wilson, Ruth, Samuel Shortt, and John Dorland, eds. 2004. *Implementing primary care reform: Barriers and facilitators*. Montreal & Kingston: School of Policy Studies.