Editorial

Primary Care in Québec at the Crossroads

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Through all the rapid demographic and epidemiologic changes that have an impact on our healthcare systems, there is one clear global consensus: primary care, and in particular Family Medicine, is the foundation for a sustainable health care system capable of promoting health and meeting the healthcare needs of the population.

Chronic disease, in the context of an aging population, is recognised as the main driver of mortality and morbidity resulting in increased complexity and multi-morbidity. There is a clear understanding of the impact of socio-economic and environmental factors and of the importance of health promotion and prevention. Finally, technological developments have created new hopes and expectations in what has come to be known as personalized medicine or personalized healthcare.

We also live in a rapidly changing healthcare system where care is increasingly moving from institutions to networks of care, often community-based; from a single professional, generally a physician, to a team of health care professionals; with increasing expectations, knowledge and involvement of patients, families and communities. Why is primary care seen as the way forward? There is evidence that health systems with very strong primary care are more effective and efficient, with better health outcomes (1, 2). But there is also one very practical and simple reason: the patients and the population are overwhelmingly in the community (3)! And there are many more reasons: primary care is the first contact with the healthcare system in over 90% of patient-MD encounters, and is the locus of longitudinal experience with the patient and family. Primary care clinicians are the best trained and equipped to deal with chronic disease and complex patients in the community, best positioned to promote wellness and prevention, and best positioned to deal with mental health issues.

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For many years, primary care was usually given by the trusted GP in solo practice with a close relationship to his/her patients but whose only training was a 12-month hospital-based internship. By the eighties and nineties, family physicians were required to complete a 2-year accredited training program. Increasingly physicians went into group practices, which were essentially shared offices.

In 2000, the Clair Commission (4) stated simply but very clearly that primary care was the foundation of a sustainable healthcare system and proposed the creation of the Family Medicine Groups, best known by its French acronym, the GMF (*Groupe de médecine de famille*). Implementation began rapidly in 2001 about the same time as the creation of the Family Health Teams (FHTs) in Ontario. The GMFs and the FHTs were in fact the world pioneers of what would later be coined by some as the 'medical home'. This approach is promoted by the College of Family Physicians of Canada (5), and has become the basis for primary medical reform in most provinces and countries around the globe.

The GMFs as originally conceived (we can call it GMF 1.0) were meant to be interdisciplinary practices with physicians and nurses (and eventually other healthcare professionals) responsible for the health and healthcare of a defined (registered) population. The GMFs were promoted by successive governments, supported by the
population and even became key promises in successive elections. Today, about 60% of Québec's family physicians practice in 280 GMFs, which cover over 45% of the Québec population.

However, accessibility as well as continuity of care and coordination clearly became the focus of a great deal of dissatisfaction in the population and frustration for clinicians. The government set out clear objectives to solve the accessibility problem: increasing the number of family physicians in the community by increasing the proportion of residency slots for family medicine (target of 55%), creating incentives and regulations for family physicians to increase the number of registered patients in community-based practices, and regulations to decrease the presence of family physicians and increase that of specialists in hospitals. The government also promoted increased accessibility of registered patients to their GMF through 'advanced access' and incentives to achieve a high level of '*assiduité*' (patient utilisation of their own GMF for their primary care rather than using the hospital emergency departments or other clinics). The government also supported the development and expansion of GMFs by increasing the number and category of healthcare professionals including nurses, nurse practitioners, social workers and pharmacists, and the implementation of electronic medical records. We are now moving into the GMF 2.0.

The population, as well as clinicians and administrators, was generally in agreement with most of the government's objectives. But rather quickly, a serious malaise developed and has persisted on how these changes were conceived and implemented; with a series of rapid, top-down changes imposed by Law 10, Law 20, and with the last-minute compromise with the *Fédération des médecins omnipraticiens du Québec* (FMOQ), as well as two new management frameworks not widely known to the public.

There is a consensus among healthcare system observers and the media that was also expressed by the speakers and the over 300 participants (patient representatives, clinicians, managers, as well as students and residents) at the May 2016 primary care policy conference (6, 7) organised by the McGill Department of Family Medicine and the Institute for Health and Social Policy: respectful public discussion mobilizing stakeholders has been replaced by denigration, threats, and a top-down approach driven by union negotiation; there has been overreliance on fee-for-service-based economic incentives for physicians to improve 'productivity'; there has been excessive centralization and micro-management by the ministry; there has been little reference to quality improvement or to the necessary transformation of the clinical model. There is also concern about contradictory measures such as depleting hospitals and emergency departments of the important contribution of family physicians or creating 'super-clinics' and at the same time penalizing GMFs if their patients seek care elsewhere. Similarly, the number of residency positions in family medicine continues to increase, but confusing regulations and implementation as well as lack of transparency has resulted in numerous residents left in limbo for extended periods of time. Many were not able to find positions after completing their training (8).

There is no doubt that primary care is at a crossroads in Quebec. Physicians are now in the era of double accountability: the traditional accountability to the individual patient is necessary but no longer sufficient. Physicians are now also accountable to the

population for population health outcomes, and to government for relevance and costs (9).

While recognizing the importance of remuneration and working conditions, observers, pundits and the population are challenging Family Medicine 'to take back the debate', to move away from the dominating focus of unions and government negotiation centred mainly on monetary/productivity issues, and to become active and proactive on the core primary care issues of health outcomes, relevance, quality and accessibility.

What are some of the key elements of GMF 3.0 that can be implemented through a bottom up approach without requesting legislation or permission?

1. A collaborative, interdisciplinary approach based on the partnership between the primary care team (physician, nurse and other healthcare professionals) and the patient /family, and on the patient experience at the core of the clinical model, emphasizing quality and accessibility; proactive comprehensive care with each family physician and clinical team responsible for the full range of timely accessible care including health promotion and prevention and care management for chronic disease; utilizing a public health approach with demographic and socio-economic patient and community data.
2. Accountability to the community/population based upon clear quality and management objectives; patient, population, clinician and community engagement and responsibility through local governance of GMFs based on transparency and accountability.
3. Continuous quality improvement based upon a peer-led process.
4. Change based upon a user-centered design process and iterative improvement based on evaluation as well as on innovation and entrepreneurship, which promotes diversity and pluralism rather than a one-size-fits-all approach.

Ideally, the GMFs themselves will develop initiatives to begin carrying out these changes with support from the *Collège québécois des médecins de famille* as well as from managers and decision makers in the CISSS/CIUSSS and at the ministry.

Academic family medicine is well positioned to provide leadership for these changes. Over the past four decades, the four university Departments of Family Medicine have grown from small training programs to large academic departments, fully recognized and appreciated as academic disciplines in their Faculties of Medicine. For example, our McGill Department of Family Medicine, functioning in both English and French, spans 6 Family Medicine Units (now known as *Groupes de médecine de famille-universitaire* (GMF-U)), in Montreal, Chateauguay, Gatineau and Val D'Or. They offer interdisciplinary comprehensive family medicine as well as innovative services in chronic disease management, infant and maternal health, adolescent health, care of older persons, and care for refugee and immigrant populations. Beyond the borders of our Family Medicine Units, our teachers and preceptors are present in almost every region in Québec looking after very diverse patients, including indigenous populations. Our research and graduate study programs with over 25 PhD and clinician scientist professors as well 85 MSc, PhD and post-doctoral students in our graduate programs (unique in the world) also reflect this commitment to improving the health of the population and our healthcare system through a community- and patient-centered approach.

Successful change also requires developing and promoting a shared vision among decision makers and managers in the ministry and at all levels of our healthcare system, among clinicians and in the population. The McGill Observatory on Health and Social Services Reforms, founded jointly by the McGill Institute for Health and Social Policy and the Department of Family Medicine in 2016, aims to support and promote evidence-informed health policies through the pursuit of a systematic, interdisciplinary scientific program of policy analysis of health reforms and the monitoring of impact indicators based on key stakeholders' perspectives. It will also promote engagement, exchange and public discussion among stakeholders.

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